

Incorporating HIV/AIDS Concerns into Participatory Rural Extension.

A Multi-Sectoral Approach for Southern Province, Zambia

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Foreword

This report is the result of a six-month project carried out by a consultant team of the Centre for Advanced Training in Rural Development (SLE), Humboldt University Berlin at request of the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ). The team members with exception of the team leader and the Zambian team member, participated in the 38th annual training course. The consultant team was composed of an agricultural scientist, a cultural anthropologist, a human nutritionist, a political scientist and a sociologist.

The project was conducted in close collaboration with the HIV/AIDS Project at GTZ headquarters, the technical co-operation projects operating in three different sectors in Southern Province Zambia and their local partners, the ASIP Support Programme (Agriculture), the District Development Programme, and the Reproductive Health Project.

Interdisciplinary consultancy projects are an integral part of SLE's training programme. The programme aims at preparing young professionals for assignments in bilateral and multilateral development organisations. Thereby, participants obtain valuable practice in using action- and decision-oriented appraisal methods. At the same time, projects contribute directly to identifying and solving problems in rural development.

In 2000, the four groups of SLE's 38th course simultaneously conducted projects in Brazil, India, Peru, and Zambia.

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We benefited greatly from the advice of a number of persons in preparing the project, in particular from Daphne Topuzis, Desiree Dietvorst, Brigitte Jordan as well as Albert Engel, GTZ, and Oyvind Thiis, UNAIDS. Many constructive comments for the field work and on the report were provided by Dierk Hesselbach and Bernd Schubert. Also, the many valuable contributions of Dick Siame throughout the project have to be mentioned.

The project would not have been possible without the interest, support and open spirit of the rural communities, especially of Sikalongo settlement and of Siakayuwa village in Choma District. We would like to express a very special sincere thanks to Dr. Bbalo who supported us in many ways not only in his

function as Provincial Agriculture Co-ordinator, but who made this a special personal experience for the team.

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List of Abbreviations

ABC	-	<u>A</u> bstinence, <u>B</u> e faithful, use <u>C</u> ondoms
AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	Antenatal Care
ASIP	-	Agricultural Sector Investment Programme
ASSP	-	Agricultural Sector Investment Programme / Southern Province
CAP	-	Community Action Plan
CATAD	-	Centre for Advanced Training in Rural Development
CAW	-	Community Agricultural Workers
CBoH	-	Central Board of Health
CHW	-	Community Health Worker
DACO	-	District Agricultural Co-ordinating Officer
DDCC	-	District Development Co-ordination Committee
ddp	-	District Development Project
ddp-sp	-	District Development Project - Southern Province
DHB	-	District Health Board
DHMT	-	District Health Management Team
DPU	-	District Planning Unit
FAO	-	Food and Agriculture Organization of the United Nations
GOC	-	Gender Operation Cycle
GPEA	-	Gender Sensitive Participatory Extension Approach
GTZ	-	Deutsche Gesellschaft für Technische Zusammenarbeit
HIV	-	Human Immunodeficiency Virus
IFAD	-	International Fund for Agricultural Development
M+E	-	Monitoring and Evaluation
MAFF-		Ministry of Agriculture, Food and Fisheries
MLGH	-	Ministry of Local Government and Housing
MoH	-	Ministry of Health
NGO	-	Non Governmental Organisation
PACO	-	Provincial Agricultural Co-ordinating Officer
PE Cycle	-	Participatory Extension Operation Cycle
PEA	-	Participatory Extension Approach
PID	-	Participatory Integrated Development
PLA	-	Participatory Learning for Action Methodology

PRA	-	Participatory Rural Appraisal
PSRP	-	Public Sector Reform Programme
SAO	-	Senior Agricultural Officer
STD	-	Sexual Transmitted Disease
T + V	-	Training and Visit
TB	-	Tuberculosis
TBA	-	Traditional Birth Attendant
UNAIDS	-	Joint United Nations Programme on HIV/AIDS
WHO	-	World Health Organization

Summary

1.

Zambia is one of the sub-Saharan countries with the highest prevalence rate of HIV/AIDS infections estimated to be at nearly 20% for the population aged 15-49 years. Around 1 million Zambians are currently living with HIV or AIDS. The impact of HIV/AIDS is devastating and nearly all aspects of society are affected. According to official figures, life expectancy at birth has dropped below 40 years by 1999 as compared to over 52 years in 1980. The number of orphans is estimated to be well over 500,000 by the end of 2000.

2.

Rural households are not only affected through the loss of labour and the burden of caring for the sick and orphans, but also through the resulting negative impacts in agricultural production. The pandemic has serious implications for food security and rural income. Furthermore, in rural areas the availability of services for HIV/AIDS prevention and awareness building is low. Related activities of governmental and non-governmental organisations (NGOs) that could provide such services are often concentrated in urban areas. Service providers active in rural areas are mostly not capable to assist rural communities in improving their HIV/AIDS prevention and coping strategies.

As a result, development efforts in rural areas are increasingly counteracted by impacts of HIV/AIDS. This trend can only be stopped if HIV/AIDS concerns are addressed effectively. However, there is a lack of information and of experience on how to respond to HIV/AIDS effectively and on how to implement joint action of service institutions and development agencies alike.

3.

A three-month project was conducted by the Centre of Advanced Training in Rural Development (CATAD), Humboldt University Berlin, with support from the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ). This project is based on two considerations: (1) A response to HIV/AIDS must be multi-sectoral and (2) Service Providers in rural areas have to be enabled to assist rural communities in their HIV/AIDS prevention and coping strategies.

Taking rural extension approaches as an entry point, the objective of the CATAD project is: (1) To incorporate HIV/AIDS concerns into participatory extension approaches and (2) To develop a framework for multi-sectoral strategies on HIV/AIDS in rural areas. Choma District in the Southern Province of Zambia was chosen as pilot area for the project. Key results include (1) a concept for a HIV/AIDS sensitisation training of rural extension workers, (2) a framework for conducting village workshops focusing on HIV/AIDS that is based on adjustments of the participatory extension approach and (3) recommendations for an institutional mechanism at district level that allows for better co-ordination and multi-sectoral responses to HIV/AIDS.

4.

Since 1994, national HIV/AIDS policies in Zambia have emphasised the importance of multi-sectoral approaches in responding to the HIV/AIDS pandemic. Government departments have been asked to elaborate specific HIV/AIDS responses, supplemented by the introduction of AIDS focal point persons within each ministry. However, multi-sectoral approaches that include government departments and NGOs are still facing structural difficulties. At district level, the district administration, which has the mandate to co-ordinate development activities, is constrained by weak technical and financial capacities. At the same time, the tasks of AIDS focal point persons in the various ministries are not clearly defined. At last, methodological problems regarding how to approach communities on sensitive topics such as HIV/AIDS hinder effective responses of extension and service providers.

5.

Participatory extension approaches (PEA) as applied by the Ministry of Agriculture, Food and Fisheries (MAFF) serve as an ideal entry point to address the topic of HIV/AIDS in village workshops. This revealed test village workshops as well as experiences with the so-called Gender Operation Cycle (GOC). In some cases, participatory approaches under the Ministry of Health (MoH) and the Ministry of Local Government and Housing (MLGH), i.e. the district administration may be the appropriate choice. When using PEA, slight modifications of the methodology are necessary. Provisions for information and demonstration sessions have to be made and it is important that potential coping strategies are discussed.

6.

Up to now, field workers did not hold specific village workshops focusing on HIV/AIDS. Specific training sessions for agricultural extension workers on HIV/AIDS never took place. Therefore, the elaboration of a training concept required a survey among extension workers, to identify the training needs. Furthermore, a village survey was conducted on assumed inhibitions and taboos related to HIV/AIDS and sexual behaviour.

The results of this surveys provide the base for the training concept.

7.

A training concept for multi-sectoral teams of field workers was elaborated and tested. After completing such a training, extension workers should have the capacity to conduct in a team participatory workshops on HIV/AIDS in rural communities. Multi-sectoral teams were composed by at least one health worker and one field worker from MoH and two agricultural extension workers servicing the villages in which subsequent HIV/AIDS workshops will be conducted.

A detailed training manual contained in the full report (see Annex B) may serve as a guideline for trainers and the workshop organisers, providing information on the objectives, contents and process of each training session. A four-day workshop was designed to train multi-sectoral teams of field workers in basic knowledge on HIV/AIDS, on prevention and coping strategies for HIV/AIDS and on participatory extension approaches addressing HIV/AIDS issues at village level. The last part of the workshop is dedicated to the preparation of subsequent village workshops.

8.

The study provides a framework for conducting workshops at village level focusing on HIV/AIDS. As these village workshops are based on a participatory extension approach, concerns related to HIV/AIDS can be addressed using selected tools. While PEAs related merely to agriculture draw heavily on indigenous knowledge and own experimentation by target groups, the HIV/AIDS related PEAs have first to create knowledge and awareness and then jointly to develop prevention and coping strategies. Thus, the aim of the HIV/AIDS village workshops is to create awareness and to improve the rural communities' capacity of coping with the impacts of HIV/AIDS.

Recommendations

Addressing HIV/AIDS at the Community Level

Recommendation 1 (a):

Special community workshops focussing on HIV/AIDS should be conducted by multi-sectoral teams, using the PEA methodology as a flexible frame for discussing HIV/AIDS-related issues.

Recommendation 1 (b):

PEA village workshops have to be conducted before addressing HIV/AIDS in a community.

Recommendation 1 (c):

It is advised to go through a GOC, preferably before conducting a workshop on HIV/AIDS. This will enhance gender awareness and behaviour changes in the communities.

Recommendation 1 (d):

It is recommended that a field guide is published as soon as possible to assist extension specialists and field staff in planning and conducting village workshops on HIV/AIDS.

Recommendation 1 (e):

By the end of 2003, multi-sectoral teams should have reached at least 50% of the communities in Choma District with HIV/AIDS workshops. That means that each agricultural extension worker will have conducted workshops in ten villages.

Recommendation 1(f):

It is recommended to harmonise the currently inhibiting separation into different administrative areas of the various sector ministries.

Recommendation 1 (g):

It is recommended to incorporate costs for village workshops and follow-up activities related to HIV/AIDS in the district budgets of the respective ministries.

HIV/AIDS Training for Field Staff

Recommendation 2 (a)

The concept for HIV/AIDS training contained in this report should be adopted and be widely used by MAFF, MoH, and other organisations to train field staff in rural areas. By 2003, all respective field staff in Choma District should be trained in conducting HIV/AIDS workshop at the community level.

Recommendation 2 (b):

It is recommended to publish a HIV/AIDS training manual based on the concept proposed by the SLE team.

Recommendation 2 (c):

It is suggested to continuously adapt the training concept based on the lessons learnt.

Developing an Institutional Framework for Implementing a Multi-sectoral Response to HIV/AIDS in Choma District**Recommendation 3 (a):**

It is recommended to the institutions concerned to set up an institutional framework under the District Council/Administration, which provides a sustainable mechanism and has the capacity to co-ordinate HIV/AIDS-related activities at district level.

Recommendation 3 (b):

For Choma, a task force at the District Council should be established as soon as possible, as the suitable option for an institutional framework. The task force will

- elaborate a strategy and policy for preventing and coping with HIV/AIDS;
- define the role of the various actors and focal points in implementing activities; and
- co-ordinate HIV/AIDS-related activities in the district.

Recommendation 3 (c):

It is recommended to establish a full time secretariat to provide adequate support and reporting to the task force and the required operational capacity for assuming day-to-day responsibility.

Visual Means and Sensitisation Materials**Recommendation 4 (a):**

The district administration in co-operation with the ministries concerned is advised to develop and produce sensitisation materials for target groups. Their availability to senior officers, field staff and as well as for rural communities (e.g. through district and community health posts) has to be ensured. Brochures and posters should be written in local language.

Recommendation 4 (b):

Condom distribution by projects, ministries and others should be continued. It should not be limited to staff members and Zambian co-operating partners only, but include target groups as well. This could be facilitated through the proposed HIV/AIDS Secretariat with support of GTZ.

HIV/AIDS Response within the Ministry of Agriculture, Food and Fisheries

Recommendation 5 (a):

It is recommended that also the role and duties within the organisation of both district and provincial HIV/AIDS focal point persons are made explicit and transparent.

Recommendation 5 (b):

It is recommended that relevant parts of the training concept be integrated within basic and advanced training activities, i.e. respective training manuals of MAFF for trainers and staff should be revised. For example, HIV/AIDS awareness building and multi-sectoral activities should be incorporated into training curricula for agricultural extensionists (including agricultural colleges and in-service training centres).

Introduction

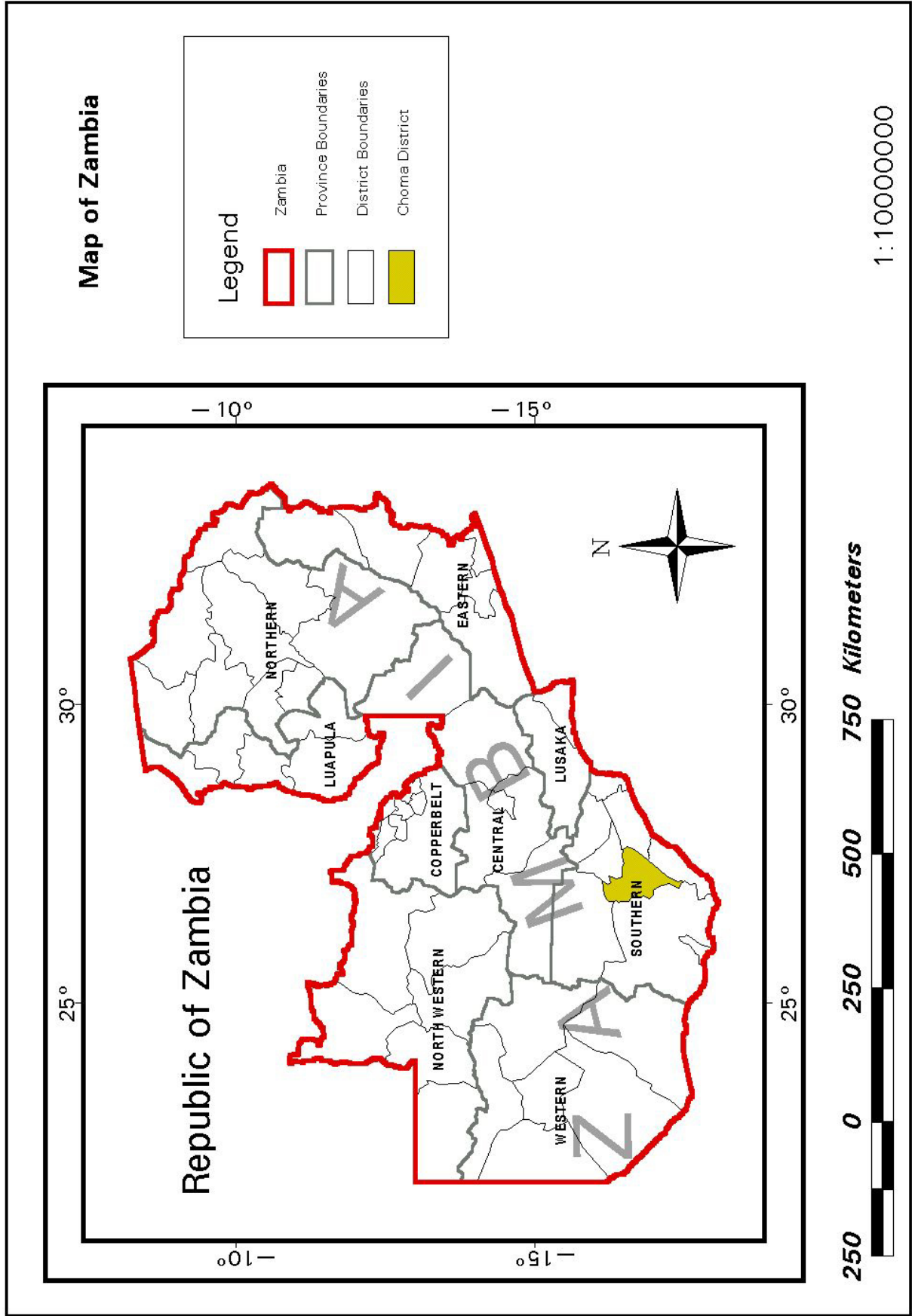
About 34 million people are living with HIV/AIDS world-wide, with Africa being the continent most severely affected. One of the sub-Saharan African countries with a very high prevalence of the pandemic is Zambia: Nearly 20% for the population aged between 15 and 49 years are estimated to be infected with HIV/AIDS. In other words, around 1 million out of the total population of 10 million Zambian people are currently living with HIV or AIDS (MoH/CBoH 1999:11).

HIV/AIDS has numerous devastating social and economic impacts not only on individual households, but also on the Zambian society as a whole. Yet as one of the poorest countries in Africa, Zambia has only very limited resources to tackle the resulting problems of the pandemic. For example, the health sector is in dire need for equipment and financial resources, while the Zambian economy is affected by the loss of labour and

Republic of Zambia

Area:	752,614 sq-km
Population:	10.5 Mio.
Pop. growth:	3.1%
Pop. density:	11.7 per sq-km
GNP (US-\$):	3,385 Mio. (1999)
GNP/per cap.:	322 US-\$
Debt (US-\$):	6,518 Mio.
Inflation:	21% p. a.

trained personnel (through death, illness, caring for the sick and orphans, etc.). Rural households are highly exposed to the risks and impacts of the pandemic, although the prevalence of HIV/AIDS is currently higher in urban areas as compared to rural areas. However, rural households depend mainly on labour-intensive agricultural production. The loss of labour has, thus, a direct negative impact on their income situation and their food security. Repeated incidence of death and illness as well as the increasing number of orphans that have to be looked after undermined the existing traditional safety nets.



In addition to that, the availability of services for HIV/AIDS prevention and awareness building is low in rural areas. Most governmental and non-governmental organisations (NGOs) that could provide such services are concentrated in urban areas. Other service providers lack the experience and capacity to respond to concerns arising from HIV/AIDS. Moreover, service providers themselves are also directly affected by HIV/AIDS, e.g. through the loss of trained personnel or high levels of absenteeism due to funerals and illness.¹

As a result, development efforts in rural areas are increasingly counteracted by impacts of HIV/AIDS. This trend can only be stopped if the effects and the spread of HIV/AIDS are addressed effectively. Yet Zambian service providers as well as international development agencies have inadequate information and experience on how to respond to HIV/AIDS effectively and on how to implement joint actions in rural areas.

Entry Point and Objectives of the CATAD Project

Given the magnitude of the HIV/AIDS pandemic in Zambia that affects virtually all aspects of society, the CATAD project is based on two main considerations:

1. A response to HIV/AIDS must be multi-sectoral. HIV/AIDS is a cross-cutting problem related to complex issues such as the change of sexual behaviour. This and the devastating impacts of the pandemic go far beyond the limited capacities and reach of single government ministries or other organisations. Thus, effective responses to HIV/AIDS have to build on co-ordinated activities of different governmental and non-governmental actors. Since the mid-1990s, multi-sectoral approaches are advocated and promoted by the Zambian government (see chapter 3) as well as by international organisations and development agencies (see BMZ 1998; WORLD BANK 1999; FAO/UNAIDS 1999; for GTZ see HEMRICH & SCHNEIDER 1997).

