

CULTURE AND HIV/AIDS IN ZAMBIA, 1984-2016

BY

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DECLARATION

I, Zindaba Ngala, declare that this dissertation:

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ABSTRACT

Most studies on HIV and AIDS in Zambia have concentrated on social-economic and political aspects. The cultural aspects are merely mentioned in passing or completely ignored. However, this study is cognizant of the fact that cultural norms and values have interacted with HIV and AIDS aspects in various ways. Therefore, confronting the epidemic requires an understanding and acknowledgement of these practices and beliefs. Since HIV and AIDS was unknown in Zambian tradition, it was perceived as an old disease variously called *kafunga*, *kaliondeonde*, *kapopo* or *kahungo*, in some local languages. The disease had symptoms that were very similar to those of Tuberculosis and HIV and AIDS. People's perception and reaction to HIV and AIDS were also rooted in their traditional beliefs about the causes of disease and death which included witchcraft, displeasure of ancestral spirits, and pollution illnesses such as *kafunga* or natural causation. When HIV and AIDS became acknowledged in Zambian society by the late 1980s, myths, misconceptions and cultural practices towards its transmission, prevention and cure unfolded. The cultural practices included; sexual cleansing, dry sex, multiple sexual partners, gender and initiation ceremonies. These cultural practices together with myths had debilitating effects on government and Non-Governmental Organisations' interventions in mitigating the effects of the pandemic. The government quickly embraced western programmes and dictated the abolition of traditional beliefs instead of integrating them. Intervention programmes such as condom use, Voluntary Counseling and Testing, Prevention of Mother to Child Transmission and Ant Retro Viral Therapy were in turn resisted by local communities that were deep rooted in culture. Non-Governmental Organisations, on the other hand, targeted their response to HIV and AIDS towards specific sections of the population such as selected shanty compounds, towns and villages and limited interventions to these sections. This study examines the myths, misconceptions and cultural practices that accelerated the spread of HIV and AIDS in Zambia between 1984 and 2010. It specifically considers the myths, misconceptions, cultural beliefs and practices associated with HIV and AIDS. It also examines the effectiveness of donor and government intervention programmes vis-à-vis the mitigation of the traditional cultural values and myths.

DEDICATION

To my husband Collins Katongo and our children; Collins (Jr), Grace Lusungu, Mirriam Mulenga and Joy Keziah Mwamba, my dear mother Mayineti Phelile Chulu Ngala and my late father Atson Manyala Ngala.

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ABBREVIATIONS

ABC	Abstinence, Be Faithful and Condomise
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal Care
ART	Anti Retro Viral Therapy
ARV	Antiretroviral Therapy
CHAZ	Churches Health Association of Zambia
CHEP	Copper belt Health Education Project
CRS	Catholic Relief Services
ECR	Expanded Church Response
GB	Global Fund
HAART	Highly Active Antiretroviral Treatment
HIV	Human Immunodeficiency Virus
IMF	International Monetary Fund
MC	Male Circumcision
MNCH	Maternal Newborn Child Health
MOH	Ministry of Health
MTP	Medium Term Plan
NAC	National HIV/AIDS/STI/TB Council
NACP	National AIDS Prevention and Control Programme
NGO	Non-governmental Organisation
PEPFAR	President Emergency Programme for AIDS Relief
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
RAPIDS	Reaching HIV/AIDS Affected People with Integrated Development Support
SFH	Society for Family Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
THPAZ	Traditional Health Practitioners Association of Zambia
UNAIDS	United Nations Joint Programme on AIDS
UNCEF	United Nations Children's Emergency Fund
UNDP	United Nations Development Project
USAID	United States Aid for International Development
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organisation
ZDHS	Zambia Demographic and Health Survey
ZPCT	Zambia Prevention, Care and Treatment

TABLE OF CONTENTS

DECLARATION.....	i
COPYRIGHT	ii
APPROVAL	iii
ABSTRACT.....	iv
DEDICATION.....	v
ACKNOWLEDGEMENTS	vi
ABBREVIATIONS.....	vii
TABLE OF CONTENTS	viii
CHAPTER ONE: INTRODUCTION.....	1
Introduction and Historical Background.....	1
Statement of the Problem.....	5
Rationale	6
Literature Review.....	6
Research Methodology	20
Organization of the Study	21
CHAPTER TWO: MYTHS AND MISCONCEPTIONS ABOUT HIV AND AIDS.....	22
Introduction.....	22
Causes of disease and death in the African traditional society	23
How Zambians viewed HIV and AIDS	29
Zambians’ Response to HIV and AIDS.....	30
Conclusion	33

CHAPTER THREE: TRADITIONAL CULTURAL BELIEFS AND PRACTICES	
<i>VIS-À-VIS</i> HIV AND AIDS	35
Introduction.....	35
HIV and AIDS and Widow/Widower Cleansing.....	35
HIV and AIDS and Dry Sex	41
HIV, AIDS and Gender.....	44
HIV, AIDS and Initiation Ceremonies.....	48
Conclusion	50
CHAPTER FOUR: GOVERNMENT AND NON-GOVERNMENTAL	
ORGANISATIONS' RESPONSE TO HIV AND AIDS	51
Introduction.....	51
Government Response and Interventions	52
Non-Governmental Organisations' Intervention Measures	67
Conclusion	72
CHAPTER FIVE: CONCLUSION.....	74
BIBLIOGRAPHY	79

CHAPTER ONE

INTRODUCTION

Introduction and Historical Background

HIV and AIDS has been in existence in Zambia for over 30 years now and its impact on every aspect of human, social economic and political life continues to be a major source of concern.

Ann Larson describes AIDS as (Acquired Immunodeficiency syndrome) as a condition which is caused by a virus Called Human Immunodeficiency syndrome (HIV) which impairs the immune system in human beings.¹ People infected with HIV reach a state in which their damaged immune system can no longer fight off viruses or bacteria which to a healthy person would not be life-threatening. HIV positive persons are considered as having AIDS when they develop some of the serious opportunistic diseases which are associated with HIV and AIDS infection. These specific medical markers of AIDS vary according to the infectious disease circulating in the wider population, and are different for infected individuals in Europe, North and South America, Asia and Africa. The virus is transmitted through sexual intercourse, blood transfusion, and from mother to child during pregnancy and birth.²

Zambia has been hard hit by the devastating effects of the pandemic. According to HIV and AIDS Programme Sustainability Analysis Tool (HAPSAT), citing the United Nations joint Programme for HIV and AIDS, about 1.1 million of Zambia's 12 million people were living with HIV by the end of 2005.³ Sixteen percent of this number, consisted of adults aged 15-49 who had

¹ Anne Larson. "The Social Epidemiology of Africa's AIDS Epidemic", *African Affairs* 8, 354 (1990), p. 5.

² Larson, "The social Epidemiology", p.6; John Iliffe, *The African AIDS Epidemic: A History* (Oxford: James Currey Ltd, 2006), p.1.