2. Service providers in rural areas have to be enabled to assist rural communities in their HIV/AIDS prevention and coping strategies. At the moment, most rural extension and service providers are ill-equipped to fulfil this task. Yet at community level, field workers often use participatory approaches that can be used as an entry point to address HIV/AIDS in village workshops. The advantages of participatory approaches, especially the

¹ LOEWENSON (1998:11) reports that in Zimbabwe 15% of agricultural extension workers have died in one province alone.

Participatory Extension Approach (PEA) of the Ministry of Agriculture, Food and Fisheries (MAFF),² are described in detail in chapter 4.

Based on these considerations the **objectives** of the CATAD project were defined as follows:

- **To incorporate HIV/AIDS concerns into participatory extension approaches in Choma District/Southern Province;**
- **To develop a framework for multi-sectoral strategies on HIV/AIDS in rural areas.**

These objectives should serve the **overall goal** of the project: **to improve the ability of the rural population and service institutions to prevent the spread of HIV/AIDS and to cope with the impacts of the disease.** As can be derived from the project objectives, our ultimate focus is on how best to assist rural communities and to train field workers to improve their services.³

Procedure of the CATAD Project

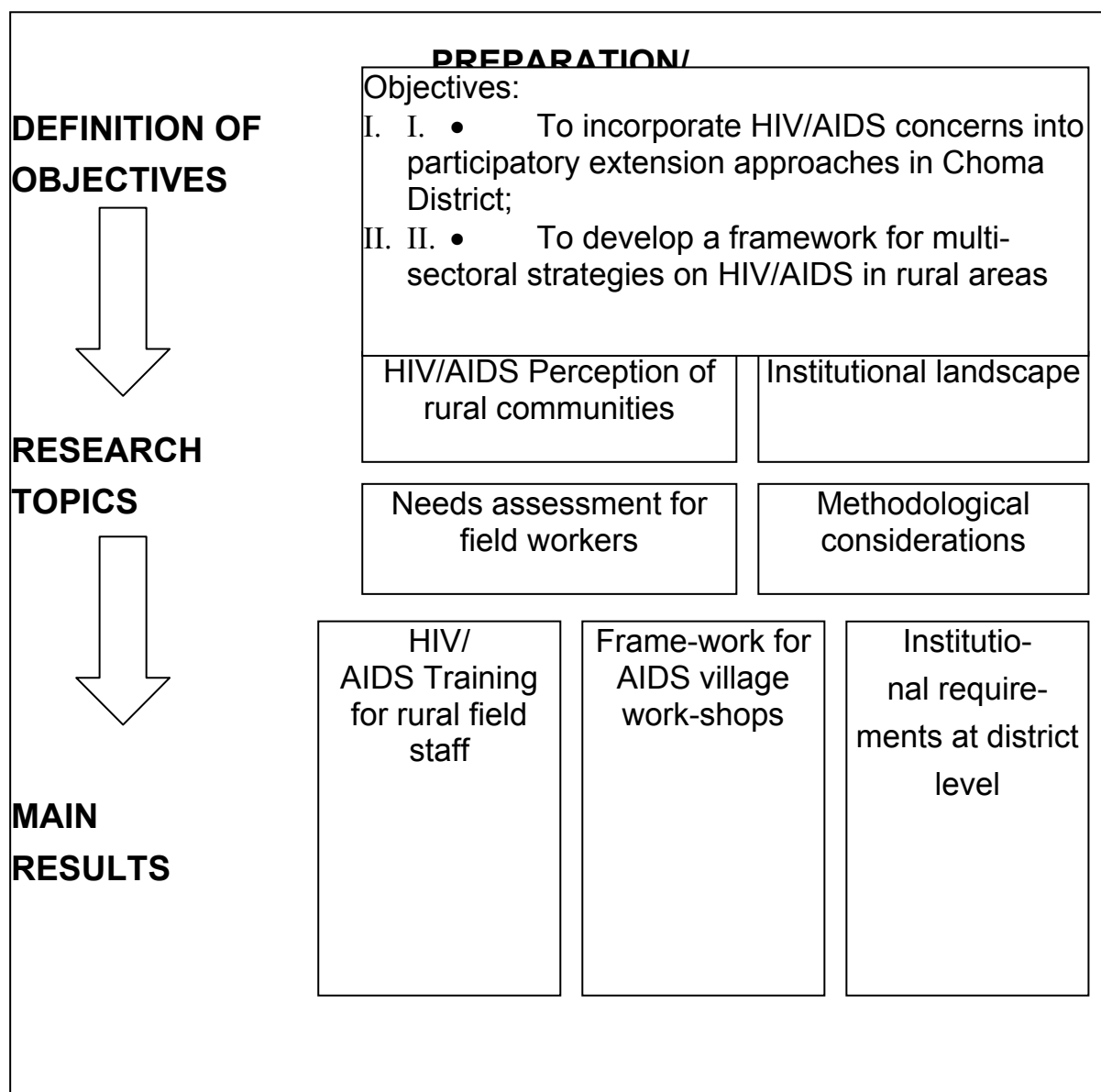
The findings and results of the CATAD project were based on a six- week preparatory phase in Berlin, Germany,⁴ and a three month- research stay in Zambia (for details see the timetable in annex A). Choma District in the Southern Province of Zambia was chosen as a pilot area for the CATAD project, because it has the logistical advantage that all three co-operating GTZ projects were located or, at least, active in the district (for details on Choma District see the box and the map at the end of this chapter).

As the following illustration shows, after having defined and discussed the objectives of the project, the research started in four main areas. The findings of these research topics shaped our final results.

² Other ministries use similar participatory approaches. For example, the District Development Projects (ddp) assisted by GTZ under the mandate of the Ministry of Local Government and Housing use a participatory integrated development approach. Participatory approaches are also applied by the Ministry of Health. For details see chapter four.

³ We also consider the direct impact of HIV/AIDS on service providers themselves (e.g. loss of trained staff, high level of absenteeism, etc.) as serious. However, due to the limited time frame of the project we decided to give priority to training of rural field workers in awareness raising and assistance to rural communities in issues related to HIV/AIDS. Addressing the existing limited knowledge among rural communities on HIV/AIDS has a immediate and direct impact. However, we consider that a sensitisation training for field staff has a positive effect on these service providers, e.g. through increased awareness of the necessity to address growing institutional inefficiencies.

Achtung Daniel: Grafik Auswechseln



about the pandemic in village workshops. To answer this question we analysed existing literature, conducted guided (individual and group) interviews with villagers and observed PEA as well as HIV/AIDS village workshops. The results are presented in the chapters 2 and 5.

The second research topic dealt with the overall institutional infrastructure of service providers as well as HIV/AIDS related activities of different governmental and non-governmental organisations in Choma District. The findings of our analysis, important for designing a multi-sectoral approach, are given in the chapters 3 and 4.

The third research topic was related to the methodology of participatory approaches used in the Southern Province. In how far can these approaches

⁴ In June, we got valuable assistance from Mrs. Mulamfu (CBoH/GTZ), Dr. Siame (ddp/GTZ) and Dr. Bbalo (PACO/MAFF) who joined the group for two weeks.

be used to address HIV/AIDS in village workshops and what kind of modifications are necessary? The findings of our analysis, which is based on participatory observations, interviews and a HIV/AIDS specific assessment of PEA results, are given in chapter 4.

Last, but not least, we asked for training needs of field workers regarding their knowledge on HIV/AIDS as well as their perceptions and attitudes. Therefore, we conducted a HIV/AIDS specific needs assessment with agricultural extension workers from Choma District. The findings of this needs assessment, which were a basic precondition for the design of our HIV/AIDS training concept, are presented in chapter 5.

As already indicated, one of the most important results of the CATAD project is the elaboration of a HIV/AIDS sensitisation training for field workers. In this context, a first pilot training workshop for field workers from the Ministry of Health (MoH) and MAFF and MoH was conducted from 5th to 7th September 2000, followed by two HIV/AIDS workshops in two villages (Sikalongo and Siakayuwa). The experiences drawn from these activities, complemented by written and oral evaluations by the participating extension workers and villagers, led to the modified design of the HIV/AIDS training as it is presented in chapter 6. A detailed manual for trainers and organisers of this training is given in Annex B.

Another important result of the CATAD project is given in chapter 7. Based on our observations and the lessons learnt from three HIV/AIDS village workshops, we propose a framework for conducting HIV/AIDS specific village workshops based on slight modifications of the PEA methodology. It should be noted, however, that the design of both the training concept and the village workshops serve as a starting point to address issues related to HIV/AIDS in rural communities. After the implementation of the proposed HIV/AIDS related training and village workshops, it might, in the longer run, be necessary to modify the design of the workshops to take into account the changing needs of extension workers and rural communities.

Finally, as part of our recommendations given in chapter 8, we suggest also an institutional mechanism at district level that take existing constraints into consideration and allows for a better co-ordination of HIV/AIDS related activities and the joint implementation of multi-sectoral responses.

Choma District

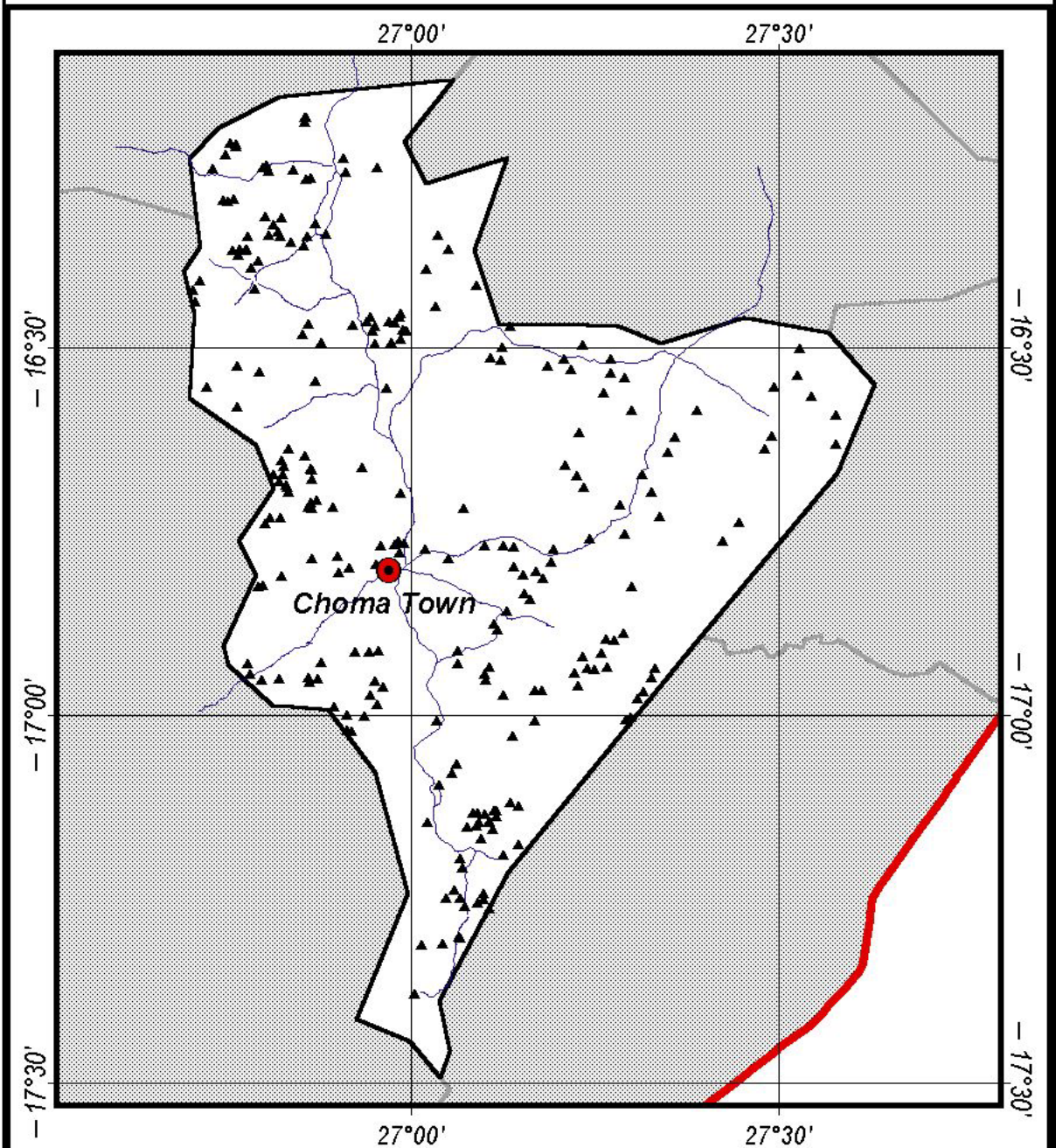
Choma District lies within the plateau of Southern Province, with a mean elevation of 1,400 metres above sea level, and covers a total area of 7,296 square kilometres. Mean temperatures range from 14 degrees Celsius in winter to 28 degrees Celsius in summer. The average annual rainfall is 800mm.

There is a total of 446 villages in the district and the population is estimated to be more than 200,000 (population census 1990). The population density is 27.4 per square kilometre. More than 50% of the population are 15 years old or below. In 1990, the annual population growth rate was close to 2.3%. Average life expectancy for the district is estimated to be 41.6 years for men and 47.6 years for women.







Agriculture is the main source of income in Choma district. Although there are several large commercial farms (especially along the main railway line), most farmers are small-scale and subsistence farmers. The poverty rate is estimated to be close to 73% (ddp-sp 2000).

Politically, the district is divided into three constituencies (Choma, Mbabala and Pemba) and 25 wards. Each of the wards elects a Councillor to represent them in the District Council. The official wards cut across traditional Chief's areas (main chiefs areas are: Moyo, Macha, Mapanza, Hamaundu and Singani).

Map of Choma District (Southern Province, Zambia)



Legend

- | | | | |
|---|------------|---|--------------------------|
|  | Choma Town |  | Choma District |
|  | Villages |  | District Borders |
|  | Roads |  | International Borderline |

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HIV/AIDS in Zambia and its Impacts on Rural Households

This chapter gives an overview on the spread of HIV/AIDS in Zambia as well as the social and economic impacts of the pandemic, with special regard to rural areas.

The Spread of HIV/AIDS in Zambia

Zambia is one of the countries with the highest number of HIV/AIDS cases in the world. According to official figures, nearly 20% of Zambia's population aged between 15 and 49 years were infected with HIV by 1998, which is more than 1 million people in total (MoH/CBoH 1999).

The prevalence of HIV/AIDS in urban areas is generally higher than in rural areas. For example, it ranges from an average of 27.3% for Lusaka Province to 11.7% for North-Western Province. The prevalence rate of HIV for Southern Province is about 15.7% (MoH/CBoH 1999:12).

According to age groups and gender, the group mostly affected by HIV infection in urban areas are men aged between 30 and 34 years. The infection rate for this group lies between 40% to 50% while the rate of infection for women aged between 25 and 29 years is between 49% to 51%. In rural areas the rate of infection for male aged between 30 and 34 years lies at 32% and the women most affected are aged between 30 and 34 years whose rate of infection is 20% (MUSONDA et. al. 1997, cited in INESOR 1999:69-70). The high prevalence of HIV among these age groups reflects the fact that young men and women are the sexually most active group.

Accordingly, about 84% of AIDS cases are to be found among adults aged between 20 and 49 years. The highest incidence of AIDS cases is among men aged between 30 and 39 years and women aged between 20 and 29 years.

**Reported AIDS and AIDS Related Complex Cases
through July 1997**

Source: MoH/CBoH 1999: HIV/AIDS in Zambia. Backgrounds, Projections, Impacts, Interventions, Lusaka, p. 17.

In Zambia, like in most sub-Saharan Africa, 90% of HIV is transmitted by heterosexual contact, followed by mother-to-child transmission. HIV infections through contaminated blood transfusions or unsterile syringe or razor blades do not play a significant role. The following are a number of cultural, social and economic factors that contribute to the high incidence of HIV infections:

- **Migration and high mobility:** favouring the frequent change of partners;
- **Poverty, lack of education, missing perspectives:** enhancing high risk social behaviour; furthering prostitution;
- **High prevalence of other sexually transmitted diseases (STD's):** wounds and sores facilitate the transfer of the virus;
- **Sexual and cultural practises:** frequent change of sexual partners and cultural practises like polygamy⁵, dry sex, widow cleansing, etc. all enhance the spread of HIV/AIDS (for details see chapter 2.3);
- **Low use of condoms:** the use of condoms is traditionally low; religious circles are reluctant to promote the use of condoms;

The general impact of HIV/AIDS is devastating and affects nearly all aspects of society. According to official figures, life expectancy at birth may have dropped below 40 years by 1999, from over 52 years in 1980 (MoH/CBoH 1999: 31). At the same time, the number of orphans is estimated to be well over 500,000 in the year 2000 (SULWE 1999:2).

Not only individual households are affected by HIV/AIDS, e.g. through loss of income caused by sickness and care for the sick and increased expenditures for medical treatment and funerals. Also, the quality and scope of services rendered by government institutions is heavily overstretched (for an early assessment see CHING'AMBO ET AL. 1995). Service institutions suffer from a high rate of absenteeism among staff members due to HIV/AIDS related illnesses and attending funerals. They are also losing qualified and experienced staff.

Some service sectors such as health have to bear a high burden in coping with the effects of HIV/AIDS resulting from an increased demand for financial and human resources. This is at a time when the Zambian government can not afford it owing to the weak economic situation of the country (SULWE 1998b:14f.; on the Zambian economy see VAN DER HEIJDEN 2000).

Impacts on Rural Households

HIV/AIDS has a serious negative effect on rural communities and agricultural production. Although the prevalence of HIV/AIDS is higher in urban than in rural areas, data suggest that the trend is reversing (cf. DRINKWATER 1993). The fact that many HIV/AIDS patients return to their home villages instead of remaining in the cities contribute to this development. Traditional safety nets and extended families offer a comparative advantage for home-based care and other assistance to the sick, at least as long as these social safety nets are not overstretched. However, the provision of governmental and non-governmental services to assist rural households is inadequate if not completely lacking especially in remote areas.

Increasingly, rural households have to bear the burden of labour loss, an increasing number of orphans and of caring for the sick. This, in turn, will lead to a loss of income, increasing expenditures for medication and results in

⁵ With the term polygamy we describe the situation, when one husband is married to several wives. Despite the fact that the correct term in this case would be "polygyny", we use the term "polygamy", because it is commonly accepted and used in Zambia.

malnutrition and a declining health status. As DRINKWATER (1993) notes, it is also likely that the fact that women face the bulk of the burden in child and patient care will affect the traditional gender division of labour.

The impact of HIV/AIDS affects the agricultural production system, since agriculture is highly labour intensive with labour being by far the most important production factor in agriculture. Although there are no concrete figures for Zambia available, comparative studies on sub-Saharan Africa suggest the following specific impacts of HIV/AIDS on agricultural production (DU GUERNY 1999; see also on Zimbabwe KWARAMBA 1997):

- **Reduction of area under cultivation:** The shortage of manpower results in the inability of a household to cultivate all fields, especially remote fields tend to be left fallow.
- **Declining yields:** Sickness delays crop cultivation and reduces land husbandry and conservation measures, resulting in poor yields and reduction in soil fertility.
- **Reduced crop diversification and change in cropping patterns:** Cash crops are often abandoned owing to the inability to provide enough labour for both cash and subsistence crops. Furthermore, there is a decline in the cultivation of more capital-intensive cash crops due to frequent HIV/AIDS related illnesses.
- **Reduced numbers of livestock:** Medical expenses incurred by HIV/AIDS patients often require the sale of livestock.
- **Loss of agricultural skills:** The transfer of agricultural knowledge and skills from parents to their children is not guaranteed if one or both parents have died. At the same time, well trained and motivated young people leave a considerable knowledge gap due to death because of HIV/AIDS.

In sum, rural communities and households are highly exposed to the adverse effects of HIV/AIDS. Especially in regions such as Zambia's Southern Province, where, according to figures given by FAO, 77% of its 1.1 million population are classified as extremely poor (FAO 1999), further impoverishment has serious consequences on food security and nutrition. Traditional coping systems are often overstretched, if not counter-productive as discussed in the following chapter (e.g. traditional inheritance regulations). Therefore, in order to assist rural communities, development policies should stress HIV/AIDS as a cross-cutting issue which influences poverty, food

security and service delivery (cf. HEMRICH & TOPOUZIS 2000; TOPOUZIS 1998; FAO/UNAIDS 1999).

The Social Dimension of HIV/AIDS in Southern Province

Diseases such as HIV/AIDS have always a “social dimension”. They are embedded in a (more or less) holistic setting of social and cultural values, norms and concepts. These social and cultural norms influence not only how communities and individuals perceive the disease, but also on how it affects its spread and its possible strategies for prevention. Therefore, certain patterns in Tonga culture, the dominant tribe in the Southern Province of Zambia, have to be taken into consideration for a broader understanding of HIV/AIDS and its local interpretation.

Tonga culture is certainly not homogenous, e.g. Tongas living in the Zambezi Valley are known to be more traditional and conservative than the sub-tribes living on the Plateau. Furthermore, in areas such as Choma District, government resettlement schemes contributed to a diffusion of Tonga culture by mixing people from different regional background. Yet what concerns HIV/AIDS, it seems that the following Tonga cultural beliefs and practices are still quite common in the Southern Province:

- **Gender roles:** Traditionally, a Tonga woman is taught to obey men and never to refuse sex with her husband even when he is known to be involved in extramarital sexual relationships. Polygamy, which is very high in the Southern Province (32% of marriage relationships being reported as polygamous) increases the danger of HIV infection, given that condoms are rarely used.

The Tonga

Out of the 72 ethnic groups in Zambia, the Tonga people constitute one of the largest (more than 15% of the whole population). They have settled in the region for more than 900 years, and are reputed to be the earliest “Zambians”. The Tonga tribe is composed of three sub-groups: The Valley Tonga, the Plateau Tonga, and the Toka Leyas around Livingstone.

In pre-colonial times, the Zambezi Valley developed into a flourishing trading centre. Traditionally, the Tonga were cattle breeders and in the 19th century highly exposed to cattle raiding from the neighbouring Lozi and Ndebele states. They suffered also from slave traders coming from Portuguese territories. With the arrival of British colonial rule, commercial farms were established on the plateau, which, by then, was passed by the main north-south traffic route. Hence, the Plateau Tongas were the first to be partly integrated into a colonial market economy. With the construction of the Kariba dam, nearly 60,000 Valley Tongas were resettled in the late 1950s, losing their fruitful land.

Kinship ties and inheritance laws are structured by a matrilineal system which leads to a powerful position of the maternal uncle in the extended family (cf. COLSON 1958). Until today, the traditional political organisation is marked by a segmentary clan structure, and the absenteeism of a Tonga paramount chief. Hence, since 1996 internal struggles ensued to choose and inaugurate a paramount chief in order to express Tonga interests more powerfully vis-à-vis government (cf. ZAMBIA DAILY MAIL, 21.9.2000).

- **Witchcraft:** The belief in witchcraft is still very strong among the Tonga as well as other tribes in Zambia. Some HIV-infected persons claim to be bewitched with the disease, meaning that somewhere exists a malevolent individual which “sent” the disease through bad spirits. This individual usually has to be identified (by support from witch-doctors), and either “purified” or excluded from society. One case is reported from Chiawa (Lusaka Province), where in 1994 a powerful witch-doctor claimed to save the community from HIV/AIDS. Doing so, he killed 16 “identified” witches in a period of six months (BAWA YAMBA 1997). The tied relation from witchcraft to accusations, revenge, punishment, blame, stigmatisation and even killing is obvious. Given the high social stigmatisation of HIV/AIDS, witchcraft may, as NDUBANI (1998) argues, also be used as an “excuse” by someone being infected with HIV/AIDS.

- **Traditional medical concepts:** Traditional medical concepts also play an important role in Tonga society, but have different implications for the social fabric than the concept of witchcraft. In traditional Tonga medicine a disease called *kafungo* is known that is partly perceived as related to or even identical with HIV/AIDS (see Box “The concept of *kafungo*”).

The concept of *kafungo*

Certain diseases, the so called “African diseases”, do not fit into western medical concepts and are thought to be curable exclusively through traditional medicine (cf. PALLESEN 1999). In Southern Province, the traditional concept of *kafungo* is perceived as being closely associated to HIV/AIDS, due to its striking similarities in terms of transmission, course and severity: *“Day by day I’m punching my head to know if kafungo and AIDS are the same, but I do not find the answer...”*, a Tonga businessman expressed his despair (personal communication, 16.8.2000).

A young female traditional healer from Choma District gives a professional insight into the course of *kafungo*:

“People fear kafungo very much. It kills like AIDS. You are slimming, hairs change colours, and few know the cure. In the long process of kafungo you will suffer like if you had TB. You get kafungo if you sleep with a woman who miscarried or if you step on the grave of the foetus. But the most serious kafungo is the one a man gets if he sleeps with a woman who miscarried, before she has washed with medicine. Then it goes right into your blood and gives you internal sores. You will always be cold, slimming and coughing. If you get kafungo that way you can transmit it to other people you sleep with” (cf. MOGENSEN 1997).

In contrast to the concept of witchcraft, there is no malevolent enemy, who could be blamed as cause of *kafungo*. Rather, the disease is caused by the, often unintended, breaking of social or, more specifically, sexual norms, which leads to a form of sexual “pollution”, as MARY DOUGLAS (1966) calls it in her book “Purity and Danger”. Consequently, the concept of *kafungo* stabilises social and sexual norms and leads to social support for the affected persons (cleansing for the woman, medicine and care for the man) rather than to accusations and stigmatisation as in the case of witchcraft (MOGENSEN 1997).

- **Customs and Rituals:** Traditional practices such as widow cleansing and practices related to customary inheritance affect the spread of HIV as well as coping strategies. Widow cleansing describes the ‘cleansing’ of widow or widower through the act of sexual intercourse with a relative of the deceased. It aims at purging someone of the “evil forces or the burden of the widow or widower’s unwanted spirits” assumed to have caused the death of a spouse. SULWE (1998a:39) relates the practice of sexual cleansing to the fear of being haunted by the spirits of the deceased, coercion from relatives and the fear of being rejected by society.

Related to widow cleansing is the customary inheritance regulation whereby Tonga women generally do not inherit the property of their husbands. Yet a brother or another close relative may inherit the property of the deceased spouse and also take over the widow.

- **Sexual practices:** Sexual practices such as ‘dry sex’ contribute to the spread of HIV/AIDS. Dry sex describes a practice whereby women lay herbs, rock salt or leaves into their vagina to “dry” vaginal fluids that should enhance the (male) joy of sex. However, the risk of getting micro-sores or other injuries during sexual intercourse is multiplied, which leads to a higher risk of transmitting HIV.

In sum, traditional beliefs and perceptions have to be considered when taking preventive measures against HIV/AIDS. They can neither be ignored nor suppressed, yet sometimes it seems to be necessary to challenge or change certain traditional practices. As SULWE (1998a) describes, traditional practices to be replaced such as widow cleansing can be adapted by using other traditionally accepted alternatives of ‘cleansing’, e.g. jumping over a lying cow. Furthermore, traditional authorities such as chiefs and chieftains, traditional healers and traditional birth attendants (TBAs), etc. may play an important role in channelling HIV/AIDS messages or in mobilising community resources (see PALLESEN 1999). Furthermore, traditional safety nets may be instrumental for implementing projects such as home-based care programmes at community level.

HIV/AIDS Policies and Approaches

This chapter highlights policy measures taken by the Zambian government and line ministries to respond to HIV/AIDS. Furthermore, an overview is given on non-governmental organisations active in fighting HIV/AIDS in Choma District. Finally, the chapter closes with a short discussion of constraints hampering multi-sectoral approaches at district level.

National HIV/AIDS Policy

After AIDS was first identified in Zambia in 1984, a National AIDS Surveillance Committee was created. In 1987 a five year plan was developed with the assistance of the World Health Organisation (WHO) that aimed at public education, care of AIDS patients and research. However, it was only after 1994 with a second medium term plan for 1994-1998 that more emphasis was laid on a multi-sectoral response to HIV/AIDS, which in fact is a multidimensional problem (SULWE 1998b:25f.).

The strategic plan for 1994-1998 aimed at reducing the impacts of AIDS at individual, family, community and national levels and to develop guidelines for co-ordinated interventions. The idea of inter-sectoral co-operation between government ministries was highlighted, including co-operation with international agencies, the Zambian private sector and non-governmental organisations; in 1994, the idea of introducing HIV/AIDS Focal Point Persons was adopted (SULWE 1998b:29f.).

A National HIV/AIDS/STD/TB Council and a HIV/AIDS/STD/TB Secretariat, respectively, are about to be established at the end of 2000. The Council will consist of 15 members representing government, NGOs, private sector and vulnerable groups. It will constitute the highest national co-ordinating body regarding HIV/AIDS. Although located within the Ministry of Health, the HIV/AIDS Secretariat will be an autonomous body reporting to the office of the president. It will assist the Council and be responsible for co-ordination and monitoring of multi-sectoral responses (ZAMBIA NATIONAL HIV/AIDS/STD/TB COUNCIL 1999).

Currently, a new HIV/AIDS strategic plan for 2000-2002 is being elaborated. As the draft of November 1999 indicates, the strategic plan will put emphasis on priority areas and identify adequate actors and 'best practices', whereby a

co-ordinated multi-sectoral approach at national and district level shall be fostered (ZAMBIA NATIONAL HIV/AIDS/STD/TB COUNCIL 1999).

HIV/AIDS Policy Frameworks

Besides the national HIV/AIDS policy expressed in the various strategic plans, the government ministries were asked to develop policy frameworks for specific responses on HIV/AIDS within their field of action (for an overview on HIV/AIDS policies of Zambian ministries see SULWE 1998b:54ff.).

HIV/AIDS Policy Framework of the Ministry of Health

The Ministry of Health (MoH) is the lead ministry in the national response to HIV/AIDS and has the mandate to co-ordinate multi-sectoral approaches. The MoH is also responsible for policy formulation at national level and is instrumental for the nine HIV/AIDS Technical Working Groups foreseen in the National HIV/AIDS Strategic Plan for 2000-2002: Mother-to-child transmission; HIV vaccine and treatment; tuberculosis; home-based care and counselling; monitoring and evaluation; information, communication and education; sexually transmitted diseases; orphans and vulnerable children; resource mobilisation. The Central Board of Health (CBoH) has taken up the role in health services delivery and, thus, the care for HIV/AIDS patients. The co-ordination of HIV/AIDS policies and activities at district level is the responsibility of the HIV/AIDS/STD/TB/Leprosy Co-ordinator.

HIV/AIDS Policy Framework of the Ministry of Agriculture, Food and Fisheries

The Ministry of Agriculture, Food and Fisheries (MAFF) is a ministry with relatively high human and financial resources. Its presence is clearly felt in rural areas where its field staff work closely with rural communities and farmers. Despite these comparative advantages, MAFF only embarked on a more systematic response to HIV/AIDS recently. In the outline of the recent national agricultural policy the ministry did not even mention HIV/AIDS (MAFF 1998). As a result, MAFF has lagged behind in terms of policy formulation and training of its AIDS focal point persons.

To reverse the situation, MAFF is planning to integrate HIV/AIDS concerns into its rural extension services. Until now, 12 members of the MAFF Headquarters have undergone training for trainers and several workshops for AIDS focal points for provincial and district levels have been held since 1999. As a further

step, MAFF intends to integrate HIV/AIDS concerns into the curricula of the agricultural colleges and training institutes (personal communication with Mr. Kawila, HIV/AIDS co-ordinator MAFF, Lusaka, 3.8.2000).

HIV/AIDS Policy Framework of the Ministry of Local Government and Housing

In its draft policy paper of 1998 on HIV/AIDS the Ministry of Local Government and Housing (MLGH) proposed to assist all district councils to develop and to administer anti-AIDS activities in their respective localities. Furthermore, the ministry planned to integrate HIV/AIDS into its training programmes and to put into place preventive measures against HIV transmission through accidents, e.g. for its emergency response personnel (SULWE 1998b:57).

Together with the MoH, the MLGH, which is represented at district level by the District Council and the District Development Co-ordination Committee, is also in charge of co-ordinating and facilitating multi-sectoral HIV/AIDS responses at district and community level. None of these plans have so far been implemented.

In Choma District, the government departments are mostly not capable to assist rural communities in their coping and prevention strategies. The national HIV/AIDS policy of multi-sectoral responses on HIV/AIDS has, so far, not been transformed into co-ordinated activities at district level. However, there is high interests and commitment on behalf of government departments to join forces in fighting HIV/AIDS.

Non-Governmental Organisations Active in the Field of HIV/AIDS

Apart from governmental plans and limited efforts to prevent the spread of HIV/AIDS and to cope with its impacts on the Zambian society, a number of non-governmental organisations (NGOs) are active in this field. While some organisations such as the Society for Family Health provide for a broad scale distribution of male and female condoms, NGOs such as World Vision Zambia, CARE International, Planned Parenthood Association, Youth Alive Zambia, Africare, Tasintha and others are active in the field of reproductive health and education on behavioural change for vulnerable groups; others such as Plan International train community-based health workers and peer educators. Kara

Counselling and Training Trust as well as some church groups provide training for home-based care, and offer assistance to HIV positives and orphans. The Network of Zambian People Living with HIV/AIDS, which comprises more than 1,000 members, aims at eliminating the stigma associated with HIV/AIDS.

Although NGOs and church groups play an essential role in the overall struggle to mitigate the spread and the impacts of HIV/AIDS in Zambia, inter-organisational linkages and co-operations are still weak. This can be attributed partly to the competition for external funding. Furthermore, most of the activities of NGOs take place in urban areas, whereas rural communities are not adequately covered. In 1999, for example, 38 of the 48 organisations and institutions that actively work with youths were located in Lusaka (ZAMBIA NATIONAL HIV/AIDS/STD/TB COUNCIL 1999).

Non-Governmental Organisations in Choma District

Choma District is covered by some national organisations such as the Society for Family Health and its programme of condom distribution. However, there are also NGOs active in the field of HIV/AIDS prevention and coping that were based in Choma. Among them are Kara Counselling and Training Trust, World Vision Zambia, Africare, and some church initiatives.

Kara Counselling and Training Trust

Kara Counselling and Training Trust is a non-church organisation, founded in 1989 by a Jesuit priest. Until 1997, when the Choma branch was established, Kara Counselling was represented in Lusaka only. While the projects of the Lusaka headquarters are funded by several international donors, the programmes of the Choma branch are funded entirely by the Government of Liechtenstein.

Kara Counselling promotes behavioural change for HIV/AIDS prevention and provides a range of counselling, education, and training services. It offers voluntary HIV testing and training courses in basic counselling skills (since 1989 more than 6,000 individuals have been trained) as well as for counselling trainers and for home-based care. Kara Counselling hosts the Choma Post Testing Club, where individuals that have been tested meet regularly and engage in peer education. In addition, Kara Counselling provides assistance to orphans, street children, and HIV/AIDS patients.

World Vision Zambia

The Zambian branch of World Vision, a Christian NGO, was established in 1981 in Lusaka. Since 1986, World Vision Zambia has been operating present in Southern Province, with the Choma office serving as its provincial headquarter.

World Vision engages in Area and Community Development Programmes and child sponsorship projects. By the year 2000, World Vision has been active in 109 places in Zambia, with more than 40,000 children in the sponsorship programme. Furthermore, emphasis is given on empowering rural communities (e.g. through socio-economic development programmes, training, woman empowerment, and health education).

Within its health component of the Area Development Programmes World Vision is active in preventative and curative initiatives for HIV/AIDS. Also, it runs a project that concentrates on long distance truck drivers, their assistants, and commercial sex workers (HIV/AIDS high transmission project). The objectives of this project include education of the truck drivers and their sexual partners as well as the diagnosis and treatment of STDs.

Africare

Africare is a Washington based NGO. It was founded in 1971 and currently works in 27 African countries. It started its operations in Zambia in 1978 and, since the early 1990s, has been active in Southern Province, with Choma as its regional headquarter.

Africare is mainly involved in agricultural projects, health and water programmes, and food security. Its activities in the health sector include reproductive health and family planning, and recently the Adolescent Reproductive Health Initiative 2000, a regional initiative that covers Malawi, South Africa, Zimbabwe, and Zambia. It aims at strengthening the capacity of community based organisations and initiatives to educate, counsel and support young adults and their families in issues related to reproductive health, family planning, STDs, and HIV/AIDS. As a result of this initiative the Youth Forum Zambia was founded; in August 2000, a branch of the Youth Forum has been established in Choma.

Other Initiatives

There are several other non-governmental initiatives in Choma district mostly linked to church groups that are related to HIV/AIDS in one way or another.

Churches are very influential in Zambia; in every village there are one or more churches. Church groups in Choma district provide help for needy families and assist HIV/AIDS patients as well as orphans. However, churches take an ambivalent stand when it comes to issues related to sexuality as well as the promotion of condom use.