³ HAPSAT Zambia Final Report (May 2006) nasegov.ng/programs, HSSP%20150212pdf (accessed on 23rd November, 2010).

already acquired the virus by 2001. Although the 2007-2008 Zambia Demographic Health Survey recorded a downward trend in the general prevalence rates among the 15-49 olds, the percent of infected women was higher than that of men.⁴

Regarding its evidence there is now conclusive evidence that HIV and AIDS originated somewhere in Western Equatorial Africa (Equatorial Guinea, Gabon, Congo, Democratic Republic of Congo, Cameroon and Central African Republic).⁵ Research has revealed that a strain of Simian Immunodeficiency virus (SIV), found in a number of Chimpanzee colonies South East Cameroon was a viral ancestor of the HIV-1 that caused HIV and AIDS in humans. Through a complex computer model of the evolution of HIV-1, the first transfer of SIV to humans occurred in the 1930s. Since studies of primates in other continents did not find any trace of SIV, the claimed African origin of HIV was said to be valid.⁶ By the 1960s, about 2000 people were estimated to have been infected with HIV.⁷ Stored blood from an American malaria research project carried out in Congo in 1959 can attest to this fact.⁸ The emerging HIV and AIDS epidemic was signaled by opportunistic infections such as cryptococcal meningitis, Kaposi sarcoma, tuberculosis and a specific form of pneumonia.

Elizabeth Colson attributes the high levels of the infections in Zambia to the ignorance of the existence of the disease.⁹ Like the case was everywhere else in the world, HIV and AIDS started as a rumour before people could realize they were dealing with a disease. In Zambia, although the first case of HIV and AIDS was reported in 1984, public discussion of the disease only began

⁴ Zambia corridors of Hope II, *Behaviour Change and Social Mobilisation* (2008), p.6.

⁵ Iliffe, *The African AIDS Epidemic*, p.1.

⁶ Iliffe, *The African AIDS Epidemic*, p.1.

⁷ Iliffe, *The African AIDS Epidemic*, p.1.

⁸ Iliffe, *The African AIDS Epidemic*, p.1.

⁹ Elizabeth Colson, "AIDS and Behavioral Change: Gwembe Valley, Zambia", *African Social Research*, 51 (2005), pp. 1-5.

three years later in 1987 when the then president, Dr. Kenneth Kaunda, addressed the nation on the radio about his son, who had died of the epidemic.¹⁰ It is evidence from this scenario that the epidemic started spreading in Zambia before people knew of its existence.

The existence of the scourge became very evident in the mid-1980s when HIV and AIDS prevalence rates began to increase. Once the disease became vivid to the Zambian, there were different reactions among stakeholders. Webby Silupya Kalikiti and Hellen Epstein noted that shock, disbelief, shame and denial of the existence of the epidemic were the initial official responses of most sub-Saharan African governments including the Zambian government¹¹ Myron Echenberg traces such responses to disease from the colonial period where authorities were reluctant to accept the existence of certain infectious diseases in order to avoid expenses.¹² Others however, attributed the insufficient government response that characterized the 1980s to governments' commitment to immediate economic concerns, war or political crisis. The general public, on the other hand, advanced myths about HIV and AIDS and sexually transmitted infections (STIs) on the eve of the outbreak of the pandemic. People's ideas were influenced by the cultural beliefs of each particular society. After a period of shock and denial, of the existence of the pandemic, the Zambian government acknowledged the existence of the disease and formulated measures aimed at reducing the spread and impact of the scourge.

¹⁰ Colson, "AIDS and Behavioural Change: Gwembe Valley", p. 1-5

¹¹ Webby Silupya Kalikiti, "Historical Background to the HIV/AIDS Epidemic in Zambia (1981-1987)", *Zango: Contemporary Issues*, 24, 14 (2003/2004), and Hellen Epstein, *The invisible Cure: Africa, The West and the Fight against AIDS* (London: Penguin Books Ltd, 2007), p. xiv.

¹² Myron Echenberg, "Historical Perspective on HIV/AIDS: Lessons from South Africa and Senegal", in Philippe Denis and Becker (eds.), *The HIV/AIDS in Sub-Saharan Africa in a Historical Perspective* (October 2006), p.25.

In 1986, the Zambian government established the National AIDS prevention and Control Programme (NACP), with assistance from the World Health Organisation (WHO) Global program on HIV and AIDS.¹³ Several national plans also followed in order to face the challenge of the emerging epidemic. The Emergence Short Term Plan was the first plan to be developed in 1987. The sole aim of this plan was to ensure safe blood and blood product supplies. Two plans were advanced. The Medium Term Plans (MTP1 and MTP2) covered the years 1988-1992 and 1994-1998, respectively.¹⁴

In the period 2002 to 2005, the government began to run the National HIV and AIDS Intervention Strategic Plan and the National Monitoring and Evaluation Plan. These comprehensive plans were mainly concerned with national level decision-making coordination. The plans were later updated to form the Zambia HIV and AIDS Strategic Framework.¹⁵ legal and other contextual factors. At the close of 2002, the National HIV/AIDS/STI/TB Council (NAC) was established by an act of parliament.¹⁶ Coordination and development support, monitoring and evaluating of the multi-sectoral national response for the prevention and mitigation of HIV and AIDS, STI and TB was the core purpose of the council. In addition to this development, the government formulated the National HIV and AIDS Policy in 2005 to provide direction and mandate for the national response.¹⁷

By the mid-2000s, it became clear that the ABCs alone were not enough for effective HIV prevention and that intervention needed to take into account social-cultural, economic, political,

¹³ National HIV/AIDS/STI/TB Council, *National HIV/AIDS/STI/TB Monitoring and Evaluation Plan* (2006-2010), p.1; and Ministry of Health/ Central Board of Health, *HIV/AIDS in Zambia: Background, Projections, Impacts and Interventions* (September 1999), p.15.

¹⁴ Ministry of Health Central Board of Health, *HIV/AIDS in Zambia*, p.15.

¹⁵ Ministry of Health Central Board of Health, *HIV/AIDS in Zambia*, p.15.

¹⁶ National HIV/AIDS/STI/TB Council, *National HIV/AIDS/STI/TB Monitoring*, p.1.

¹⁷ National HIV/AIDS/STI/TB Council, *National HIV/AIDS/STI/TB Monitoring*, p.1.

Between 2005 and 2010, the National HIV /AIDS Strategic Framework (NSF) was developed to prevent halt, and begin to reverse the spread of HIV and AIDS BY 2010. The major themes of NSF included: intensifying prevention; expanding treatment; and support; mitigating the social – economic impact; strengthening decentralized response and mainstreaming HIV and AIDS; improving the monitoring of the response; and advocacy and coordination of the multi-sectoral response.¹⁸

Despite these intervention programmes, gaps still existed at implementation level which resulted in continued increase in the prevalence rate of the epidemic. Neo Simutanyi noted that while certain programmes such as prevention Mother to child (PMTCT) were a success story, they could have done even much better if traditional leaders were involved as they were the ones close to the people.¹⁹

Statement of the Problem

Despite increased HIV and AIDS donor and government interventions in the fight of HIV and AIDS, the impact and prevalence rates of the scourge still remain alarmingly high in Zambia. This is because the government and donor projects that were aimed at reducing the spread of the epidemic had not into consideration traditional cultural values. Zambia is in the middle of a social and cultural transition where dominance of traditional beliefs in witchcraft, sexual cleansing, and so on are slowly being replaced by modern science. This transitional state has had an impact on how effective measures employed in the fight against HIV and AIDS epidemic could be. In view of this, the study investigates how the neglect of traditional cultural values led

¹⁸ National HIV/AIDS/STI/TB Council, *National HIV/AIDS/STI/TB Monitoring*, p.1; and Ministry of Health Central Board of Health, *HIV/AIDS In Zambia*, p.15.