Public Service Providers in Rural Areas and Participatory Approaches

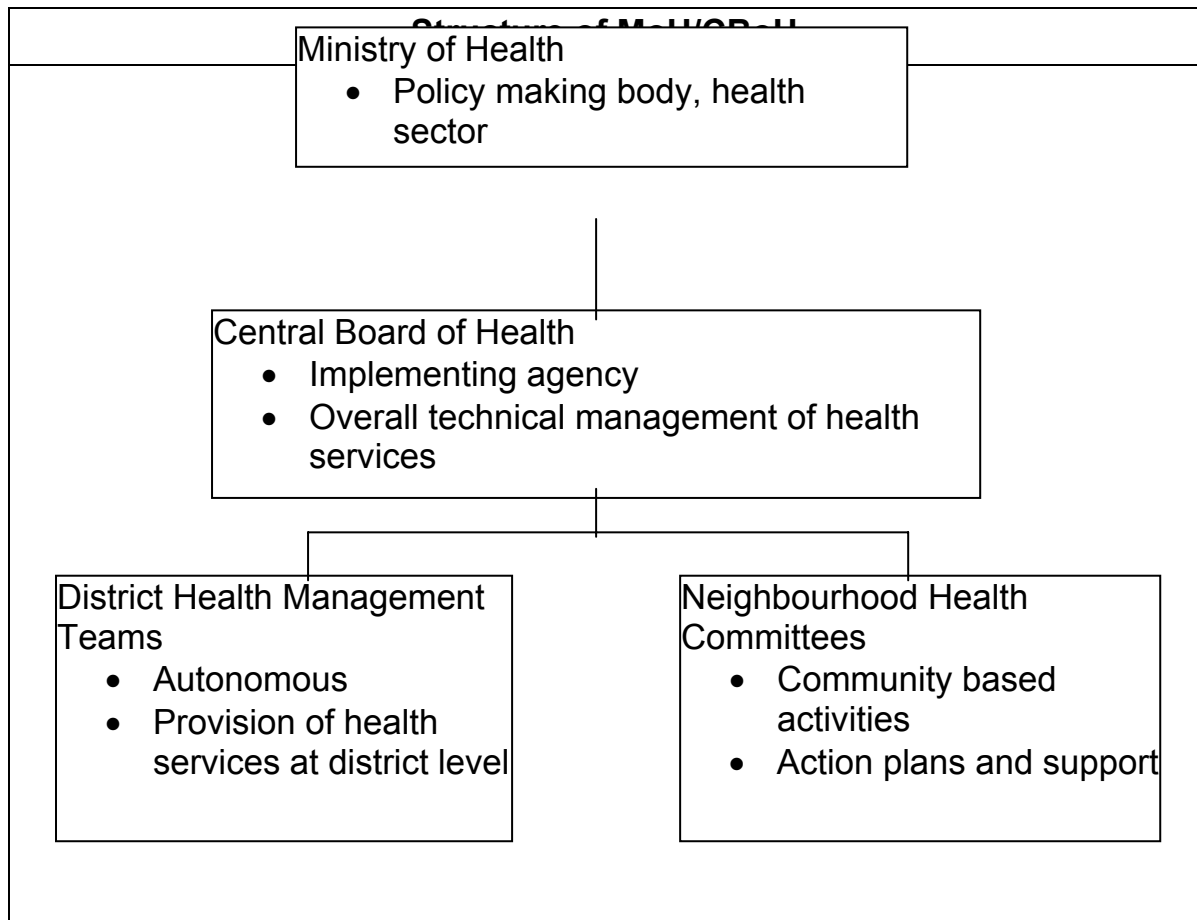
This chapter starts with an introduction into the structure and mandate of public rural service providers, in particular the Ministry of Health (MoH), the Ministry of Agriculture, Food and Fisheries (MAFF) and the Ministry of Local Government and Housing (MLGH). It also describes the participatory approaches used by these ministries. Afterwards constraints for a multi-sectoral approach on district level are presented. Finally, the participatory approaches of the line ministries are compared, and the ones used by MAFF are presented in more detail.

Ministry of Health

In 1991, the Government of Zambia embarked on a radical health reform process aiming at decentralisation and increased community involvement. With the reform process, the Ministry of Health (MoH) was completely restructured and splitted into two bodies: the ministry itself, as the policy making body for the health sector, and the Central Board of Health (CBoH), which is responsible for the overall technical management of health services. Currently, MoH/CBoH is undergoing recurrent changes in its organisational structure.

The health reform, described in the National Health Strategic Plan 1998-2000, addresses, among others, the following issues (CBoH 2000):

- Decentralisation;
- Improving financial performance and accountability;
- Introducing fees to share costs and to influence health seeking behaviours;
- Increasing community involvement and community ownership.



Structure of MoH / CBoH in Choma District

At district level, different kinds of health committees on behalf of the CBoH were established, with the District Health Board (DHB) having the overall responsibility for planning and monitoring of health programmes and the District Health Management Team (DHMT) acting as a technical board for the actual implementation. Within the DHMT recently a District HIV/AIDS/STD/TB/Leprosy Co-ordinator was introduced. The HIV/AIDS Co-ordinator is in charge of HIV/AIDS programmes at district level and of integrating HIV/AIDS issues in all line ministries as it was decided upon in the National HIV/AIDS Strategic Framework 2000-2002. In addition to this structure, Hospital Boards and Health Centre Boards are in place at district and sub district levels.

Extension Methods Used by MoH / CBoH

In its day-to-day activities, MoH rarely applies participatory approaches for conducting village workshops. Yet they work closely with rural communities, e.g. through the establishment of Neighbourhood Health Committees and the

training of Traditional Birth Attendants and Community Health Workers (CHW's). However, in some districts, but not in Choma District, participatory tools such as the Participatory Learning for Action methodology (PLA) are applied. The PLA is similar to PEA methodology, which is used by extension workers from the MAFF (see next chapter).

Ministry of Agriculture, Food and Fisheries

The Ministry of Agriculture, Food and Fisheries (MAFF) is one of the largest ministries in Zambia in terms of financial resources and labour force employed. The national agricultural policy of MAFF (1998) focuses mainly on the following points:

- To assure national and household food security;
- To ensure that the existing agricultural resource base is maintained;
- To generate income and employment to maximum feasible levels;
- To expand significantly the sector's contribution to the national balance of payments.

Since 1996, MAFF has been undergoing a restructuring process as a result of the Agricultural Sector Investment Programme (ASIP), which includes four main components:

- Policy and institutional reforms;
- Support for private sector investment;
- Rehabilitation and strengthening public sector agricultural services;
- Funding of the key implementation support activities.

Despite the decentralisation process initiated in 1993, MAFF remained essentially a line ministry. However, at district level, decision-making power and financial autonomy were strengthened. Currently, MAFF is undergoing recurrent changes in its organisational structure.

At headquarter level, MAFF is divided in administrative units and different directorates⁶. The directorate of Economics and Market Development is responsible for the activities of the Provincial Agricultural Co-ordinating Officer (PACO) on provincial level, who co-ordinates the activities of the District Agricultural Co-ordinating Officers.

⁶ These are Seed Controls and Certification; Human Resources & Administration; Research; Field Services; Economics and Market Development.

The Structure of MAFF in Choma District

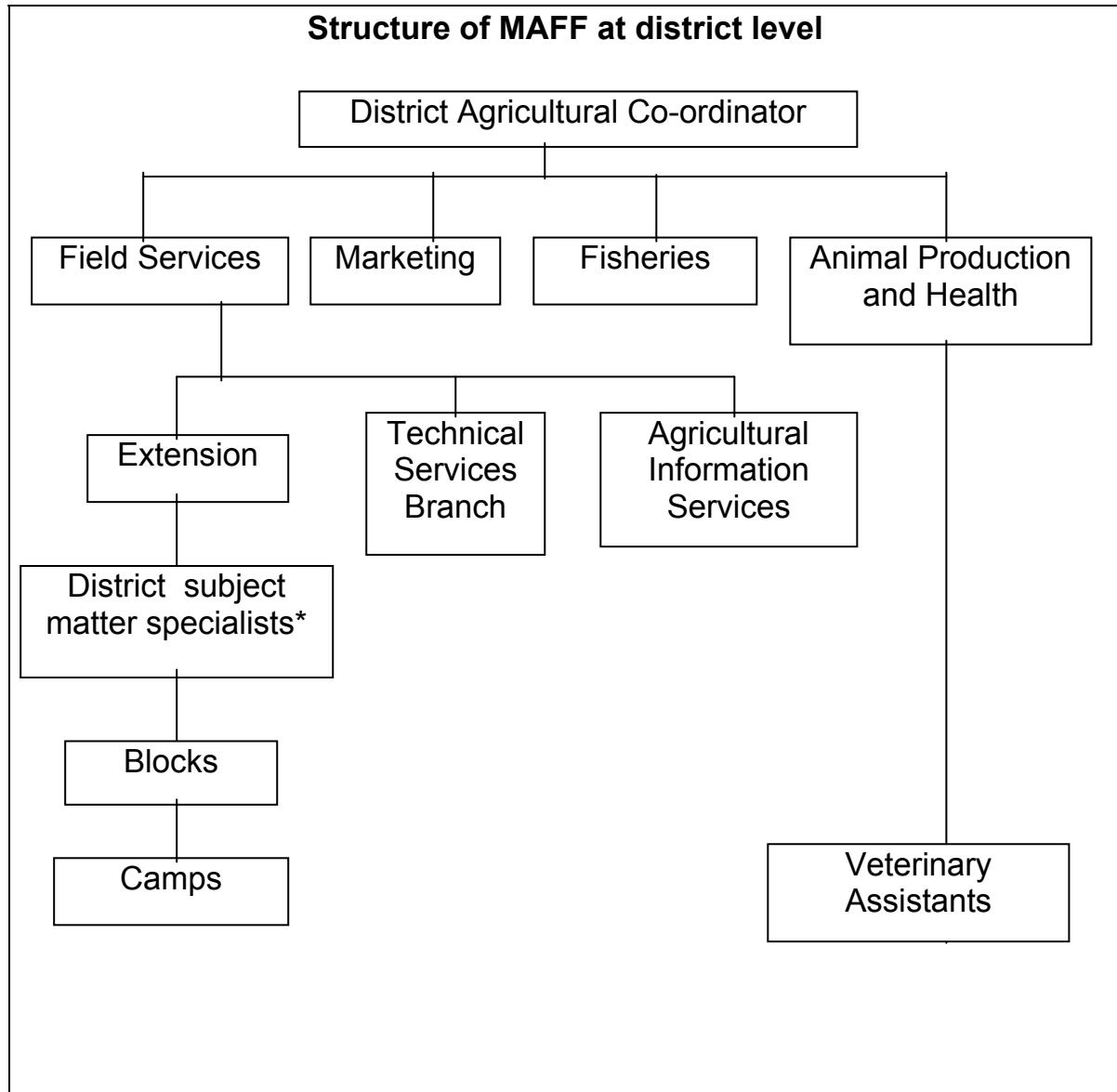
At district level, the District Agricultural Co-ordinating Officer co-ordinates the activities of four departments (Animal Production and Health; Fisheries; Economics and Market Development; Field Services). The department of Animal Production and Health has field workers at village level (the so-called veterinary assistants) and trains community volunteers. The Field Services Department consists of three branches⁷. One of them is the extension services branch which employs the most field workers.

The Extension Services Branch of MAFF

The extension services branch consists of four Subject Matter Specialists (Extension Methodology; Farm Management; Crop Husbandry; Women and Youth) and several field workers.

Choma District is divided into 5 blocks, and each block is headed by one Block Officer. Each block consists of five to six camps, which in turn are headed by Camp Officers. In total there are 33 camps within the 5 blocks and further 3 camps within the state land. However, several camps are not covered adequately since positions are vacant and new appointments are being delayed (see also INESOR 1999: 78f.). The Ministry promotes the training of voluntary Community Agricultural Workers; however, their selection and training has not taken place in Choma district so far.

⁷ These are National Agricultural Information Services; Technical Services Branch; Extension Services.



* District subject matter specialists are: Extension Methodologist, Farm Management Officer, Crop Husbandry Officer, Women and Youth Programmes Officer.

Currently MAFF uses different extension approaches in which communities are actively participating and express their needs; in Southern Province, these are the Participatory Extension Approach (PEA) which is a locally adapted version of Participatory Rural Appraisal (PRA), Gender-sensitive Participatory Extension Approach (GPEA), and the Gender Operation Cycle (GOC). A detailed description of these approaches is given in the chapter 4.6.

Ministry of Local Government and Housing

The Ministry of Local Government and Housing (MLGH) is the government agency responsible for the implementation of the Zambian decentralisation policy. In 1993, the MLGH was given the mandate to co-ordinate operations of

line ministries at national and district levels. The District Planning Unit (DPU) and District Development Co-ordination Committee (DDCC) have the task to assist the District Councils, which were established with the Local Government Act of 1991 and whose members were elected by the district population (BERG ET. AL. 1997). While the DPU is responsible for the elaboration of district development plans, the DDCC has the overall task to plan, co-ordinate and monitor development activities in the district.

The Structure of Local Government in Choma District

The highest decision-making body in Choma District is the District Council, which consists of 25 elected members of whom three are also Members of Parliament. The District Council meets quarterly. Supervision and assistance to the Council is provided by the MLGH, e.g. through human resources, budgeting and finances. The Council has three standing committees, namely Finance, Establishment and Plans, Works and Development (DDP-SP 2000). The DDCC consists of members of the Council, the heads of district departments of the Zambian ministries, NGOs, para-statal organisations and private enterprises. It has four sub-committees, namely:

- Planning and Advisory
- Commerce, Industry, Mining and Tourism
- Agriculture and Natural Resources
- Economic Infrastructure and Social Services

Although the DDCC and its sub-committees are instrumental in the planning and co-ordination of development activities at district level, they do not seem to function well in Choma District. For example they meet only irregularly, if at all. A District Development Project Southern Province (ddp-sp), that is run by the MLGH and assisted by GTZ and that aims at strengthening the capacity of the council, only started in January 1999 in Choma (METSCH 1999) and is still in early stages of implementation.

Participatory Methods Used by the ddp in Choma

The District Council itself normally does not use participatory approaches. However, the DDCC applies, especially in the districts where the ddp-sp is active, participatory approaches for development planning. Village workshops are conducted using the Participatory Integrated Development Approach (PID).

The PID approach was introduced in Kalomo District in 1997 (see BERG ET. AL. 1997). As part of the ddp-sp, the districts of Siavonga, Mazabuka, Monze and Choma followed; the coverage of other districts is currently under discussion. The ultimate objective of PID, as described by DIETVORST & SIAME (2000), is “to achieve a co-ordinated and integrated development at grassroots level based on beneficiary participation and ownership”.

Thus, the overall strength of PID is its co-ordination function. It aims at assisting the District Councils in formulating an integrated development approach in their Strategic District Development Plans, thus strengthening political decentralisation and co-operation of government departments as well as NGOs at district level.

But at village level, it turned out that PID workshops are very time-consuming and require high facilitation skills. Furthermore, the possibility of project funding tends to promote a ‘shopping-list’ mentality among the communities. As a result, the potential for community self-help is under-utilised (DIETVORST & SIAME 2000).

In Choma District, so far one PID training for potential stakeholders took place, but no further village workshops were conducted.

Constraints for Multi-Sectoral Work at District Level

Despite the efforts undertaken by the Zambian government to facilitate and to co-ordinate multi-sectoral approaches, e.g. through the National HIV/AIDS/STD/TB/Leprosy Secretariat (MoH) in terms of the content of the activities, or through the District Council in terms of the administrative co-ordination, multi-sectoral approaches face a number of constraints at district and community level. Among the most important constraints in combined responses are the following:

- **Inefficiencies of the District Development Co-ordination Committee (DDCC):** The DDCC comprises of the District Council, government departments, NGOs, and para-statal organisations. Under the mandate of the MLGH, the DDCC is the responsible body at district level for co-ordination and planning of district development activities. However, the DDCC in Choma district, like in most other Zambian districts, lacks the capacity to co-ordinate multi-sectoral initiatives effectively. The District Development Project-Southern Province (ddp-sp) that aims at giving

technical assistance to strengthen the capacity of the District Council and the DDCC in service delivery only started its operations in Choma District.

- **Lack of financial resources of the District Council:** Inadequate financial resources also constrain operations of the District Council. In contrast to the operational units of line ministries at district level (whose budgets are provided by the headquarters of the ministries in Lusaka), the District Councils have only limited resources at their disposal. In Choma, for example, the budget of District Council comprises mainly of local taxes and fees (ddp-sp 2000).
- **Weak co-ordination of line ministries by the District Council:** Although the MoH and the MLGH, through the DDCC, have the official mandate to co-ordinate HIV/AIDS policies at district level, they cannot force other ministries to follow their line. Most ministries, however, seem to be committed to share information with other sectors. Yet when it comes to sharing of (financial) resources, the situation is more complicated.
- **Lack of clearly defined tasks of AIDS focal points:** The tasks of AIDS focal point persons in each of the ministries seems not to be clearly defined. For MAFF, e.g., AIDS focal points consider tasks ranging from counselling, the provision of condoms and information to the staff, monitoring AIDS interventions and keeping health records to educating farmers to be within their responsibility. The lack of clearly defined tasks of these AIDS focal points, thus, impede effective co-ordination with other ministries. Furthermore, the work of AIDS focal points is often a mere appendix to their normal routine work, which affects their overall performance.
- **Methodological problems:** Another problem of multi-sectoral approaches is related to the fact that different ministries and NGOs have different methodologies to address communities. For example, while some ministries like MAFF use participatory approaches in village workshops, other ministries like MoH or NGOs such as Kara Counselling offer direct health or counselling services to private clients. Others like the Ministry of Education are involved in education and information delivery. Certainly, these approaches are complementary. Yet multi-sectoral responses to HIV/AIDS have to be co-ordinated with respect to the question of how to address rural communities.
- **Separation into different administrative areas:** The different sector ministries are working with different administrative areas. At sub-district level, each ministry uses different areas as an administrative unit. Therefore,

field workers from MAFF cover different villages than, for example, their neighbouring community health worker or the teacher in the same compound. This hinders or at least minimises the efficiency of multi-sectoral teams on sub-district level. Therefore, administrative boundaries of the line ministries should be harmonised.

In order to establish multi-sectoral approaches at sub-district level, one has to face the problems deriving from the constraints mentioned above.

As far as possible, we took those constraints into consideration (e.g.: strengthening of the District Council, establishment of an HIV/AIDS Task Force at district level, clarification of tasks of HIV/AIDS focal points and harmonisation of administrative boundaries) while elaborating the „recommendations for institutionalising a multi-sectoral training approach on HIV/AIDS“. (For details see chapter eight)

Relevance of Participatory Approaches for Addressing HIV/AIDS

The following chart gives an overview on strengths and weaknesses of the extension services described (MAFF, MoH and MLGH) as well as the participatory methods applied.

Participatory Approaches	Strengths	Weaknesses
PLA of MoH	<ul style="list-style-type: none"> • Works within local communities • Participation of community members 	<ul style="list-style-type: none"> • Rarely used
PEA, GPEA, GOC of MAFF	<ul style="list-style-type: none"> • Community participation • Social group differentiation and relationship sensitive • Sustainable • Encourages utilisation of local knowledge and resources 	<ul style="list-style-type: none"> • Difficulties in co-ordination • Concerns of youth not adequately covered • Requires initially frequent follow-ups
PID of ddp	<ul style="list-style-type: none"> • Co-ordination of line 	<ul style="list-style-type: none"> • Limitation in

	ministries <ul style="list-style-type: none"> • Avoids duplication • Addresses cross-cutting issues 	resources
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All of those approaches could be used to address HIV/AIDS issues. PLA, PEA and PID as well provide a participatory framework, in which HIV/AIDS issues could be integrated, but which is the most efficient one?