¹⁹ Neo Simutanyi, “Pitfalls of HIV/AIDS Policy in Zambia”, *Zambia Analysis*, Issue 03 (August 2007), pp.26-27.

to the failure of most donor and government intervention programmes vis-à-vis HIV and AIDS during the period under study.

The objectives of the study were to:

1. investigate how myths, misconceptions and cultural practices accelerated the spread of HIV/AIDS in Zambia between 1984 and 2010,
2. examine peoples' and governments' response to the HIV and AIDS pandemic, and
3. show the dynamics in governments' prevention strategies over the years.

Rationale

This study may contribute to the cultural dimension of HIV and AIDS. The study may also add another dimension to the academic debate on the subject of HIV and AIDS in Zambia. It may further provide literature on the dynamics of HIV and AIDS mitigation measures over the years. The study also makes a contribution to the already existing body of Literature on the subject of HIV and AIDS in Zambia.

Literature Review

During the first decade of the HIV and AIDS epidemic, literature on the pandemic was rare and unreliable. There were mainly vague articles in medical journals and press reports of 'allegation and counter allegation regarding the issues of the origin of the virus, racial discrimination, political incompetence, and medical imperialism'.²⁰ In the media, there were warnings against associating with people showing symptoms of the disease.

²⁰ Jonathan Mann, "AIDS: A Worldwide Pandemic", in M.S. Gottlieb, D.J. Jeffries, D. Mildvan , A.J. Pinching, and T.C. Quinn, R.A. Weiss, John Wiley and Sons (eds.), 2, *Current Topics on AIDS* (1989).

The initial reports of the African HIV and AIDS epidemic were received by Africans and concerned Africanists with extreme uncertainty. The international Press, as had always been the case used the conventional approach in which they portrayed Africa's misfortunes as natural disasters. Famines, political upheavals, refugee movements, and poverty were always presented as impossible situations ignoring the fact that these problems had social and political causes and hence in theory resolvable.²¹ According to Ann Larson most of the readily available information on the new HIV and AIDS epidemic in Africa conformed to this same pattern of reporting which were in any case normally based on inaccurate or misinterpreted data.²²

John Iliffe gives a fascinating story that attempts to explain the origins, nature, and spread of the virus from its detection in the early 1980s to its current progression throughout the continent.²³ His book contains information on the advance of the scourge across the African continent from its alleged origins somewhere in Western Equatorial Africa (Equatorial Guinea, Gabon, Congo, Democratic Republic of the Congo, Cameroon, and Central African Republic) and offered convincing evidence of its spread from the region to East, Southern, and West Africa. He attributed the rampant spread in the first half of the 1980s to a combination of widespread labour migration, high ratio of men in the urban populations, low status of women, lack of circumcision and prevalence of sexually transmitted diseases. Iliffe argued that the disease affected Africa more than other continents because it was there that the virus originated, and that by the time it was recognized medically, it had already spread widely among the population.²⁴ Iliffe further demonstrated that the political, cultural, social, and economic contexts, and particularly the colonial economy based on labour migration, also made sub-Saharan Africa susceptible to the

²¹ Larson, "The Social Epidemiology", p.5.

²² Larson, "The Social Epidemiology", p.5.

²³ Iliffe, *The African AIDS Pandemic*, p.158

²⁴ Iliffe, *The African AIDS Pandemic*, p.158

rapid spread of the epidemic.²⁵ He concluded that there was hope for Africa despite the tragic consequences the epidemic had brought because the epidemic was declining and prevalence rates kept at very low rates in countries such as Uganda and Senegal.

Jonathan Mann agrees with the views of Iliffe on the pandemic. He notes that the dominant characteristic of the first period of the epidemic was silence, for HIV and AIDS was unknown and transmission was not accompanied by signs or symptoms clear enough to be noticed.²⁶ With regard the start of the pandemic, Mann noted that some rare, erratic case reports of HIV and AIDS and sero-archaeological studies showed human infections with HIV and AIDS before the 1970s. However, he confirmed the start of the pandemic to have been in the mid to late 1970s.²⁷ He observed that HIV and AIDS spread to at least five continents (North America, South America, Europe, Africa and Australia) by 1980. In his capacity as the director of the Global Programme in 1987, Mann estimated that one to several million Africans may already have been infected with HIV and AIDS.²⁸

Although there was conclusive evidence that HIV was the only cause of AIDS, some scholars cited other causes. Mwizenge Tembo identified excessive consumption of beer over long periods, powerful chemicals, medications, viruses, bacteria, parasites and other pathogens, legal and illegal substances and stimulants, exotic physically risky and damaging heterosexual and perhaps homosexual sex, high levels of stress as being other causes of AIDS.²⁹ His analysis was based on Peter H. Duesberg's premise that HIV may not be the only cause of AIDS. According

²⁵ Iliffe, *The African AIDS Pandemic*, p.158

²⁶ Mann, "AIDS: A Worldwide Pandemic".

²⁷ Mann, "AIDS: A Worldwide Pandemic".

²⁸ Mann, "AIDS: A Worldwide Pandemic".

²⁹ Mwizenge S. Tembo, "The Deadly Fallacy of the HIV-AIDS-Death Hypothesis: Exposing the Epidemic that is Not", Paper first presented at the Annual Conference of the Virginia Social Association, (VSSA) at Radford University, (June 1999) and Peter Duesberg, *Inventing the AIDS Virus*, Washington D.C: Regnery Publishing, Inc., 1996.

to Tembo, Duesberg asserted, for example, that excessive use of tetracycline suppressed the body's immune system and caused numerous yeast or fungal infections due to dead bacteria.³⁰

M. Costa and A. Ayalew also noted a number of myths and misconceptions about the disease alongside confusion with other diseases such as malaria which often led to over-estimation of the prevalence rates.³¹ This brought fear which culminated into stigma towards those who were infected with HIV and AIDS. Stigma was often related to the association of HIV and AIDS with prostitution, promiscuity and high – risk lifestyles. In its genesis, the disease was associated with prostitutes only.

Brooks Grundfest Schoepf noted that in many countries, powerful interest groups treated HIV and AIDS (and classic sexually transmitted diseases before them) as moral and political rather than a health issue.³² This made it difficult for some governments to conduct rational prevention campaigns.

Arguing from a political perspective, Myron Echenberg indicated that the historical discourse surrounding the HIV and AIDS pandemic in Africa had been politically charged from its inception.³³ Closely associated with the politics of HIV and AIDS in South Africa were views of the then President of South Africa, Thabo Mbeki. Echenberg asserted that Mbeki held that the HIV and AIDS issue perpetuated the negative image of Africa as a sick continent and as such led to “Afro- pessimism” (the belief that there is no hope for the future). Evidence from South Africa's epidemiological records show that the politics of race had always been inextricably

³⁰ Tembo, *The Deadly Fallacy of HIV-AIDS-Death Hypothesis: Exposing the Epidemic that is Not*.