To identify possible ways to address HIV/AIDS a small survey on workshop results of different approaches was conducted. This HIV/AIDS specific assessment of PEA and PID results (for PLA no workshop reports were available) was done:

- to find out if and how problems related to HIV/AIDS are expressed by the communities during PEA respectively PID sessions; and
- to evaluate the tools being used with regard to their relevance for addressing HIV/AIDS issues.

A total of 24 workshop reports of Choma, Kalomo and Monze Districts were evaluated with the following results:

It was found that health problems are among the most pressing problems of rural communities. These include, for example, the lack of a Health Centre, high morbidity rates and insufficient drug supply.

Regarding the relevance of different tools for addressing HIV/AIDS it turned out that some of the tools and methods (e.g. river code role play, informal interviews, resource maps, village walks, institutional analysis, relationship diagrams, historical path, brainstorming, simple ranking and problem trees) already refer to HIV/AIDS. Especially the problem tree and the human disease calendar are already hinting to diseases and HIV/AIDS during PEA and PID workshops.

The problem tree is used to elaborate causes and effects of specific problems and to identify the root problems. This is an important precondition to develop realistic solutions in the community action plans. Diseases were often mentioned in the problem trees as causes as well as effects. In some of the problem trees direct causes to HIV/AIDS were elaborated, e.g. STD's, prostitution as a result of poverty, divorce, long walking distances and promiscuity.

The human disease calendar is a common PRA tool. Normally, villagers list the diseases in their community in the calendar and rank them in accordance to their severity. In some villages, HIV/AIDS was listed in the human diseases calendar, but not as the disease affecting the community most. This leads to the conclusion that a modified version of the human disease calendar can be used to elaborate the importance of HIV/AIDS in communities.

In general, our experiences have shown that especially PEA is highly effective to incorporate HIV/AIDS issues in village workshops. In contrast to PLA and PID, PEA is widely applied in Southern Province and currently used by a high number of agricultural extensionists. PEA consists of a continuous extension cycle, initiating a learning process from awareness building to reflection, decision making, implementation and monitoring. With its gender specific modifications, the approach already addresses behavioural change between men and women. Furthermore, PEA, GPEA and GOC provide a very flexible methodology that meets the specific needs of different communities. Therefore PEA was chosen to address HIV/AIDS at community level. A more detailed description of PEA, GPEA and GOC is given in the following chapter.

Participatory Extension Approaches used by MAFF

Since the early 1990s, approaches promoting community participation were introduced by MAFF in Zambia, which include PRA, PEA, GPEA and GOC. These approaches replaced the formerly used „top down approaches“ like the T&V system.

The objective of all these participatory approaches is to gather information using participation of the target group and the subsequent planning for community action.

The Participatory Extension Approach (PEA)

In Southern Province, PEA has been promoted since 1998 through the ASIP Support Southern Province (ASSP), covering the districts of Choma, Mazabuka, Monze and Siavonga. Initially the PEA was designed and introduced as the local adaptation of PRA tools in Siavonga District in 1992 (NAGEL ET AL 1992). This approach has been also supported by the Southern Province Household Food Security Programme of MAFF and by NGOs such as World Vision, Care International and Africare.

PEA is based on a process where communities play a key role in identifying, analysing and solving problems as well as implementing and monitoring activities. It is a participatory learning process. Power relations and conflicts within the communities are addressed as well. All active members of a community are encouraged to jointly attend participatory extension exercises. Women and youth are now actively involved in the process, creating more transparency and commitment in the implementation of action plans.

Years of experience in PEA promotion have trimmed the original approach down to a leaner version called „The Road to Progress“, which retains only a smaller number of appropriate PRA tools and has dropped the more cumbersome or less useful ones.

Today, the „Road to Progress“ describes a process consisting of a sequence of participatory steps to encourage self-help within the communities. It first reflects on positive developments, highlighting potentials (‘achievements and enjoyments’), then analyses constraints (‘setbacks and sufferings’) and concludes with a self-help action plan (see MAFF/GTZ 2000). Setbacks are visualised as obstacles along a line representing the „road“. The community action plan describes how each obstacle can be overcome. The change in attitude, required by both the extension worker and the farmer, is visualised in the steps of a Farmer - Extension Interaction Cycle (DIETVORST & SIAME 2000).

Strengths of PEA

PEA empowers communities through focusing on communities’ potential to resolve their own problems, while identified solutions include activities which require little or no outside funding. As a result, co-operation and organisation among farmers is strengthened. Also, the sustainable use of agricultural resources as a series of low cost interventions is promoted.

The PEA method - especially in its leaner version „The Road to Progress“ - is easy to understand and to apply. Field staff feel comfortable in using them and farmers understand the process and say that communication with field staff has improved. Furthermore, PEA is adaptable across disciplines, is flexible and can be used by a wide range of service providers such as health and community development.

With regard to the ability of PEA to address HIV/AIDS concerns it turned out that the PEA toolbox already provides some tools, which can be efficiently used in relation to HIV/AIDS. Problem trees in which diseases or HIV/AIDS are

already stated in a former PEA session are very useful when introducing an HIV/AIDS workshop to communities. A modified version of the human disease calendar can be used to elaborate the importance of HIV/AIDS in communities.

Weaknesses of PEA

As its principle is based on a multi-sectoral approach, one of the major weaknesses is the lacking mandate of MAFF personnel on district level to coordinate. Workshops following the PEA vary in length, because interest and time constraints of all village groups have to be taken into consideration. The elaboration of definite workshop plans or programmes is not possible. Instead, check lists for several workshop steps are used.

Incorporating Gender Issues in PEA

Soon after introducing the Participatory Extension Approach (PEA) it became obvious that the approach had a good impact on male farmers, but it was later felt that women were not well targeted by agricultural extension staff despite their high labour input in agricultural production. To address this concern a process to integrate women and to incorporate gender issues in PEA was initiated. Training needs of female farmers and constraints for their participation in the meetings were identified. First steps to develop and adopt PEA tools were done. Activities were adjusted to women's schedules to improve their attendance during workshops.

The Gender-Oriented Participatory Extension Approach (GPEA)

The GPEA was launched in 1993/1994 to intensify and to promote the work on gender issues (SADP 1995). Extension staff was trained to initiate and to internalise gender awareness among staff and target groups.

In 1995, the **Family Approach** was initiated as a joint learning process among family members. To create more transparency, husbands, wives and older children were invited to attend meetings and field demonstrations. The main objective was to make all members of the family understand and tackle problems as a unit.

In 1996, the **Couple Approach** followed as a second adjustment of the GPEA. The main reason for including this approach was to further reflection on social and civic aspects of human relationships and to improve co-operation. In this approach, individuals and the community get the possibility to identify what

they like and dislike in relation to gender roles and in relation to the entire community (ASSP 2000b). The aim of such an approach is to create awareness and to improve existing relationships between couples, in families and across the different social groups of the communities. Participants reflect on positive and negative issues in inter-human relations, discuss causes, effects and possible solutions. Crop use and cooking demonstrations were part of these workshops.

An impact assessment of the **GPEA** highlights the changes in relationship between men and women, their roles, access to and control over resources, decision-making and division of labour and responsibilities (ASIP 1999).

These gender specific issues are crucial to household food security and well being of the family and community. They are crucial in planning and in agricultural production.

Gender-Operation-Cycle (GOC)

In 1999, GOC was initiated to address specific gender issues and to further civic awareness. The Gender-Operation-Cycle (GOC) follows similar steps as the PE Cycle (ASSP 2000c). Participants create awareness of their problems in relationships. They reflect on what they like and dislike of being male or female. They prioritise dislikes and work out causes and effects of their relationship problems. Solutions are identified and action plans are elaborated. Problems like property grabbing, adultery, polygamy, not working together in a family, unequal sharing of money, love portion practice⁸, family planning etc. are tackled during GOC workshops in the communities.

According to results in Siavonga District where this approach is widely used, some of the main findings indicate that there has been some major changes. Youth, women and man are now free to attend meetings and to speak freely. Changes in decision making and co-operation (e.g. growing crops together) are observed. Resources and responsibilities (e.g. raising money for school fees) are shared. A process is started to discuss problems within the family or with friends to solve problems and to reduce disputes at home.

It is obvious that the GOC initiates a positive process to reflect on gender roles and to create awareness on cultural and social patterns.

⁸ With love portion the Tonga describe a practice where usually a wife brews a portion which she administers secretly to her husband to be assured of his love. Beside magical concepts, love portion practice can also describe the simple and soft poisoning of the husband. So he has to stay home and his wife can take care of him.

Since the GOC initiates awareness on socio-cultural attitudes and roles and furthers discussions on inter-human relationships, it provides an ideal entry point for multi-sectoral extension staff to address HIV/AIDS in specific workshops later on. The GOC furthers open discussions on behaviour changes. It is for this reason that it is recommended to be used before or after conducting village workshops on HIV/AIDS issues in rural communities.

Strengths of the GOC

In addition to its participatory aspect, GOC concentrates on analysing the relationships that exist between men and women, which is a vital aspect when discussing issues of HIV/AIDS in communities as these issues require the involvement of all social groups in the community.

Both, men and women should discuss freely together, it takes into account problems of the different genders and concentrates on finding solutions to specific concerns. It also aims at empowering women by educating them on legal aspects. Above all, it enhances a spirit of understanding and co-operation. Experience has shown that women have been empowered to make their own decisions.

Weaknesses of the GOC

One of the major weakness of this approach is that results tend to take long to be seen and as such the community may lose interest.

Communicating HIV/AIDS: An Assessment at Field Staff- and Community Level

The systematic incorporation of concerns related to HIV/AIDS into agricultural extension work is a novelty in Zambia. In the past agricultural extension workers neither held village workshops focusing on HIV/AIDS or had been trained in this regard. Therefore, one can assume that the current existing level of knowledge on HIV/AIDS among extension workers is poor and diverse and probably mixed with myths and misconceptions just like in the general public.

An initial village workshop on concerns related to HIV/AIDS without any training for the involved extensionists was held by an exclusively agricultural team on 8th and 9th of August in Mandala Village, Choma District. During this workshop it turned out clearly that the extension workers need more knowledge on HIV/AIDS and on how to communicate it. For example misconceptions (e.g.: sharing the same spoon transmits HIV/AIDS) on HIV/AIDS were discussed among the participants without any intervention from the extensionists.

The elaboration of a training concept under such circumstances requires at least a survey among field staff, aiming at identifying the basis where to start. Another point one has to take into consideration is the fact that communicating a highly sensitive subject like HIV/AIDS requires specific facilitation skills.

Therefore, a survey was conducted in the Batoka, Pemba, Mbabala, and Mapanza agricultural blocks of Choma District with a total of 21 participants out of the agricultural extension staff. The survey was a mixture of individual questionnaires and group discussions and finally led to a needs assessment. This approach shaped the training concept.

The needs assessment among field staff was completed by a village survey (Munga Village, Monze District) focusing on the level of knowledge and frankness to talk about HIV/AIDS. Munga Village was chosen for this purpose because it had already undergone a GOC-cycle.

The following chapter synthesises the results with regard to designing the training concept, which is presented in the next chapter.

Knowledge, Perception, and Attitudes of Agricultural

Extension Workers towards HIV/AIDS

Individual Predispositions of Agricultural Extensionists

The whole sample included 21 interviewees and was composed as follows:

Sex	Male: 19		Female: 2
Marital status	Married: 20		Single: 1
Origin	Southern Province: 13		Others: 8
Age	Mean: 40 Years	Max: 53 Years	Min: 28 Years
Working for MAFF	Mean: 16 Years	Max: 32 Years	Min: 5 Years
Working in that particular camp	Mean: 9 Years	Max: 15 Years	Min: 2 Years
No. of children	Mean: 7	Max.: 24	Min: 0

Within our sample, the MAFF extension worker is in average male, married, 40 years old, has been working for MAFF for 16 years, and working in his camp for 9 years.

The long average time of 9 years extensionists already have been working in their camp indicates that they should be known and accepted by the villagers. On the one hand, this is an advantage for addressing sensitive matters like HIV/AIDS. On the other hand, they are known as agricultural and not health extension workers. This fact could lead to some difficulties in terms of introducing the topic of HIV/AIDS, which is, in the first place, not directly related to agriculture.

Looking at the questionnaire and the group discussion, it seems that nearly all extension workers are ready to receive specific facilitation training skills for incorporating HIV/AIDS issues in village workshops. The discussions took place in an open, free and friendly atmosphere.

The questions concerning their individual or private behaviour towards discussions on HIV/AIDS were answered as follows:

Do you, as an extension worker, discuss matters related to HIV/AIDS within your family?

Yes	17
No	2
Not much	2

Imagine you would do so, how would you feel?

OK, all right, protected	18
Uncomfortable	2

A bit shy	1
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To put the focus on those extensionists who expressed being uncomfortable talking about HIV/AIDS, it is interesting to have a look at the next question:

Do you think you are able to demonstrate the use of condoms?

Yes	13
Yes, if trained	5
No	2
Only male condoms	1

Only two individuals answered that they are not able to demonstrate the use of a condom and those two wrote that they do not discuss matters of HIV/AIDS within their families and further on that they would feel uncomfortable or a bit shy in doing so.

Those two men were among the 4 oldest men of the whole sample and have been working for more than 12 years in their camps. Conclusion is, that during the training on HIV/AIDS the trainers have to be aware of the difficulties elderly men have in communicating such a topic to communities.

What is your opinion on HIV-testing?

It is good to know your status	12
It is bad (to know that you are HIV positive)	4
Ambivalent answers	2
...	...

Six out of 21 interviewees expressed that they see problems in HIV-testing, mainly because they fear for somebody to know that he or she is positive („devastating results for some people“, „some could commit suicide“). This fears should be taken seriously when discussing HIV-testing, although this position might reflect also an underestimation of the role the asymptomatic stage of HIV plays for the transmission and the spread of HIV/AIDS for the society as a whole.

Medical Aspects

With regard to the medical aspects like transmission, curability and course of HIV/AIDS nearly all of the persons interviewed have at least a basic knowledge about HIV/AIDS.

What is AIDS (Acquired Immune Deficiency Syndrome)?

Disease which destroys / destroyed immune system	12
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Incurable (killer) disease	4
Disease acquired through sexual intercourse	3
Disease which attacks by different symptoms	1
Symptoms of HIV	1

The major part of the sample described AIDS as a disease, which destroys (or already destroyed) the human immune system, or an incurable killer disease. Also the other answers like 'AIDS is acquired through sexual intercourse' or 'AIDS are the symptoms of HIV' reflect the basic knowledge extension workers have about AIDS. Similarly the answers to „What is HIV“ reflect a good basic knowledge, even though two people did not answer at all:

What is HIV?

Virus which causes AIDS	12
Somebody who carries the virus	5
First step after being infected	1
The disease developed after getting AIDS	1

HIV was mentioned as the 'virus causing AIDS' or even the state where people are infected but not yet developed symptoms. Only one answer (HIV is the disease developed after getting AIDS) was completely wrong.

The extensionists were also asked to write down the signs and symptoms which indicate AIDS respectively HIV. Those answers lead to a more elaborated picture.

Both questions (Symptoms of AIDS, Symptoms of HIV) were filled in by the whole sample, and nearly every known symptom of any disease is mentioned. In the answers to „What are the symptoms of AIDS?“ we find a total of 56 symptoms. On the other hand for „What are the symptoms of HIV?“ 15 (false) symptoms of HIV were mentioned, but 9 answers were more or less correct („HIV is only known by testing“, „No symptoms“, „Loss of immunity“). This points to the fact that the difference between the asymptomatic „incubation period“ HIV and the stage of full blown AIDS is only known by a minority.

The answers referring to the duration of the incubation period are quite dispersed:

What is the incubation period of the disease?

I do not know	7
Varies from one individual to another	3
Depends on nutritional status	1
...	...

Eight extensionists estimated the duration of the incubation period in any length from between 7 days or 3 months to 15 years.

It is important to mention that all of those nine who gave correct answers on the symptoms of HIV wrote that they have no idea on the incubation period. On the other hand the ones which gave more or less exact dates on the incubation period had false knowledge on the symptoms of HIV.

This point already refers to the fact that extensionists at least know something about HIV/AIDS but that nobody really has an entire picture about the course of the disease.

With two exceptions (No answer, deep kissing) the whole sample shows a good knowledge on the main ways of transmission of HIV/AIDS:

How is HIV/AIDS transmitted?

(Unprotected) sexual intercourse	20
Blood transfusion	7
Unsterile needles, razor blades, tattoos	6
Through sexual fluids, blood, contact sores	3
Deep kissing	1
Mother to child transmission	1
No answer	1

The fact that AIDS is not curable is confirmed by 19 extensionists.

Both from those who claimed it is curable, one mentioned natural herbs for cure (but thought more of suppressing symptoms than curing them) and the other wrote that the cure is too complicated, so prevention is better. The difference between cure and suppression of symptoms led to some confusion.

Prevalence, Spread, and Risk Groups

The question „What do you know about the prevalence of HIV/AIDS“ was posed on three different levels: Province, district, and camp. It came out clearly that the answers given by the extensionists tend to underestimate its prevalence the closer the question refers to their immediate environment. As example one extensionist is quoted here, who estimated the prevalence of HIV/AIDS in Southern Province with 40%, in Choma District with 5%, and in his camp with 0.01%. One exception is made by a camp officer who is based at Maamba road with lots of bypassing truck drivers and businessmen, who is very aware that he lives in a highly risky environment.

In identifying risk groups nearly the whole sample referred to age groups in between 13 and 45 years, and most of them mentioned the high sexual activity in this group as the main cause. Some extensionists differentiated risk groups

following sex or education. Other groups mentioned (but only once each) as exposed to a high risk were: businessmen (due to their mobility), prostitutes, drunkards, and males who cleanse widows.

Keeping in mind that, by listing the risk groups, most extensionists have shown that they are very aware about the fact that unprotected sexual intercourse is the main form of transmission, they mentioned many different ways of transmitting HIV/AIDS:

Although many extensionists mentioned unsterile needles, razor blades, blood transfusions, etc. as possible ways of infection, this list gives a very clear picture that they are very aware that high transmission rates almost exclusively take place during unprotected sexual intercourse.

Knowledge on Traditional Aspects in Relation to HIV/AIDS

The main answers to relationships between traditional beliefs or practices and HIV/AIDS were the following:

Do you know of any traditional aspects (beliefs, practices, attitudes,...) that are related to HIV/AIDS?

Some (infected) say it comes through witchcraft	5
Widow cleansing	4
Widow cleansing disappeared, no clear inheritance	2
Razor blades, tattoos	2

Even if five extensionists only carefully mentioned witchcraft to be thought as a reason for HIV/AIDS for some people, it obviously plays a role in discussions on HIV/AIDS. In addition, the topic of widow cleansing plays a role in traditional customs which influence the spread of HIV/AIDS. But as we will refer to later in the analysis of the group discussions in both meetings, the extension workers agreed unanimously on the fact that widow cleansing by sexual intercourse has totally or at least nearly disappeared. This has led to confusion and quarrels on the inheritance customs. The reason for this is the important role the cleanser of the widow plays in inheritance patterns.

In estimating the roles of traditional healers and traditional medicines an interesting difference between them becomes apparent. The most frequent answers were grouped as follows:

What is the relationship between traditional healers and HIV/AIDS?

(For the sake of money) some claim to cure AIDS	8
They suppress symptoms	4

They cure symptoms	2
What is the role of traditional medicines in HIV/AIDS?	
(Only) to suppress symptoms	10
Boosting immunity	3
They can not treat it, not effective	2

Where traditional healers are seen as claiming or trying to cure AIDS (one even wrote „for the sake of money“) or at least the symptoms by half of the extensionists, the same number of extensionists believe in traditional medicines to suppress symptoms of AIDS. Here, even the extensionist already mentioned above who believes in the curability of AIDS through natural herbs wrote: „Natural medicines cure HIV/AIDS for sometime, but do not cure the disease completely“.

The awareness of extension workers with regard to traditional medicines is good, but the difference between suppressing symptoms respectively curing diseases should be clarified.

Knowledge on Agricultural Aspects in Relation to HIV/AIDS

With regard to the impacts of HIV/AIDS on agricultural production the major part of extension workers have already observed or foresees a drop in agricultural production. Among the main reasons they identify, the high death rates among farmers (specially among the most productive ones) and the loss of labour force because much time is spent on caring for the sick ranked highest. Also mentioned as causes but only once were the increasing death rates among agricultural extension workers, loss of time due to funerals, and diversion of investments in medicines instead of agriculture.

The topic of losing labour force due to care for the sick or attending funerals was mentioned rarely in the questionnaire but came up strongly in the latter group discussions.

For future agricultural development some extensionists also fear an overburdening of households with children, food shortages, and increasing crimes.

Only three extensionists mentioned that they have not yet observed major changes, and only two do not foresee any future change as described above.

Participatory and Counselling Skills

The level of participatory and counselling skills is roughly described as follows: Almost all extension workers are trained in PEA methodology, and they have

adopted it. Only seven are trained in the gender sensitive GPEA / GOC approach and eight have adopted this approach. Even though, one has to mention that the interviewees who confirmed that they received a training in GPEA are not necessarily the ones who are using it. Consequently one extension worker wrote, that one of the weaknesses with regard to GPEA is the „improper staff training“ in this approach. So it would be risky to build an HIV/AIDS component on GPEA without further staff training in this approach. None of the extension workers is trained in counselling.

The direct question on what kind of support they would like to have was answered as follows:

What kind of support would you like to have in disseminating information on subjects like AIDS / sexual behaviour on community level?

Training on HIV/AIDS / Information	19
Training materials (Booklets, Manuals, Posters)	10
Better transport	4
Visual aids	2
Better funding	2
Supporting assistance	1
Allowances	1
Drama group	1

Nearly all of the extension workers expressed that they would need specific training on HIV/AIDS before they are able to work on it. While half of the interviewees expressed the need for training materials like booklets, handouts, manuals, or pamphlets. The latter requirements like materials, transport, funding, allowances, and better support, correlates strongly with the expressed constraints in their work. Mostly the extension workers indicated their problems as poor transport, poor allowances, and lack of training materials and stationary.

The main answers concerning the likes of their work were related to the fact that most extension workers enjoy the direct contact with the farmers, the sharing of ideas and the participatory approach they use.

Other Topics that Came up During the Group Discussions

In the group discussions on the methodology to use in introducing the topic of HIV/AIDS, the following main points were mentioned:

- The extensionists are known as MAFF staff working on agriculture. So one should avoid conducting a whole village workshop only on the medical implications of HIV/AIDS; that would lead to confusion among the villagers

and „they would never come back“ to another workshop. HIV/AIDS should be dealt with also in relation to its impacts on agricultural production.

- The extension workers agreed that they should deal with HIV/AIDS impacts in agriculture (some because the „donors want to see an HIV/AIDS component in each project.“) and the necessity to be trained in. They also fear to be blamed by the farmers on not knowing much about HIV/AIDS.
- In both group discussions, it was agreed that MAFF should co-operate with the MoH, but the agricultural extensionists wish to organise the meetings by themselves, because they think that they have much better approaches to reach the farmers. MoH approaches are „too top down and too academic“.
- The extension workers in one group discussion mentioned that the approach with the human disease calendar may work but with difficulties because the farmers will express all diseases easily with the exception of HIV/AIDS
- Widow cleansing by sexual intercourse already disappeared in many cases because people fear to be infected; but it depends on the cause of death to the husband. So they still practice widow cleansing by sexual intercourse when the husband died for example in an accident, because than they may assume that he was not HIV positive.

Knowledge, Perception, and Attitudes in Rural Communities towards HIV/AIDS

The survey among extension workers was complemented by a village survey to clarify some controversial assumptions that came up during the discussion sessions with extension workers. If verified, these topics could have severe impacts on the whole project, or could even be taken as seriously hampering HIV/AIDS awareness training.

Therefore, a small survey based on semi-structured interviews was conducted in Munga Village with a gender-balanced sample of 10 interviewees. With one exception (a 74 years old man), all of them belonged to the age-group ranging from 20 to 45 years of age, which is the group most affected by HIV/AIDS.

The possible problems to be examined were the following:

- Assumption 1: MAFF staff members are not accepted as trainers on HIV/AIDS in communities, because they are already known as agricultural extension workers.

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- Assumption 2: In village workshops, HIV/AIDS is not communicable at all because to many taboos or fears are related to it.
 - Assumption 3: In group discussions on community level, sexual behaviour, the use of condoms, respectively is not communicable at all because too many taboos or resistance are related to them.

In addition, the community survey gave a first impression of the current knowledge on HIV/AIDS in general, on prevention and on coping strategies.

Concerning the presumed taboos of community members towards talking about health topics with agricultural staff, it turned out clearly that the interviewees do not have any reservations. On the contrary, they mentioned the good relationship they have maintained over many years with „their“ extensionists, as a real advantage with regard to the sensitivity of the subject. Some of the interviewees have even shown awareness about the fact that the prevalence on HIV/AIDS and the drop in agricultural production are closely related subjects, which even improves the acceptance of MAFF members in the community.

With regard to the frankness of communicating HIV/AIDS and sexual behaviour, one can state in general that in single as well as in group interviews we did not observe any severe inhibitions. The interviewees were talking frankly about use of condoms, their helplessness to find adequate coping strategies as well as about the problems which affected families, orphans or infected persons have.

Concerning the level of knowledge on HIV/AIDS, one can state that a good knowledge on the more general items is expressed. Unprotected sexual intercourse was identified as the main way of transmission and AIDS is known as an incurable killer disease and awareness exists about the common ways of prevention, as suggested in the ABC-pattern (Abstinence, Be faithful, use Condoms). Furthermore, women were clearly better informed about HIV/AIDS than men, which derives obviously from the fact that nearby an Ante Natal Clinic with a specific HIV/AIDS programme is found where pregnant women are informed on the disease. However, the existing knowledge is sometimes mixed with misconceptions or an overestimation of irrelevant ways of transmission (e.g.: Kissing). Beside the existing general level of knowledge, it turned out clearly that when getting more into detail, the interviewees have shown interest to be better informed. Asked for their preferred ways on how to obtain further information, most of the interviewees explicitly expressed their desire for specific HIV/AIDS related village workshops.

Coming back to the main purpose of this village survey, one can state that the fears and inhibitions to address HIV/AIDS mentioned above, were probably observed some years ago, when HIV/AIDS was a new and frightening issue. However, nowadays when the impacts of HIV/AIDS obviously affect each family as well as the society as a whole, resistance almost completely has disappeared and given space to growing interest to be better informed on the pandemic.

Conclusions Regarding the Specific Needs for the Training Concept

This chapter presents the conclusions and recommendations which were extracted from the survey on field level. They reflect the levels of knowledge, the attitudes and the perceptions with regard to HIV/AIDS which exist among the agricultural extension workers currently working in Choma District as well as among members of rural communities. This conclusions played an important role for the elaboration of the training concept, which is presented in the next chapter. Therefore, they finally led to a sensitive and locally adapted shape of the training concept.

Training Needs for Agricultural Extension Workers

- In general, one can state that extension workers are willing to incorporate HIV/AIDS issues in their daily work. An exception has to be made for some elderly staff, who obviously have problems to communicate topics related to HIV/AIDS or sexual behaviour to communities.
- Asked for the type of support they would like to have when working on HIV/AIDS, nearly all of the extensionists expressed their wish to be trained specifically in HIV/AIDS facilitation skills and half of the sample requested training materials like booklets, manuals, pamphlets etc. Therefore, in addition to the training, a specific HIV/AIDS field guide and sensitisation materials for extension workers have to be developed.
- The extension workers as a whole have a better understanding of the ways of transmission (exception: Mother to child transmission) of HIV/AIDS and the course of the full blown disease (AIDS). They have less knowledge on the „invisible“ course of the disease during the asymptomatic stage and the duration of the incubation period.

A training concept has to incorporate the different knowledge levels of extension workers into an entire holistic image of the course of HIV/AIDS, with special consideration of the role the long but „invisible“ incubation period plays in transmission and spread of the disease.

- The fact that HIV/AIDS is not curable is confirmed by the whole sample, but the difference between „curing a disease“ and „suppressing symptoms“ has to be clarified.
- Concerning the knowledge on the prevalence of HIV/AIDS in different areas, it comes out clearly that extension workers have a clear picture of the prevalence in general terms but tend to underestimate the threat the closer the areas they think about are related to their daily lives or camp. Therefore, a sensitisation on the risks of HIV/AIDS in everybody's immediate neighbourhood has to take place.
- The expressed opinions on HIV testing expressed by the interviewees are very different. Whereas most extensionists agreed on the usefulness of HIV testing, about 1/3 of them disagreed and mentioned the enormous problems people face when they know they are HIV positive. Advantages of testing as well as aspects of „positive living“ should be discussed, without disregarding the fears people may have.
- Some extensionists expressed that they do not see a relationship between HIV/AIDS and agriculture. While, at least some extensionists observed agricultural problems deriving from HIV/AIDS. e.g.: drop in agricultural production due to high death rates of farmers; loss of labour force due to lack of time which is spent on caring for the sick or funerals; overburdening of households with orphans. The ability of most extensionists to decode the relationship between HIV/AIDS and agricultural production has to be improved.
- The MAFF extensionists pronounced that they are known as agricultural extension workers and that a workshop conducted by them on pure medical aspects of HIV/AIDS would lead to serious confusion on side of the villagers. Therefore, within a multi-sectoral team MAFF staff should deal with HIV/AIDS in relation to agriculture, while health workers should cover the medical aspects.
- With regard to the work in a multi-sectoral team, it was agreed that MAFF staff should work together with the MoH, but the workshops should be

organised by MAFF, because they have „much better participatory approaches“ to reach the farmers. A point of view the CATAD Team shares.

- With regard to the participatory facilitation skills, nearly all of the extensionists are trained in and have adopted PEA. Only 1/3 of the extensionists are trained in GOC and 1/3 use this approach. Although, the extensionists who use GOC are not always the trained ones. Consequently, the HIV/AIDS component can not build on GOC without further gender training.
- None of the extension workers is trained in counselling. Taking into account the difficulties of professional counselling, extension workers at least have to be sensitised on the difference between facilitation and counselling. Furthermore, they have to be provided with information on and addresses of counselling institutions, where they can refer somebody in need of counselling.
- Traditional aspects mentioned by extensionists to be related with the HIV/AIDS are witchcraft, widow cleansing and tattooing. Therefore, how to deal with traditions, myths and misconceptions has to be part of a training on HIV/AIDS.

Communicating HIV/AIDS in Communities

- We did not observe any severe inhibitions, which would hinder open discussions on HIV/AIDS or related aspects as sexual behaviour.
- Agricultural extension workers are accepted to deliver information on HIV/AIDS, especially when they are well known in the village.
- Even in remote rural areas, basic knowledge on HIV/AIDS exists, but it is mixed with wrong assumptions or misconceptions. While talking about HIV/AIDS all interviewees expressed their desire for further information on the disease.

A Training Concept for Sensitising Field Staff on HIV/AIDS

With regard to the results of the needs assessment (see chapter 5), a training concept was elaborated to enable field staff to address HIV/AIDS at community level. In training workshops, multi-sectoral teams formed, at least, by field staff of agriculture and health should build the capacity to conduct village workshops on HIV/AIDS following the participatory extension approach.

Elaborating the Concept

Based on the needs assessment the design of the training concept and the concept of the village workshop was elaborated in three main steps:

Pilot Training on HIV/AIDS

A two-and-a-half-day training workshop for field staff was held from 5th to 7th September 2000 in Choma. In different sessions, the following aspects related to HIV/AIDS were addressed and discussed:

- medical aspects and the prevalence of the disease
- prevention and coping strategies
- traditional beliefs and misconceptions related to HIV/AIDS
- psychological skills and facilitation skills
- participatory extension approaches applied to addressing HIV/AIDS issues at village level

The last half day of the training was used for the preparation of two village workshops on HIV/AIDS by two multi-sectoral teams.

Different sessions were conducted by different trainers, according to their professional expertise (e.g. by Kara Counselling, by staff from health and agricultural sector). Moderation was done by the CATAD team.

Village Workshops on HIV/AIDS

Following the above training workshop, two village workshops on HIV/AIDS were conducted from 12th to 15th of September in Sikalongo Settlement and in Siakayuwa Village, Choma District. Both workshops were conducted by local multi-sectoral field worker teams, trained in the former workshop. Each team consisted of the block extension officer, the camp officer, the veterinary

officer, the community health worker and a nurse. In addition in Siakayuwa one member of MAFF at district level was part of the team.

The village workshops were conducted according to the programmes the teams had elaborated during the last day of their training. The starting position for the two communities was different. While the community of Sikalongo Settlement was informed on the purpose of the workshop, the community of Siakayuwa did not know that the workshop was dealing with HIV/AIDS. Therefore, the workshops in the two villages followed a different process.

While in Sikalongo the issue of HIV/AIDS was addressed directly from the beginning (by brainstorming on the existing knowledge on HIV/AIDS and on the relationship of agriculture and HIV/AIDS), in Siakayuwa the first day was dedicated to the outlining of the existing diseases and their effects on the community. HIV/AIDS was set subject of the workshop only afterwards by a secret voting, ranking the diseases that are the most difficult to cure. Both communities elaborated a cause and effect analysis of HIV/AIDS. Due to the fact that HIV/AIDS was discussed in Sikalongo from the beginning, there were also held discussions on traditional beliefs and misconceptions related to HIV/AIDS as well as on prevention measures (including condom demonstrations). On the last day both villages worked out a community action plan and a monitoring and evaluation system, in order to continue the process that had started during the workshops.

Evaluation

Looking at the evaluation of the training workshop and the village workshops on HIV/AIDS in its entirety, the pilot training of the field staff can be seen as a success. Not only the field staff felt prepared to address HIV/AIDS and to discuss related concerns at community level (after the training), but also the communities appreciated the teams' efforts and their information inputs on HIV/AIDS. Nevertheless evaluating the pilot training as well as the village workshops provided also some critical contributions that helped to improve the design of the training concept.

Methodology

The training workshop as well as the village workshops were monitored and evaluated by the CATAD team and the participants of the training and village workshops. During the **training workshop**, daily feedback sessions on

atmosphere and content of days deliberation were held. In addition, a final evaluation in form of a questionnaire took place.

The **village workshops on HIV/AIDS** were evaluated through questionnaires completed by field staff facilitating the workshop. One week after the village workshops, individual interviews were conducted in the communities to identify the level of knowledge acquired by the villagers with regard to a potential change of behaviour towards HIV/AIDS.

Lessons Learnt from Training Workshop

In general, it can be said that the field staff gave a very positive feedback on the training, especially on the structure and the content of the programme. The following aspects were suggested to be taken into consideration for further training workshops on HIV/AIDS:

- **Duration of the workshop**

It turned out that the workshop was planned for too short. To cover a complex issue as HIV/AIDS and its related concerns in only two and half days time, overloaded the programme.

- **Participatory approaches and tools**

Training on participatory approaches and tools was not given enough time. They have to be explained in detail and there have to be done exercises simulating actual field work. This is of even more importance as participants have different backgrounds regarding their professional expertise and not all of them are trained in applying participatory methods.

- **Preparing village workshops on HIV/AIDS as a multi-sectoral team**

Working together as a multi-sectoral team needs practice. Not enough emphasis on (multi-sectoral) teambuilding, led to difficulties in co-ordination during the preparation phase for village workshops as well as during the facilitation of the workshop.

Lessons Learnt in Village Workshops on HIV/AIDS

As it could already be assumed from the results of the village survey (see chapter 5) participatory workshops on HIV/AIDS were highly appreciated by the communities. HIV/AIDS can be addressed directly. There is no resistance to communicate even on more sensitive topics such as sexual behaviour or traditional beliefs. Villagers were actively participating and showed big interest in being better informed on the disease as well as in discussing prevention and coping strategies. Working together with a multi-sectoral team (consisting of

staff from agricultural and health sector) proved to be of great value as HIV/AIDS could be addressed in all its complexity. During the evaluation interviews people expressed that they have a more profound understanding of HIV/AIDS, the transmission of the virus, the spread of the disease, preventive measures and the effects of the disease on the livelihood and farming system in the settlement due to the workshop. First follow up activities have already taken place and keep the process of fighting HIV/AIDS going.

Concerning the conduction of village workshops on HIV/AIDS the following aspects are of importance:

- **Adaptation of the PEA Cycle**

Differing from a normal PEA there is need to transfer knowledge on HIV/AIDS to the communities. Field staff has to be trained on the delivery of information and there has to be given enough time to information sessions during village workshops on HIV/AIDS.

Using the PEA cause-effect analysis (problem tree) without adaptation emphasis prevention and neglects effects and thereby discussions on coping strategies. Field staff should be trained to work on the effect-side of the problem tree as well. Facilitators need more experience on how to interpret problem trees.

- **Facilitation skills**

Although facilitation skills were in general adequate, further training would give more support to the field staff in addressing a sensitive topic such as HIV/AIDS.

- **Field guide**

A field guide for village workshops on HIV/AIDS was requested by the field staff. They also require visual means.

Building on these experiences and findings of the analysis and evaluation of the workshops an improved concept for the training workshop and an improved concept for the village workshops on HIV/AIDS was elaborated.

The Training Concept

As a result of the evaluation, the training workshop was extended from two and a half days to a four-day workshop. The objective of the training is to enable field staff to work in multi-sectoral teams on concerns arising from the HIV/AIDS pandemic. Participants of this training acquire the skills to conduct participatory workshops on HIV/AIDS in rural communities.

The training workshop is intended for staff of different sectors, such as agriculture and health. There should be not more than 20 participants. Staff from different levels should attend the training, including field and district level staff. From the MAFF, camp officers, block officers and staff at district level should be invited. From the health sector, community health workers, nurses and traditional birth attendants should participate in the training workshop. The composition of the participants is chosen according to the villages, which are being serviced by them and where the HIV/AIDS-workshops subsequent to the training will be conducted.