³¹ M. Costa and A. Ayalew, “Stories of AIDS in Africa”, in Nolen. S. (ed.), *Portobello Books* (2007), pp.131-152.

³² Brook Grundfest Schoepf “AIDS”, in Joel Krieger (ed.), *The Oxford Companion to Politics of the World* (Oxford: Oxford University Press, 1992), p. 14.

³³ Echenberg, “Historical Perspective on HIV/AIDS”, p.89.

linked to public health issues. Africans associated the arrival of some diseases such as rinderpest in the 1890s as a deliberate White conspiracy to destroy and drive pastoralists into wage labour. Echenberg further asserted that the tendency by colonial authorities to deny the existence of serious diseases in order to avoid medical expenses had continued to be the general pattern even today.³⁴

Webby Silupya Kalikiti examined the history of HIV and AIDS in Zambia.³⁵ He explored on roles of the local media and government on the question of HIV and AIDS in the first four years of its appearance in Zambia. Kalikiti pointed out that in the early years; it was difficult to have a clear picture of the prevailing situation. This was because foreign media, medical journals and the Zambian government could not provide reliable information required by the anxious public. It was evident that initial political reaction was slow and confused since HIV and AIDS was a new medical phenomenon. News that HIV and AIDS had spread to Zambia worsened the situation as people were now filled with shock and disbelief followed by denials of its existence by the government. This study is important to our study as it has added to the knowledge on government's response to the HIV and AIDS epidemic.³⁶

Skolastika Lipinge, Kathe Hofnie and Steve Friedman set out to explore the cultural practices in Namibia that perpetuated the spread of HIV and AIDS infections by exploring in particular the relationship between gender roles and HIV and AIDS infection. They examined how gender

³⁴ Echenberg, "Historical Perspective on HIV/AIDS", p.89.

³⁵ Kalikiti, "Historical Background", p.10.

³⁶ Kalikiti, "Historical Background", p.10.

relationships contributed to increasing HIV and AIDS infection rates and suggested gender-based responses/interventions to the pandemic.³⁷

Arguing from a cultural perspective, Cheyeka noted that if education and prevention programmes were to be successful in Zambia, there was need to understand and appreciate the traditional worldview of HIV and AIDS.³⁸ Rodlach and Cheyeka separately argued that in cultures around the world, belief in sorcery or witchcraft represented a way in which people made sense of the origin and spread of HIV and AIDS.³⁹ Webb also wrote on similar lines, adding that the cultural context of HIV and AIDS infection and the manifestations of different cultural constructions of the disease were to be considered in analyzing responses.⁴⁰

Joseph Chita explored factors that conditioned children's right to access HIV education in two Zambian Catholic Secondary Schools. The study was based on the premise that unlike government- run schools, Catholic-run schools tended to put more value on HIV interventions that were meant to protect and promote children's right to education in HIV and AIDS- related topics.⁴¹ He, however, noted that children continued to be vulnerable in such schools due to such factors as curriculum, organisation, culture and religion. The people (teachers) charged with the responsibility of teaching HIV and AIDS in these schools put in very little or no efforts at all in teaching pupils as some lacked interest in the subject while others were preoccupied with completion of the syllabus content where assessment was mandatory. Chita observed that

³⁷ Scholastika Lipinge, Kathe Hofnie and Steve Friedman, *The Relationship between Gender Roles and HIV Infection in Namibia: USAID* (February, 2004), p.6.

³⁸ Austin Cheyeka, "'Irrational' or 'Rational'? Indigenous Bantu Knowledge about HIV/AIDS in Zambian Communities", *Journal of Humanities* 9 (2009), p.8.

³⁹ Alexander Roblach, *Witch, Westerners and HIV: AIDS and Cultures of blame in Africa*, (Walnut Creek: Left Coast Press, 2006), p.4; and Cheyeka, 'Irrational' or 'Rational'? p.4.

⁴⁰ Douglas Webb, *HIV/AIDS in Africa* (London: Pluto Press, 1997), p. 71.

⁴¹ Joseph Chita, "Children's Rights of Information and HIV Education: A study of the School Based HIV Education in Two Catholic Schools in Zambia", MED Thesis, University of Oslo, 2008, p.117.

education from Catholic-run schools alone was not enough to protect the children from their vulnerability to HIV and AIDS. He observed that for this education to be effective there was need to embrace every form of education as long as it valued the protection of children from HIV and AIDS and its effects. He added that for these forms of education to be effective there was need to re-orient religious-cultural and secular teachings conflict with the interest of a child in the shadow of HIV.⁴²

Martin Edward Mwansa's study examined the discourses of the Catholic Church and of secular institutions on the use of condoms in the prevention of HIV transmission. In particular, he assessed the preferred discourse among Catholic students of nursing school. After a close study of the Catholic Church and secular discourses, he failed to come up with students' most preferred discourse as most of them preferred both.⁴³

In other words, although in principle students supported the church's message of abstinence; in practice, they favoured the secular's message of condom use. It is also evident from his study that the failure of the church and the secular authority to implement their HIV policies in schools coupled with the social cultural factors, influenced students' perceptions and response to HIV preventive strategies. Mwansa, therefore, challenged the Catholic Church and the secular authorities to work together in order to come up with a common view on the use of condoms.⁴⁴

Larson⁴⁵ and Sibanda⁴⁶ blamed the development of the colonial economy for the rapid spread of HIV and AIDS and sexual behaviour of people in some Southern African countries.⁴⁷ Larson in

⁴² Chita, "Children's Rights to Information and HIV Education", p.122.

⁴³ Martin Edward Mwansa, "The Catholic Church and the Secular Discourses on the use of Condoms in HIV Prevention: Assessing the Popular Discourse among Catholic Students of Kasama School of Nursing", M. ED Dessertation, University of Zambia, 2011, p.vi.

⁴⁴ Mwansa, "The Catholic Church and Secular Discourses on the use of Condoms for HIV Prevention", p.vi.

⁴⁵ Larson, "The Social Epidemiology" p.7.

particular synthesizes the recent literature on the HIV and AIDS pandemic and the social dynamics that fueled its spread. She noted that in Africa between 80 to 85 percent of transmission occurred through heterosexual vaginal intercourse. She further noted that because women were as likely to be infected as men, Africa also faced a serious problem of infected infants who acquired the infection from their mothers.⁴⁸ The works held that the spread of HIV and AIDS was largely determined by the historical development of sexual relations in towns and cities and the sexual ties between urban and rural areas. Sibanda explains that in an effort to establish and expand their commercial activities, the white settlers created a dual economy which left women poorer and dependent on men for cash.⁴⁹ She concluded that it was the economic power which empowered men socially and politically, a development which gave them significant influence and control over women. She, however, acknowledged the fact that the cultural background to sexuality made solutions to HIV and AIDS complex.

Significant to our study, too, are the views of Chiponde Mushingwe on local Tswana classification of disease, disease patterns and health care.⁵⁰ According to Mushingwe's study, the local Tswana believed that there were mainly two disease categories in Botswana: a 'European disease' (an ailment imported to Botswana by colonialists) and a 'Tswana disease' (health hazards for Botswana that could be treated successfully only by Tswana traditional healers). Mushingwe's analysis was based on the assertion that disease patterns and health care could not be dissociated from social, economic and political power, or from their historical legacy. He argued that specific colonial legacies that continued imperial ties and an individual country's position in

⁴⁶ Sibanda Ezillyn, "AIDS in Zambia: Crisis in rural development", *SAFERE: Southern Africa Feminist Review* 3, 1 (1998), p.33.

⁴⁷ Larson, "The Social Epidemiology", p.7.

⁴⁸ Larson, "The Social Epidemiology", p.7.

⁴⁹ Sibanda, "AIDS in Zimbabwe", p.33.

⁵⁰ Chiponge Mushingwe, *The Role of Capitalism in the importation of Venereal Disease in Botswana 1820-1945 Zambia Journal of History* 2 (1989), p.44.

international division of labour were crucial to an understanding of contemporary disease patterns and health care.⁵¹

In Micheal Latham's view, scholars writing about HIV and AIDS in Africa have a tendency of arguing about the numbers of persons currently infected, the huge problem of orphans, how any claims of the validity of new treatments in Africa were often pushed aside and about the evidence concerning the origin of HIV and AIDS in African monkeys.⁵² On the other hand, he is against views which held the genesis of HIV and AIDS in a germ warfare laboratory or in a malaria experiment that went wrong. Latham argues that although these were interesting assertions for academics, much more important than the exact numbers of cases or the origin of the virus was the fact that millions of Africans—men, women, and children- were now infected both in urban and rural areas. In Latham's view, for any prevention and educational efforts to be successful, local behavior patterns that influenced the spread of HIV and AIDS should be considered. In other words, education needed to be culturally sensitive and conform to societal norms.⁵³

Olusoji Adeyi's work is also significant to our study. It provides a comprehensive overview of Nigeria's dynamics of the epidemic through an analysis of prevention efforts, and offering valuable information to researchers and policymakers.⁵⁴ Adeyi's discussion on stigmatisation, social - cultural aspects and efforts to control the disease in Nigeria are crucial to our study. They

⁵¹ Mushingi, "The Role of Capitalism", p.44.

⁵² Latham, "AIDS in Africa", p.41.

⁵³ Latham, "AIDS in Africa", p.41

⁵⁴ Olusoji Adeyi et al, (eds.), *AIDS in Nigeria: A nation on the Threshold* (Cambridge: Harvard Centre for Population and Development Studies, 2006), pp.vii-578.

provide valuable insights on how the Nigerian society handled the epidemic and the gaps and failures of the system in responding to the scourge.⁵⁵

In trying to answer the question why certain regions of Sub-Saharan Africa such as Uganda were more affected by HIV and AIDS than others, Denis refers to stigmatization.⁵⁶ He demonstrates that feelings of shame which accompanied HIV and AIDS had their roots in history and culture. He suggested that there was need to have an in-depth study of how traditional societies and their colonial archetype experienced sexual behaviour, disease and death.

Anne Buve's work examined the severity of the HIV and AIDS epidemic in Sub-Saharan Africa.⁵⁷ Buve observed that the spread of HIV and AIDS was as a result of the interplay between sexual behaviour and biological factors. Sexual behaviour patterns were shaped by cultural and socio-economic contexts. Several cultural and social economic features of African societies conspired to enhance the vulnerability of the African population to HIV and AIDS, including the subordinate position of women, impoverishment, rapid urbanization and modernization and wars.⁵⁸ Buves' works are important to our study in that they draw our attention to the need to take into account the role of cultural values in trying to understand why the fight against HIV and AIDS was unsuccessful.

⁵⁵ Adeyi, *AIDS in Nigeria*, p.578.

⁵⁶ Philippe Denis, "Towards a Social History of HIV/AIDS in Sub-Saharan Africa (University of Kwazulu-Natal)", in Philippe Denis and Charles Becker (eds.), *The HIV/AIDS in Sub-Saharan Africa in a Historical Perspective* (October 2006), p.25.

⁵⁷ Anne Buves, "The HIV Epidemics in Sub-Saharan Africa: Why So Severe? Why so Heterogeneous? An Epidemiological Perspective", in Philippe Denis and Charles Becker (eds.) *The HIV/AIDS in Sub-Saharan Africa in a Historical Perspective* (October 2006), p.55.

⁵⁸ Buves, "The HIV Epidemics in Sub-Saharan Africa: Why so Severe? Why so Heterogeneous? An Epidemiological Perspective", p.55.

Writing from a gender perspective, Michael Kelly viewed the HIV and AIDS epidemic as being driven by the low status of women, gender inequality and gender inequity.⁵⁹ Kelly states that if we stopped the spread of HIV and AIDS among women and girls in Southern Africa, we would succeed in mitigating the epidemic. He identified an interconnection between gender equity and HIV and AIDS. According to him, many of the gender norms accepted within Zambian society strongly influence sexual practices. The socially constructed picture of the controlling male that appeared in cultures worldwide gave rise to the image of a man as the initiator of sexual activity and the dominant partner in most sexual interactions.⁶⁰ From Kelly's study, we hope to draw some ideas on important elements of common cultural beliefs that have had an impact on the fight against HIV and AIDS and measures that the government could take in order to successfully fight the epidemic.

Jacob R.S. Malungo argues that the government may reduce the burden on social services by exposing sexual behavior patterns that increased the risk of contracting HIV and AIDS, including prostitution and group sex.⁶¹ He observed that if the growing sexual relations with prostitutes in Zambia were not checked it would seriously increase the risk of HIV and AIDS infection. He also suggested that if nations were to attain reduced levels of the spread of HIV and AIDS, then high-risk traditional practices and high-risk behavior such as sexual cleansing and levirate marriage were to be discouraged.⁶² Malungo's work provides us with important cultural practices common in Zambia which put people at risk of contracting HIV and AIDS and ways in which the government could successfully fight the scourge.

⁵⁹ Micheal Kelly, "Addressing AIDS from a Gender Perspective", *Zambia Analysis*, Issue 03 (2007), pp.6-7.

⁶⁰ Kelly, "Addressing AIDS from a Gender Perspective", p.7.

⁶¹ J.S.R. Malungo, "Emerging Patterns of Prostitution and Sexual Networking in Zambia: The Risk of Contracting HIV/AIDS and Demographic and Social-Economic Implications", *African Social Research*, 51 (2005), pp.42-62.

⁶² Malungo, "Emerging Patterns of Prostitution", p.42.

Joseph ZoaZoa explored the spatial-temporal spread and evolution of HIV and AIDS in the Lake Chad basin by investigating the situation of cattle breeders' seasonal movements of livestock.⁶³ According to his observation, the breeding sector has changed little since 1985 when the first cases of HIV and AIDS were identified in the Lake Chad Basin.

ZoaZoa stated that a population of breeders who were for the most part illiterate was constantly moving from one country to another. Cattle breeders have been carriers of HIV and AIDS for a long time. Unfortunately, most of the programmes against HIV and AIDS ignored them and few awareness campaigns targeted them.⁶⁴ ZoaZoa further demonstrated how traditional practices in the cattle breeding sector perpetuated the spread of HIV and AIDS which is also the focus of our study.