According to the multi-sectoral approach of the workshop, trainers working in the agricultural sector and trainers from health sector, including non governmental organisations (NGOs) in the area of counselling and training shall be contracted. To ensure that the training is sustainable and to keep the costs low, local trainers shall be involved.

Each day of the four-day workshop is dedicated to different subjects. The first day deals with basic knowledge on HIV/AIDS. The second day is related to prevention and coping strategies for HIV/AIDS. The third day is dealing with participatory extension approaches addressing HIV/AIDS issues at community level. And the last day is used for the preparation of village workshops on HIV/AIDS that will be conducted by the multi-sectoral teams.

An elaborated training manual providing detailed information on planning and conducting a training workshop on HIV/AIDS as well as detailed descriptions of each session are included at the end of this report (see Annex 2). In this chapter only an overview on the content of the different training workshop days is given.

Day 1: Basic Knowledge on HIV/AIDS

Objective: At the end of the first day the participants should have familiarised with the topic HIV/AIDS and have a good working knowledge on the medical aspects of HIV/AIDS. The participants should be sensitised towards myths, misconceptions and traditional beliefs related to HIV/AIDS.

The first day includes the following sessions:

Day 1: Basic Knowledge on HIV/AIDS
Session I: Getting to Know Each Other
Session II: Introducing the Programme
Session III: Facts and Figures - HIV/AIDS in Zambia

Session IV: Comfort Levels

Session V: Medical Aspects - From HIV to AIDS

Session VI: Traditional Beliefs and Misconceptions Regarding HIV/AIDS

Day 2: Prevention and Coping Strategies

Objective: At the end of the second day the participants should have discussed methods of safer sex and know about different ways of prevention. The participants also should be able to conduct condom demonstrations. They should have improved their communication skills and be able to address death and dying. Participants should be sensitised towards HIV/AIDS concerns related to their field of professional expertise. They should also be informed about possibilities of counselling and HIV testing within their working area.

The second day includes the following sessions:

Day 2: Prevention and Coping Strategies

Session VII: Strategies of Prevention, HIV Testing, Positive Living

Session VIII: Psychological Skills

Session IX: Impacts of HIV/AIDS on Agricultural Production and Health Needs in Villages

Session X: Teambuilding

Day 3: Participatory Extension Approaches and HIV/AIDS

Objective: At the end of the third day the participants should know the participatory tools needed for a village workshop on HIV/AIDS and be able to use them adequately. Facilitation skills of the participants should have been improved.

Different PEA tools were adapted or modified in order to address HIV/AIDS adequately e.g. HIV/AIDS problem tree. A sequence for the village workshops is worked out to make sure that these workshops are homogeneous and that the aim of these workshops is reached by the multi-sectoral teams.

The third day includes the following sessions:

Day 3: Participatory Extension Approaches and HIV/AIDS

Session XI: Participatory Approaches and Tools

Session XII: The HIV/AIDS Problem Tree

Session XIII: Facilitation Skills

Day 4: Preparation of a Village Workshop on HIV/AIDS

Objective: At the end of the last day the multi-sectoral teams should have prepared a village workshop on HIV/AIDS and the participants should be aware of the importance of follow-up activities. The participants should have developed a good co-operation within their teams.

To support the multi-sectoral teams during the preparation of the workshops, a checklist for the planning phase is worked out.

A field guide has to be finalised and printed in order to assist the field staff for planning and conducting a village workshop.

The fourth day includes the following sessions:

Day 4: Preparation of a Village Workshop on HIV/AIDS
Session XIV: Follow-Ups Session XV: Organising a Multi-sectoral Team Session XVI: Teambuilding Session XVII: Preparing a Village Workshop Evaluation

To put the theoretical knowledge acquired during the training workshop into practice, village workshops should immediately be conducted after finishing the training workshop. This consolidates the knowledge of the participants and ensures that the trained field staff really acquired the capacity to conduct workshops on HIV/AIDS. On the other hand, the initial village workshop ensures that multi-sectoral teams really start working in their administrative areas and further the process of implementation.

Village Workshops on HIV/AIDS: Applying HIV/AIDS Training at Community Level

To stop the increasing spread of HIV/AIDS in rural areas a concept for conducting village workshops on HIV/AIDS was elaborated. Multi-sectoral teams trained on HIV/AIDS should address systematically concerns arising from the disease in rural communities.

The objective of the workshop is to deal with information on HIV/AIDS and to create awareness on HIV/AIDS in rural communities. During the workshop information on prevention strategies should be provided and the communities' capacity to cope with the impacts of HIV/AIDS should be improved. Participants should be encouraged to reflect and discuss issues related to HIV/AIDS and sexual behaviour. In long terms this should lead to changes of behaviour to reduce the spread of HIV/AIDS. To reach this objectives a longer ongoing process in the community is necessary which should be monitored and supported by the multi-sectoral team.

Planning the Implementation

A first village workshop has to be planned during the HIV/AIDS training workshop and should be conducted by the multi-sectoral teams a few days after finishing the training. Further village workshops on HIV/AIDS should take place in other communities organised by the multi-sectoral team in their administrative area.

Villages which are selected for a workshop on HIV/AIDS, should have been joined in a Participatory Extension Approach (PEA) or a similar approach before e.g. the Gender Operation Cycle (GOC). This ensures that the methodology and the tools which are used in the workshops on HIV/AIDS are known in the community and that the community is familiar with some of the team members. This is an important precondition to create a relaxed atmosphere right from the beginning of the workshop and to ensure follow-up activities. Therefor at least the MAFF camp officer responsible for the selected community as well as the community health worker or the traditional birth attendant in the community should be part of the team.

The workshop on HIV/AIDS shall last two or two and a half day. The timing of the workshop should take into account agricultural seasons. The best time for the start-up workshops on HIV/AIDS is after harvest time because at this time

of the year, people are less occupied with agricultural activities. Follow-up meetings can be spread through out the year.

The first village workshop on HIV/AIDS should concentrate on HIV/AIDS only, while follow-up activities can be linked up with other activities or even be embedded in the routine work of the field workers.

For detailed planning, all duties of the different social groups in the community have to be considered (e.g. the availability of women due to their duties in the household). As many community members as possible should be encouraged to attend the workshop on HIV/AIDS. To make sure that the process can be discussed and implemented among all household members, couples should be invited to the workshop. Emphasis should be put on the mobilisation of the adolescents and the youth as they are at the beginning of their sexual active phase. Communication and understanding between different age groups will become much easier when all age groups are present at the workshop than if they are not.

Date and duration of the workshop as well as the venue and other logistical arrangements have to be discussed and agreed upon with the community or key persons of the community.

Conducting the Workshop

For conducting village workshops on HIV/AIDS an approach with different phases is elaborated (see HIV/AIDS cycle). Multi-sectoral teams should follow different steps using specific participatory tools to address HIV/AIDS at community level (see Annex B in Toolbox 2 for a detailed description).

A workshop is started by introducing the multi-sectoral facilitation team and the topic to the community. After that the multi-sectoral team should start with the first phase of the HIV/AIDS cycle.

- **Awareness Phase**

To familiarise the community members with the workshop topic a Human Disease Calendar and a Brainstorming Session on the existing knowledge on HIV/AIDS should be done. The aim of the Human Disease Calendar is to find out the prevalent diseases in the community and to work out the specificity of HIV/AIDS. During the Brainstorming Session the existing knowledge on HIV/AIDS in the community should be explored e.g. symptoms, transmission etc.. This phase is called the Awareness Phase. It is useful to find out the level of knowledge and the existing misconceptions on HIV/AIDS in the community.

- **Reflection Phase**

The Reflection Phase aims at identifying causes and effects of concerns related to HIV/AIDS. According to the field of expertise of the facilitation team members problem trees (flow diagram) on HIV/AIDS in general and on HIV/AIDS focusing on the impacts on agriculture should be elaborated. These problem trees are very useful to work out a holistic picture of the problem and to illustrate the relationship between causes and effects of the problem. In a further step the causes then will be the entry point to start working on prevention strategies. The effects show the impacts of HIV/AIDS and can be used to work out coping strategies in the community.

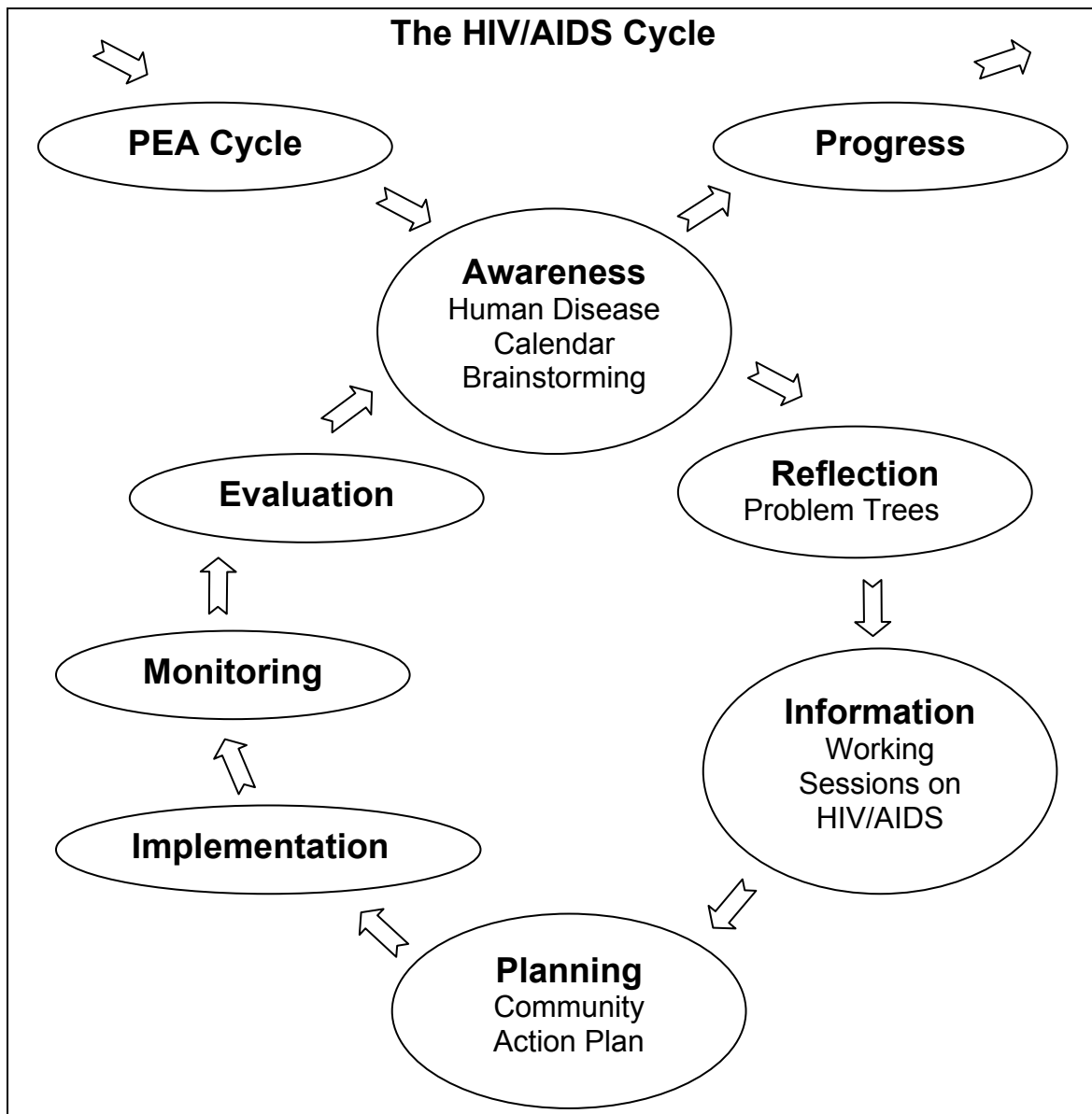
- Information Phase

Differing from a normal PEA, there is need to transfer knowledge on HIV/AIDS in special sessions in order to deliver information to community members and to clarify misconceptions. The facilitation team should refer to discussions and / or questions that came up before especially during the Awareness Phase. These Information Sessions should meet the specific needs of the community. Discussions on Traditional Beliefs Related to HIV/AIDS or Prevention Strategies including a condom demonstration may be topics for these Information Sessions. While PEAs related to agriculture draw heavily on indigenous knowledge and own experimentation by the target group, it is very important that the workshops on HIV/AIDS first create knowledge on HIV/AIDS and clarify misconceptions before prevention and coping strategies are developed.

- Planning Phase

In the Community Action Plan (CAP) that is subsequently developed, follow-up activities are fixed and activities for monitoring and evaluation have to be agreed upon. Topics which could not be dealt with during the workshops should be discussed in further meetings. Community members should identify root causes and main impacts of HIV/AIDS in their community, discuss possible solutions and action required in future.

After participating in this village workshop on HIV/AIDS community members should have a basic knowledge on HIV/AIDS and misconceptions and myth should be discussed and clarified. Awareness on HIV/AIDS should be created so that this workshop could be used as a basis for further discussions on concerns related to HIV/AIDS in the community. Follow-up activities can be specifically focused on HIV/AIDS or even be embedded in other meetings.



During most of the sessions the community members divide into sub-groups, because sub-group discussions are more freely and there is more participation during the discussions. Besides different topics can be dealt with at the same time. The results of the sub-groups are presented and discussed in plenary.

The workshop has to be jointly organised by the multi-sectoral team which will be conducting the sessions on HIV/AIDS in the community. Co-ordination on content and facilitation within the multi-sectoral team is required. Team members are expected to be trained on HIV/AIDS to ensure that basic information on HIV/AIDS is delivered to the community. Team members have to be prepared to agree on each one's role within the team and share responsibilities for facilitation, note taking and report writing. Responsibilities regarding the invitation of the community, logistics and information exchange on follow-up activities, have to be clarified.

The main idea of conducting workshops with multi-sectoral teams is to enable teams to address a wide range of issues related to HIV/AIDS. Each facilitator of the team should put emphasis on his field of expertise.

To assist the facilitators in planning and conducting village workshops a field guide will be finalised and published. Such a field guide should provide an overview on the basic facts of HIV/AIDS as well as its prevention and coping strategies. It should inform on psychological and facilitation skills necessary to address HIV/AIDS within the community. The guide should be a reference to regional counselling and testing facilities, health and other governmental and non-governmental programmes that render HIV/AIDS-related information and support for rural communities. And it should be a guide on how to plan and to conduct a workshop on HIV/AIDS. It also should give an orientation how to carry out follow-up activities, and how to organise responsibilities within a multi-sectoral team.

Closing Remarks

Due to the fact that overcoming HIV/AIDS is expected to be a rather long process, it is recommended to repeatedly address HIV/AIDS in the communities. To stop the spread of the disease, it is necessary to inform communities on HIV/AIDS and to enable them to communicate HIV/AIDS freely. The communities have to be encouraged to reflect and to talk about their personal sexual behaviour. Without increased awareness of these issues, it is not possible to create any changes of behaviour and to reduce the spread of the disease.

For many people, HIV/AIDS is just one of many problems they have to face every day. Nevertheless, there is great need to continue to address this problem in the communities due to the long-term impacts of the pandemic. Therefore it is necessary to develop coping strategies to deal with the already existing impacts of the disease e.g. the orphans. Possibilities of self-help activities and external assistance should be discussed to promote strategies to overcome the enormous impacts of HIV/AIDS.

Conclusions and Recommendations for Institutionalising a Multi-sectoral Training Approach on HIV/AIDS

This chapter summarises the overall conclusions and recommendations of this report arising from the research, training, field testing, and evaluation undertaken. The main findings and recommendations were discussed at a stakeholder workshop (Annex A). The outcome of this workshop was taken into consideration in finalising this chapter. The recommendations are addressed to all stakeholders involved in rural development and to any individuals and organisations affected by HIV/AIDS concerns in their daily work.

The multi-sectoral approach seems to be very effective and efficient in meeting the rapidly increasing demand of rural communities for assistance in addressing the impacts of HIV/AIDS, on how to prevent its further spread, and on how to cope with it. HIV/AIDS is not any longer treated as a health or sectoral problem. Discussions in communities using the participatory extension approach (PEA) offer the opportunity to make relationships of HIV/AIDS with various aspects of rural livelihood explicit.

The training and the community workshops conducted by multi-sectoral teams were well received by all stakeholders involved. In order to expand the development of HIV/AIDS-related responses and to enable multi-sectoral teams to operate beyond this pilot project and to ensure their continuity, a more systematic co-operation will be needed.

Addressing HIV/AIDS at the Community Level

It is important to note that communities and their members were actually prepared to openly discuss HIV/AIDS-related issues and concerns. In addressing the HIV/AIDS complex, communities appreciated that:

- (a) Different aspects of HIV/AIDS are effectively dealt with simultaneously (being sensitised and informed about HIV/AIDS; having misconceptions clarified, discussing related social issues such as polygamy; creating awareness of linkages with agriculture production issues);

(b) Efficient use of time is made and adverse effects on the work schedules in the community are minimised; expertise contributed by agriculture and health field and extension staff is highly complementary; villagers requested that membership of multi-sectoral teams be extended to include teachers and NGOs.

A workshop focussing on HIV/AIDS seemed to be most effective to initiate a discussion process at community level. For this purpose, the PEA methodology used was highly appropriate for addressing HIV/AIDS-related issues in rural communities and to open discussions on behaviour changes. The Gender Operation Cycle (GOC) initiates awareness on socio-cultural attitudes and roles and it encourages discussions in human relationships.

Communities as a whole do not participate in such discussions, unless actively promoted. Special care has to be taken to involve young women and adolescents to participate in these sessions. Discussions focussing on HIV/AIDS require that community members are familiar with the PEA process and the tools, and that field staff facilitating HIV/AIDS-related meetings is known to the community.

Recommendation 1 (a):

Special community workshops focussing on HIV/AIDS should be conducted by multi-sectoral teams, using the PEA methodology as a flexible frame for discussing HIV/AIDS-related issues.

Recommendation 1 (b):

PEA village workshops have to be conducted before addressing HIV/AIDS in a community.

Recommendation 1 (c):

It is advised to go through a GOC, preferably before conducting a workshop on HIV/AIDS. This will enhance gender awareness and behaviour changes in the communities.

Initial workshops at community level revealed that field workers require a field guide. Such a field guide should provide

- an overview on basic facts of HIV/AIDS as well as prevention and coping strategies;
- basic information on psychological and facilitation skills necessary to address HIV/AIDS within a community;
- a reference to regional counselling and testing facilities, health and other governmental and non-governmental programmes that render HIV/AIDS-related information and support for rural communities;
- a guide on how to plan and to conduct a workshop on HIV/AIDS;
- orientation how to carry out follow-up activities and how to organise responsibilities within a multi-sectoral team.

Recommendation 1 (d):

It is recommended that a field guide is published as soon as possible to assist extension specialists and field staff in planning and conducting village workshops on HIV/AIDS.