Catherine Campbell⁶⁵ and Neo Simuntanyi⁶⁶ focused on the failure of HIV and AIDS programmes. Campbell, for instance, cited that funds from international donors and the deluge of headlines about HIV and AIDS in South Africa never yielded any results. She further stated that for years the song of "Abstinence, Be faithful and Condomise", had been on the lips of HIV and AIDS activists and educators throughout the continent and yet infections still increased in South Africa. According to her, most of these programmes failed due to biomedical and behavioral understandings of sexuality and health. Campbell suggested that stigma, shame, economic dependence, ignorance and inability to meet one's basic needs were some of the social dynamics that were to be considered in developing HIV and AIDS programmes. She argued that while it

⁶³ Joseph ZoaZoa, "Cattle Breeders and the Spread of AIDS in the Lake Chad Basin", in Philippe Denis and Charles Becker (eds.) *The HIV/AIDS in Sub-Saharan Africa in a Historical Perspective* (October 2006), pp.73-84.

⁶⁴ ZoaZoa, "Cattle Breeders", p.84.

⁶⁵ Catherine Campbell, "Letting them Die: How HIV/AIDS Prevention Programmes Often Fall", *African Journal of AIDS Research*, vol.3, 1 (2004) and Neo Simuntanyi, "Pitfalls of HIV/AIDS Policy in Zambia", *Zambia Analysis*, Issue 03 (August 2007), pp.27-27.

⁶⁶ Campbell, "Letting them Die".

was important to bring together skilled practitioners and funding, the fight against HIV and AIDS would only succeed if there was an understanding of the context that formed the basis of community life.⁶⁷

Similarly, Simutanyi noted that despite efforts by the Zambian government to contain the epidemic, infection rates continued to rise.⁶⁸ Simutanyi's work showed an increase in HIV and AIDS sponsors in the past years. Millions of dollars flowed into the fight against HIV and AIDS alongside health campaigns, counseling, treatment and care. Even then, the impact on HIV and AIDS had been quite dismal. He further observed that in the last 20 years, government's response to HIV and AIDS had been uneven adding that social and cultural attitudes remained basically unchanged.⁶⁹ Simutanyi's work informs our study greatly because it took into account the issues of culture in the fight against HIV and AIDS.

Hellen Epstein provides valuable insights on donor-funded HIV and AIDS programmes in Africa⁷⁰ She observes that the most successful HIV and AIDS projects in Africa were those that were conceived and run by Africans themselves or missionaries and aid workers with long experience in Africa. She further demonstrated the coping strategies the early Bantu settlers from the North adopted when they were faced with diseases like malaria, tuberculosis and sleeping sickness in the forests, deserts, or lakesides. In view of this, Epstein concluded that most donor-funded HIV and AIDS projects failed because the donors overlooked the fact that Africans

⁶⁷Campbell, "Letting them Die".

⁶⁸ Simutanyi, "Pitfalls of HIV/AIDS Policy in Zambia", pp.26-27.

⁶⁹ Simutanyi, "Pitfalls of HIV/AIDS Policy in Zambia", p.27.

⁷⁰ Epstein, *The Invisible Cure*, p.xiv.

themselves had the best solutions to their own problems.⁷¹ We hope to examine this aspect in our study.

In examining behavior change among the Tonga of the Gwembe Valley, Elizabeth Colson has recorded that behavior among the Tonga of the Gwembe Valley was often contradictory and sometimes non-rational in its acceptance of risk.⁷² She pointed out that people of Gwembe valley tended to disregard advice and behaved as though they were unaware of the consequences or as if they assumed that they have the power to mold the world to their own desires.⁷³ This study is important to our study as it helps us understand behavior among the people of Zambia vis-a-vis HIV and AIDS.

Another work that is relevant to our study is that of Phillimon Ndubani.⁷⁴ It describes witchcraft as an explanation for HIV and AIDS among the Goba of Chiawa chieftaincy. Ndubani indicates that Zambia was in the middle of social and cultural transition where the dominance of beliefs in witchcraft was slowly being replaced by the beliefs in modern science. As such, the two were co-existing. Ndubani notes that people in Chiawa continued to look to witchcraft for explanation for the many deaths in the area. He suggests that educational campaigns against diseases such as HIV and AIDS needed to pay special attention to the beliefs in witchcraft which impeded the assimilation of new values and perceptions about disease and death.⁷⁵ Ndubani's study will help us appreciate traditional perceptions about HIV and AIDS.

⁷¹ Epstein, *The Invisible Cure*, p.xiv.

⁷² Elizabeth Colson, "AIDS and Behavioural Change: Gwembe Valley, Zambia", *Africa Social Research*, 51 (2005), p.20.

⁷³ Colson, "AIDS and Behavioural Change", p.20.

⁷⁴ Phillimon Ndubani, "Death, Witchcraft, and AIDS", *African Social Research*, 51 (2005), p.62.

⁷⁵ Ndubani, "Death, Witchcraft, and AIDS", p.62.

Joseph Schartz records that male circumcision was seen as a ‘breakthrough’ in the fight against HIV and AIDS.⁷⁶ However, some medical analysts such as Luo and Mwanza feared that people may take it to be a ‘magic bullet’ and stifle the efforts to promote safe sex. Schartz observes that circumcision was not 100 percent effective in preventing HIV and AIDS infection, so in theory, it should not lead men to engage in risky behaviour, or ignore the core of prevention message touted by donors.⁷⁷

Research Methodology

Data for the study came from various sources. Substantial amount of data was obtained from the University of Zambia library, especially the Special Collections in Division. From there, we consulted books, journals, articles, newspapers and dissertations. These sources provided us with information for the literature review, historical background of HIV and AIDS, and risky traditional cultural practices and beliefs. These documents also provided us with information on governments’ initial response to the scourge. Additional information on government response as well as the general public came from the National HIV/AIDS/STI/TB Council (NAC) where reports, strategic and legal frameworks, HIV/AIDS/STI/TB policy, and plans were consulted. To identify cultural practices, beliefs and myths about HIV and AIDS we visited the National Archives of Zambia (NAZ) where books and reports from NAC were accessed. From the Faith Encounter in Zambia (FENZA) we had access to books and articles on various issues concerning HIV and AIDS. Oral interviews were also conducted with selected individuals in Lusaka and some places in North-Western Province to get the perceptions of people on the cause of HIV and AIDS and their feeling about government’s reaction to the HIV and AIDS pandemic. Data was also obtained electronically from NAC and the internet. This data gave us an insight on

⁷⁶ Joseph Schartz, “Not the Magic Bullet”, *Zambia Analysis*, Issue 03 (August 2007), pp.22-23.

⁷⁷ Schartz, “Not the Magic Bullet”, p.22-23.

government and Nongovernmental organization's efforts in the fight against HIV and AIDS. Some books, handouts and articles, were simply bought from UNZA Press, Book World or borrowed from colleagues. These documents highlighted on traditional understanding of the cause of diseases and death.

Organization of the Study

The study comprises five thematic chapters. Chapter One is the Introduction. Chapter Two discusses myths and misconceptions about HIV and AIDS. It specifically examines how these misconceptions influenced people's response to HIV and AIDS. Chapter Three examines local cultural practices and beliefs vis-à-vis HIV and AIDS. The chapter demonstrates how these practices accelerated the spread of HIV and AIDS and the changes they have undergone over the years. Chapter Four is an analysis of the effectiveness of government and donor HIV and AIDS intervention programmes. Chapter five is the Conclusion.

CHAPTER TWO

MYTHS AND MISCONCEPTIONS ABOUT HIV AND AIDS

Introduction

It has been observed that most professionals knew only one part of the world and one pattern of HIV and AIDS transmission.¹ This often resulted in projection of assumptions and lessons from the area one knew best onto the rest of the world. However, there are different patterns of HIV and AIDS transmission; thus, making assumptions about HIV and AIDS in Africa based on the knowledge elsewhere would not be very helpful. It is, therefore, important that prevention and mitigation programmes follow the distinctive epidemiological patterns found in various populations and regions of the world. More importantly, prevention also ought to follow what is known about the culture of the populations of interest, bearing in mind that culture is a broadly inclusive term that includes behavioral patterns, society, economy, polity, beliefs, and values.² It is against this background that suggestions for the Zambian government to begin to consider educational and prevention programmes that understood and appreciated the traditional world view of the HIV and AIDS pandemic were made. It was hoped that once the concept of HIV and AIDS was narrowed down to the traditional level, then the fight against the scourge would be more successful. This chapter examines traditional beliefs about the causes of disease and death in Zambian traditions, how Zambians viewed HIV and AIDS and people's response to the epidemic.

¹ Edward C. Green, *Rethinking AIDS Prevention: Learning from Success in Developing Countries* (London: West Port, 2003), pp.6-23.

² Green, *Rethinking AIDS Prevention*, pp.6-23

Causes of disease and death in the African traditional society

In traditional Zambian societies, disease and death are closely related to the social relations that exist in a given community. In an African social context, a person was defined in part by one's descent group and how that person maintained a constant relationship with both the living and the dead ancestors and peers.³ Life among most ethnic groups in Zambia was to be lived in a community, clan, and family under a headman in chiefdom, including dead ancestors.⁴ Thus, personhood was deconstructed by interrupting the flow of relations that originally established it. In a similar manner, disease and death were experienced as a symptom of destructive activities initiated by peers, spirits or an individual. The focus of disease, therefore, was not the body but the interpersonal and social relations which existed.⁵ In other words, one needed to be careful in the way one conducted oneself because careless behaviour could threaten the security or wellbeing of the entire community one lived in. Under this arrangement, there were three categories of diseases; these were pollution illnesses, those caused by witchcraft and natural causes.

Pollution illnesses were those diseases that came as a result of breaking taboos and careless behaviour that threatened the well-being of the community. Illnesses related to immoral sexuality such as tuberculosis (*kafunga* among the Goba of Chiawa Chieftency) fell under pollution illnesses. Beliefs in *kafunga* were highly held by various ethnic groups in Zambia though they appeared under different names and guises. Other indigenous terms for *kafunga* included; *ubulwele bwantanda bwanga* among the Bemba, *kahungo* among the Tonga and *kaliondeonde*

³ P assador L.H. Thomaz or Raca, "Sexalidade, e doencaem Mozambique" *Revista Estudos Feministas* 14 (2006), pp.263-286.

⁴ Paul Dover, "Morality and Misfortune: Discourses around III health in a Zambian Village", *ONE STEP FURHER-Response to HIV/AIDS: Sida Studies*, 7, p.168.

⁵ Thomaz, "Sexalidade, e doenca", p.264.

among the Chewa and Ngoni. Symptoms of *kafunga* were perceived by people as being similar to HIV, AIDS and tuberculosis. The causes of this particular disease were the same everywhere. For instance, all the ethnic groups mentioned above believed that one contracted *kafunga* after having sexual relations with a woman who had just aborted or miscarried.⁶

Among the Bemba *ubulwele bwantanda bwanga* occurred when a woman who had just aborted had sex with a man who was not her husband or partner. It was believed that since this person was of different blood the *akapopo* (spirit of the aborted fetus) would be angry and therefore attack this foreign person. According to one Bemba woman, if the same woman slept with her own husband or partner, the man would not be affected because he was of the same blood since he was the one who had impregnated her.⁷ It is also evident that in certain instances a person got *ubulwele bwantanda bwanga* by simply eating or stepping in the compound or yard of the woman who had just aborted or miscarried. It was alleged *akapopo* entered such a person and started moving inside the body looking for a place where it could come out. The same view was held among the Ngoni and the Chewa. During an interview, some men of Ngoni origin explained how the *akapopo* manifested itself.⁸ There was an assertion among both the Ngoni and the Bemba that *akapopo* came out at any point of the body; on the cheek, thigh, feet, neck and left a very big hole or a boil similar to the ones associated with HIV and AIDS. The disease was also contracted if one stepped on a grave of a still-born baby or by one having sex with a widow or widower who was ritually unclean. *Kafunga* was usually characterized by loss in weight, hair

⁶ Austine Cheyeka, “Irrational or Rational? Indigenous Bantu Knowledge about HIV/AIDS in Zambian Communities”, *Journal of Humanities* 9 (2009), p.8.

⁷ Interview, Elizabeth, Chama, Solwezi, 30/12/2010.

⁸ Interview, Richard Mwale and Andrew Msoni, Mtendere Market, Lusaka, 06/07/2010.

and nails growing thin and long. A person suffering from *kafunga* also had persistent cough and loss of strength.⁹

In Goba tradition, ‘hot’ and ‘cold’, ‘wet’ and ‘dry’ terms were used in various taboos surrounding issues of sexuality and reproduction. A sexually active state meant a ‘hot’ bodily state or fertility while a state of infertility or sexual inactivity was related to a ‘cold’ bodily state.¹⁰ Consequently, when a woman was found to be ‘cold’ by the traditional healer she would be given medicine to warm up the body. In traditional Zambia, matters related to sexuality and reproduction was highly confidential. This helps us to understand why at the time when HIV and AIDS just appeared people were not free to disclose their status even to a medical doctor. Children in particular were not supposed to be exposed to such sexual issues to prevent them from engaging in pre-marital sexual activities. It was also embarrassing to discuss sexual matters because sex and reproduction involved private parts.¹¹ In certain instances, adults employed the fear factor in order to deter children from engaging in sexual activities outside marriage. The Bemba of Northern Province prevented their children from engaging in sexual activities before marriage by telling them that they would lose their parents through death or they would develop long fingers.¹²

Traditional reproduction involved three major processes: heating, forming and cooling in the development of the foetus.¹³ During these processes blood played a symbolic and causal role. This was not actual blood but rather semen or vaginal fluids. In view of this, when a man and a woman had sexual intercourse their bloods mixed and the formation of a foetus took place

⁹ Dover, “Morality and Misfortune”, p.167.

¹⁰ Dover, “Morality and Misfortune”, p.166.

¹¹ Racheal Tuju **AIDS: Understanding the Challenge** (Nairobi: ACE communication Ltd, 1996), p.19.

¹² Interview, Chama.