Recommendation 1 (e):

By the end of 2003, multi-sectoral teams should have reached at least 50% of the communities in Choma District with HIV/AIDS workshops. That means that each agricultural extension worker will have conducted workshops in ten villages.

One of the factors that adversely affects the operation of multi-sectoral teams, i.e. the co-operation of field staff from different line ministries, is related to the differences in coverage of administrative areas of respective ministries and their services. Measures to increase compatibility of the various administrative areas will greatly enhance the efficiency of a multi-sectoral extension approach.

Recommendation 1(f):

It is recommended to harmonise the currently inhibiting separation into different administrative areas of the various sector ministries.

Follow-ups of initial village workshops on HIV/AIDS, which were conducted by the multi-sectoral field worker teams, are required. These include among others filling remaining knowledge gaps on HIV/AIDS, addressing open questions, and facilitation of the development and monitoring of community

action plans. It is also critical to provide backstopping and support to multi-sectoral field worker teams.

Recommendation 1 (g):

It is recommended to incorporate costs for village workshops and follow-up activities related to HIV/AIDS in the district budgets of the respective ministries.

HIV/AIDS Training for Field Staff

Training on HIV/AIDS involving different sectors was well received by all extension specialists and field staff. The concept for this training, which was designed and tested by the SLE consultant team, apparently matched an urgent training need to field workers and enhanced the currently practised PEA.

The training enabled field staff to work in multi-sectoral teams addressing HIV/AIDS-related concerns in village workshops. The training was based on the expertise of trainers, locally available. It was developed and tested to meet the specific needs in Choma District.

Based on the experiences and discussions during the project, a four-day training was designed including

- the delivery of basic knowledge on HIV/AIDS to rural communities
- prevention and coping strategies for HIV/AIDS
- specific PEA applied for addressing HIV/AIDS issues at village level
- preparation of village workshops on HIV/AIDS by multi-sectoral teams.

To expand the positive experiences described above more field staff and multi-sectoral teams have to be trained.

Recommendation 2 (a)

The concept for HIV/AIDS training contained in this report should be adopted and be widely used by MAFF, MoH, and other organisations to train field staff in rural areas. By 2003, all respective field staff in Choma District should be trained in conducting HIV/AIDS workshops at community level.

Recommendation 2 (b):

It is recommended to publish a HIV/AIDS training manual based on the concept proposed by the SLE team.

As further training workshops are being conducted, trainers and staff organising the training activities will gather further experiences in applying the manual. These experiences should be evaluated and incorporated to benefit future training and subsequent field activities of extensionists.

Recommendation 2 (c):

It is suggested to continuously adapt the training concept based on the lessons learnt.

Developing an Institutional Framework for Implementing a Multi-sectoral Response to HIV/AIDS in Choma District

Up to now, line ministries, including district and community levels, have operated largely within their mandates and defined areas of responsibility. Involving, for example, field staff from more than one ministry on a regular basis for carrying out joint HIV/AIDS-sensitisation activities, requires institutional arrangements.

Such arrangements at district level would remove the current limitations of individual sectors in implementing HIV/AIDS sensitisation in rural areas and, through co-ordination, greatly increase the effectiveness of extension approaches. At the same time, this would facilitate the rapid spread and wider implementation of a multi-sectoral approach to benefit the rural community at large.

Recommendation 3 (a):

It is recommended to the institutions concerned to set up an institutional framework under the District Council/Administration, which provides a sustainable mechanism and has the capacity to co-ordinate HIV/AIDS-related activities at district level.

Recommendation 3 (b):

For Choma, a task force at the District Council should be established as soon as possible, as the suitable option for an institutional framework. The task force will

- **elaborate a strategy and policy for preventing and coping with HIV/AIDS;**
- **define the role of the various actors and focal points in implementing activities; and**
- **co-ordinate HIV/AIDS-related activities in the district.**

The task force should be comprised of the district heads of key ministries with sector responsibility at district level (including Agriculture, Health, Education, Community Development among others), representatives from NGOs, and church initiatives.

Recommendation 3 (c):

It is recommended to establish a full time secretariat to provide adequate support and reporting to the task force and the required operational capacity for assuming day-to-day responsibility.

The role and activities of the secretariat should be defined by the task force during its first meeting. Activities of the secretariat may include the following:

- Support the integration of HIV/AIDS concerns into participatory extension approaches of development agents;
- Support multi-sectoral field activities;
- Develop further HIV/AIDS sensitisation material in local and English languages and ensure that specialised information needs are met;
- Organise training of trainers;
- Co-ordinate with HIV/AIDS focal points of the line ministries and other organisations, including NGOs;
- Monitor implementation activities on HIV/AIDS in the district.

There is also an urgent need for liaison with other actors at provincial and district level involved in HIV/AIDS-related field activities and the development projects in Southern Province.

An organisational mechanism as described above, is considered essential for Choma District. Eventually similar organisational arrangements have to be set up in other districts as well, taking into consideration the institutional mechanisms in place. For example, district planning units and DDCC sub-committees for social services could serve as functional arrangements. In

addition, existing services like the District Information System set up for Choma District should be utilised.

Visual Means and Sensitisation Materials

The evaluation of the training workshop as well as of the subsequent community workshops revealed that visual means such as posters, leaflets and the like, are urgently needed for sensitisation and awareness building activities at target group level.

Recommendation 4 (a):

The district administration in co-operation with the ministries concerned is advised to develop and produce sensitisation materials for target groups. Their availability to senior officers, field staff and as well as for rural communities (e.g. through district and community health posts) has to be ensured. Brochures and posters should be written in local language.

Recommendation 4 (b):

Condom distribution by projects, ministries and others should be continued. It should not be limited to staff members and Zambian co-operating partners only, but include target groups as well. This could be facilitated through the proposed HIV/AIDS Secretariat with support of GTZ.

HIV/AIDS Response within the Ministry of Agriculture, Food, and Fisheries

Explicit guidelines were lacking at the time when this project started to provide orientation to MAFF staff at national, provincial, and district levels on how to implement HIV/AIDS-related activities.

The twin-appointment of one female and one male Focal Point Person in each district was an important first step to address the vast increasing demands from HIV/AIDS within the ministry. However, given the limited human resources, they will need to concentrate on a few activities, not disperse their efforts.

Recommendation 5 (a):

It is recommended that also the role and duties within the organisation of both district and provincial HIV/AIDS focal point persons are made explicit and transparent.

Beyond the immediate staff-related concerns, there is a need to provide adequate guidance and strategic orientation for developing appropriate HIV/AIDS-related responses at the programmatic level within the different ASIP sub-programmes, including extension, and to co-ordinate HIV/AIDS-related training activities with other ministries. This need goes far beyond the specific responsibility and capacity of HIV/AIDS Focal Point Persons.

Regarding rural field work, HIV/AIDS-related issues are expected to become an integral part of the day-to-day activities. Hence, agriculture district officers and field staff, PE trainers of trainers at all levels will require education in HIV/AIDS-related aspects.

Recommendation 5 (b):

It is recommended that relevant parts of the training concept be integrated within basic and advanced training activities, i.e. respective training manuals of MAFF for trainers and staff should be revised. For example, HIV/AIDS awareness building and multi-sectoral activities should be incorporated into training curricula for agricultural extensionists (including agricultural colleges and in-service training centres).

Outlook Beyond this Project

The authors of this report hope that the report and the results contained herein render a small contribution to the growing efforts geared towards rural communities on preventing HIV/AIDS and coping with its effects, especially those by service providers, extensionists, and rural communities themselves in Southern Province of Zambia.

There seems a great potential in extending the experiences in HIV/AIDS sensitisation and awareness building for rural communities obtained by this project to other districts in Southern Province. Decision makers, extensionists and development projects are welcome to make use of the enclosed training

concept and to support the implementation of a multi-sectoral team approach to address HIV/AIDS in rural communities.

We trust that very soon a training manual for those responsible in organising and conducting HIV/AIDS training of multi-sectoral extension teams and a field guide for conducting village workshops will be available. However, at both provincial and district level, catalytic support is required until training and extension activities are fully established and operational.

In extending the lessons learnt to other places, development agents are welcome to adapt the multi-sectoral approach presented here according to their needs and opportunities in order to make it most practical and effective in implementing HIV/AIDS sensitisation and related extension activities.

Rural communities may realise benefits of HIV/AIDS sensitisation much earlier if the multi-sectoral approach is kept open to include further actors in rural development. Among them, the education sector should receive priority, considering the critical role of teachers in training the future generation.

This project could only take a first step in advancing HIV/AIDS sensitisation for rural households and communities. Much more needs to be done to create a better understanding of the impacts of HIV/AIDS and to promote change processes. The ultimate aim of all efforts must be to enhance the ability of rural households to cope effectively with HIV/AIDS and to continue to improve living conditions for rural communities.

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ANNEX A

Terms of Reference of CATAD / SLE Study

Title of study: **“Incorporating concerns related to HIV/AIDS into participatory rural extension approaches in the Southern Province of Zambia”**

The study group of the Centre for Advanced Training in Agricultural and Rural Development (CATAD) will assist the Ministry of Agriculture, Food, and Fisheries (MAFF) through the ASIP Support Project (ASSP) and the Ministry of Local Government and Housing (MLGH) through the District Development Project Southern Province (DDP) with support of the Health Project Choma and the HIV/AIDS-Sector Project of GTZ

- In developing concrete proposals/options and actions for targeted responses to address impacts of HIV/AIDS;
- To incorporate concerns arising from HIV/AIDS into the development framework in Zambia's Southern Province using a participatory integrated development and rural extension approach.

The study will be conducted 28 July – 24 October with a 5-week preparatory phase 13 June – 20 July at CATAD, Berlin. The team will specifically address the existing gaps within the framework of ASSP taking ongoing activities into consideration:

Assess existing rural extension approaches (incl. those of NGO) and existing schemes in terms of their effectiveness and efficiency for strengthening the coping ability of rural communities and farm households arising from impact/concerns of HIV/AIDS;

Describe the different target groups, their perception and level of concern regarding HIV/AIDS as well as existing action strategies;

Analyse the training/information and advisory needs of the various groups (incl. farm/household and rural communities; camp officers/extensionists; health workers; NGO staff; district, provincial, and national level staff);

Develop adapted training methodology/modules according to target groups for incorporating HIV/AIDS within the various extension foci of the project to be used in the participatory rural extension approach;

Test modules in the field using Choma district as a pilot;

Discuss preliminary findings with co-operating partners and incorporate suggestions in the draft report;

Document results and lessons learnt in the context of DDP/ASSP in Southern Province of Zambia in incorporating concerns of HIV/AIDS and make them available to interested stakeholders.

Goal, Project Purpose and Results of CATAD Study

Overall goal

The ability of the rural population and service institutions to prevent the spread of HIV/AIDS and to cope with the impacts of the disease is improved.

Project purpose

Concerns related to HIV/AIDS are incorporated into participatory extension approaches in Choma District (Southern Province), Zambia.

A framework for operationalising multi-sectoral strategies on HIV/AIDS in rural areas is developed.

Expected results

- Overview on the prevalence of HIV/AIDS and problems deriving from HIV/AIDS in Zambia, Choma District/S.P., is given, with special consideration of the social dimension of HIV/AIDS.
- Overview on national AIDS policies and state institutions dealing with HIV/AIDS in Zambia is given.
- Overview on relevant existing organisations working on HIV/AIDS in Choma District/S.P., and their approaches is given.
- Overview on participatory extension approaches currently used is given (focusing on PEA).

- HIV/AIDS specific assessment of GPEA/PID results is made.
- Needs assessment for the agricultural extension service concerning HIV/AIDS is made.
- A concept for sensitisation training on HIV/ AIDS for field workers is developed, building on PEA, which is currently used; aiming to
 - a) sensitise towards linking problems expressed by the community with HIV/AIDS;
 - b) work towards increased transparency of these linkages for the community;
 - c) address HIV/AIDS-concerns related to their field of expertise;
 - d) provide basic information about concerns not related to their field of expertise and to identify additional support/sources, if possible.
- Selected field staff is trained to address HIV/AIDS concerns.

- A draft is provided, which serves as a preliminary manual for village workshops.
- At least one test workshop in at least one village with a trained multi-sectoral team is conducted.
- A concept on how to conduct a village workshop on HIV/AIDS is developed
- Recommendations are given for:
 - a) The sustainable embedding in a multi-sectoral institutional landscape in Choma District;
 - b) Transferring results from Choma District to other locations and/or organisations
 - c) Concrete activities to follow-up the process initiated.

Timetable of CATAD Study

23 May 2000 – 30 November 2000

Preparatory Phase (Berlin, Germany), 23.5. - 21.7.2000

- 23.5. – 9.6. Preparatory visit to Zambia (Team leader)
13.6.- 11.7. Elaboration of research plan.
From 20.6. - 30.6. in collaboration with Dr. Bbalo (MAFF, Zambia), Dr. Siame (ddp / GTZ, Zambia), Mrs. Mulamfu (CBoH / GTZ, Zambia)
20.7. Final presentation of research plan

Field Phase (Zambia), 29.7. - 20.9.2000

- Week 1 Arrival in Lusaka
Start up workshop in Choma
Visits of stakeholders and other organisations in Livingstone and Lusaka
- Week 2 Initial field visits
Evaluation of initial field visits
Research phase
- Week 3 - 4 Splitting in Subgroups:
- Institutional landscape: Analysis of MAFF, MoH, CBoH, District Council and NGOs
 - Needs assessment of extension workers (Batoka, Pemba, Mbabala, and Mapanza blocks) and communities (Munga, Monze District)
 - Assessment of former PEA, GPEA and PID results with regard to HIV/AIDS
- Test phase**
- Week 5 Elaboration of training concept for rural field workers
- Week 6 Training workshop for field workers and district staff
Delivery of draft of results to field workers
Evaluation of training workshop

Week 7	Village workshops on concerns related to HIV/AIDS in Sikalongo Settlement and Siakayuwa Village Evaluation of village workshops
Week 8	Interviews with participants of village workshops Report Writing
Week 8 - 9	Writing of preliminary project report Delivery of preliminary project report to stakeholders Presentation of CATAD project at meeting of German Development Service (DED) in Siavonga
Week 10	Excursion
Week 11	Incorporation of remarks from stakeholders Presentation of results in stakeholder workshop in Choma
Week 12	Finalising of preliminary project report

Final Phase November 2000

3.11.	Presentation of results at Ministry of Economic Co- operation, Berlin
6.11 - 17.11.	Final editing of project report
4.12.	Presentation of results at GTZ, Eschborn

List of Resource Persons and Institutions contacted

(other than immediate partners)

1.8.00	Choma	Mr. Musulwe, District Agricultural Co-ordinating Officer, MAFF Choma
2.8.00	Livingstone	Mr. Hakayobe, Permanent Secretary Southern Province
3.8.00	Lusaka	Mr. Schröder, German Ambassador Mr. Kawila, Mr. Mwanza, HIV/AIDS Committee and AIDS Focal Point, MAFF Headquarter Dr. Sichone, Mr. Mwale, National HIV/AIDS Secretariat Traditional Healers Association Mr. Ndumbani, Institute for Economic and Social Research, University of Zambia
4.8.00		Mr. Ofosu-Barko, Mr. Thiis, UNAIDS Dr. Khonje, Mrs. Sibaziya, Director and Assistant Director Physical Planning, MLGH Headquarter Mr. Rasmussen, Danish Embassy
9.8.00	Monze	MAFF AIDS Focal Points Southern Province
14.8.00	Choma Choma	Mr. Hangwemu, Townclerk/District Council
17.8.00		Sr. O'Sullivan, Kara Counselling Choma, World Vision Zambia, Choma
18.8.00		Mr. Mukwesa, Senior Agricultural Officer, MAFF Extension Services Choma Africare, Choma Mr. Mwalusaka, Programm Officer, MAFF Provincial Office
22.8.00		Mrs. Mulamfu, CBoH / Reproductive Health Project, Choma
23.8.00		Dr. Mkandawire, Mrs. Shonga, DHO Mr. Chavwanga, Camp Officer/GOC experts, MAFF Monze

		Mr. Chama, Mrs. Mofya, AIDS Focal Points, MAFF Choma
25.8.00	Livingstone	Mrs. Malata, AIDS Focal Point, MAFF, Livingstone Care International, Livingstone Society for Family Health, Livingstone
29.8.00	Lusaka	Mrs. Kapwepe, Consultant Aids Project Mr. Chileya, Mrs. Verstralen, FAO Dr. Kamona, Dept. of Field Services / Extension, MAFF Headquarter Network of Zambian People Living with AIDS (NZP+)
31.8.00	Choma	Mr. Mwimba, Kara Counselling Choma
1.9.00		Mr. Mweemba, HIV/AIDS Co-ordinator, DHO Choma Dr. Bbalo, Provincial Agricultural Co-ordinating Officer Southern Province, MAFF
4.9.00		Mr. Sulwe, National Research Co-ordinator, Population Council / Aids Project
22.9.00		District Planing Unit Choma Mazabuka, MAFF District Agricultural Co- ordinating Officers (Mazabuka, Monze, Siavonga)
30.9.00	Siavonga	Mr. Kreiensiek, Country Director DED, and other DED project members in Zambia

Report on Stakeholder Workshop

Incorporating HIV/AIDS into participatory rural extension

13 October 2000, Choma Hotel
Southern Province Zambia

Major findings and conclusions of the 3-month pilot project of the Centre for Advanced Training in Rural Development (CATAD), Humboldt University Berlin, were presented and discussed during a one-day workshop. The meeting was attended by 70 representatives of Ministries of Health, Local Government, Education, and Agriculture from national, provincial, and district levels; NGOs and Churches; the local farmers association; and development agencies.

Representatives from the villages involved as well as extension officers reported their experience with the multi-sectoral approach and training in HIV/AIDS. The workshop was covered by the Zambia Press and audio-visual documentation of the National Agricultural Information System.

The multi-sectoral approach to HIV/AIDS at community level was well received. The major conclusions and recommendations by CATAD (as described in the full report) were agreed upon. In terms of follow up actions, the townclerk of Choma was requested at the workshop to call for an inception meeting of the Task Force within two weeks, incorporating existing experiences in Choma District. An HIV/AIDS Secretariat is to be established under the District Council and the Task Force.

While the National HIV/AIDS Council is awaiting establishment, it was agreed that Choma should go ahead in implementing a co-ordinated response to HIV/AIDS in the district. In finalising the field guide, comments of the MoH will be taken into consideration. The National Authorities on HIV/AIDS will be briefed on the actions and lessons learnt arising from this project.

In addition to the recommendations by CATAD, matters arising from the HIV/AIDS training project and HIV/AIDS issues related to rural agriculture were discussed at length. It was emphasised at the workshop that:

- The current impact of HIV/AIDS on agriculture has to be assessed;
- There is need to support income generating activities specifically aimed at mitigating the impact of HIV/AIDS;
- The training manual that will be produced should be widely distributed to stakeholders;
- Particular note should be taken of existing training materials.

Choma, 19, October 2000

ANNEX B

Achtung nochmal Titel checken

Training Field Staff for Participatory Village Workshops on HIV/AIDS - Manual