¹³ Dover, “Morality and Misfortune”, p.166.

alongside the heating process. Thus, a woman who had sex was considered to be carrying hot blood. Such a woman was a threat to the wellbeing of people of weak and cold bloods such as children. People with small babies avoided physical contact with potential carriers of hot blood. It was a common trend in most *Zambian* villages for small children to wear medicinal amulets to protect them from such dangers. The same concept of hot blood was used as a control measure for the spread of such diseases as measles. When a child had measles, the couple was not supposed to have sex as that worsened the sickness or even led to the death of the child. Likewise, other members of the family were told not to touch the child if they engaged in sexual activities.

Menstrual blood was also considered as hot waste blood which had not been utilized in procreation.¹⁴ Therefore, a woman having her menstrual period was not expected to have sexual intercourse with her husband, cook food or add salt to food or light fire. Instead, female relatives or children were asked to perform some of these tasks on her behalf. This may be the more reason why the concept of living in a community was important in the traditional society. However, a woman who had miscarried or aborted a foetus was even a greater danger to those around her than a woman who was menstruating. Therefore, cooling medicines and baths were to be administered immediately to a woman in that condition after isolating her from the rest of the community. Miscarriage was viewed as a period when the life of the forming baby in the womb was cut. Claims were that since the blood was ‘creating something’ it was ‘very strong’ and if a woman happened to sleep with a man or let alone add salt to food she would cause *kafunga*.¹⁵ Among the Bemba peoples of the Northern Province of Zambia, the waste hot blood

¹⁴ Dover, “Morality and Misfortune”, p.166.

¹⁵ Dover, “Morality and Misfortune”, p.166.

issuing from a woman who had a miscarriage contained a spirit of the life that had been cut off called *akapopo*.¹⁶

Witchcraft was believed to have been another cause of sickness and death in traditional Zambian societies. Sicknesses that did not adhere to treatment or deaths that occurred in unexplained situations were usually blamed on witchcraft. Although they were fully aware of possible natural and circumstantial causes of death such as old age, accidents, natural calamities and many others, African peoples believed that a particular person would only die from one of these physical causes because some human being, agent or spirit had brought it about by means of a curse, witchcraft, magic, or displeasure of ancestral spirits. To determine whether a certain death was caused by mystical causes or physical circumstances, diviners and medicine men were consulted.¹⁷

The same notion may have been used in the 1980s to classify AIDS as a disease that was caused by witchcraft. Msiska, Fylkesnes, and Brunborg bemoaned the failure of most Zambians to translate the knowledge they had about HIV and AIDS into behaviour change.¹⁸ The most appropriate answer to this dilemma was culture. In examining witchcraft in relation to HIV and AIDS in Kenya which might also apply to Zambia, Tuju noted that, since there was no culture of germs in African history, the only thing that made meaning of HIV and AIDS was witchcraft.¹⁹ He correctly observed that there were no simple solutions to problems that were rooted in culture, Witchcraft, ancestral spirits, natural causes, broken social norms or sexual moral

¹⁶ Interview Chama.

¹⁷ J.S. Mbiti, **African Religion and Philosophy** (London: Heinemann, 1969), p. 117.

¹⁸ K. Fylkesnes, H. Brunborg and R. Msiska, "The Social-Economic Impact of AIDS: Zambia: the Current HIV/AIDS Situation and the Future Demographic Impact", *HIV/AIDS BIBLIOGRAPHY: An Annotated Review of Research on HIV/AIDS in Zambia* (UNICEF 1996), P.23.

¹⁹ Tuju, *AIDS: Understanding the Challenge*, p.19.

transgression were therefore perceived as major causes of sickness. These were cultural aspects of the people.

People in Zambian traditional society had their own ways of explaining the source of each sickness or death.²⁰ For instance, an affliction that did not respond to treatment or sudden death caused by an accident, lightening and animal attack was usually linked to witchcraft.²¹ Issues of floods, drowning, and earthquakes were perceived as a direct result of the displeasure of spirits. Old age or treatable ailments were accepted as natural circumstances. It is also interesting to note that even with the introduction of modern science and medicine, Africans were still able to tell which diseases could respond to modern treatment or which ones were caused by people and required a diviner and prescription of traditional medicines. This is similar to the traditional Tswana classification of venereal diseases. The Tswana believed that there were two disease categories that existed in Botswana: a 'European disease' and a 'Tswana disease'.²² A European disease was an ailment believed to have been imported to Botswana by the colonialists and as such unknown to the Tswana. 'Tswana diseases,' on the other hand, were those diseases that were known only by the Tswana society before their encounter with whites. The implication behind this classification was that European diseases could respond to modern treatment because they were outside the domain of traditional treatment. 'Tswana diseases' were those diseases that could only respond to traditional treatment. In Zambia terms such as AIDS *yamanje* (the present AIDS) and AIDS *yakudala* (the AIDS of olden days) were common in people's conversations whenever they referred to AIDS.²³ The fact that people were able to differentiate between the old

²⁰ Mbiti, **African Religion**, p.117-118.

²¹ Mbiti, **African Religion**, p.118.

²² Chiponge Mushingi, "The Role of Capitalism in the importation of Venereal Diseases in Botswana, 1820-1945", **Zambia Journal of History**, 2 (1989), p.44.

²³ Mushingi, "The Role of Capitalism", p.44.

and the new disease shows that they were now aware of the new disease and its effects. In the light of HIV and AIDS, this is very significant because awareness would more likely translate into behavior change.

How Zambians viewed HIV and AIDS

While some people may have used *kafunga* and witchcraft to explain immoral sexuality and mysterious diseases and deaths, *kafunga* and witchcraft came to provide an alternative explanation for AIDS patients due to stigma surrounding the disease. When HIV and AIDS came on the Zambian scene in the mid-1980s, the Zambian people did not have words to identify the nature of the disease in local languages. Many Zambians perceived AIDS as *kafunga* which had just taken on a new English name.²⁴ The numerous articles in the British *Sunday Times* questioning the existence of HIV and AIDS in Africa provided Africa's general perception of the disease at its inception.²⁵ Many Zambians argued that if HIV and AIDS really existed, then it was an old disease under a new name and guise. Given the similarities in symptoms and mode of transmission, Zambians associated HIV and AIDS to *kafunga*. Its symptoms were similar to tuberculosis. Even then people still had divergent views about HIV, AIDS, tuberculosis and *kafunga*. Dova's study on Chiawa shows that while traditional healers were able to distinguish between *kafunga* and AIDS and tuberculosis, some elders of the area saw no difference. Most traditional healers claimed that a person suffering from *kafunga* could be cured but one with AIDS could not. The elders were of the opinion that AIDS was a late, untreatable stage of *kafunga*. *Kafunga* was also seen to have increased in recent years because of modern women's negligence in maintaining the customary taboos and the increased home abortions accelerated by

²⁴ Cheyeka, "'Irrational' or 'Rational'?" p.8.

²⁵ Fylkesnes, Brunborg and Msiska, *The Social –Economic Impact of AIDS*", P.21.

laxity in reinforcing sexual morals in young people.²⁶ Dova demonstrates that, of the two, *kafunga* and AIDS, the diagnosis of the former gave some straw of hope and dignity to both the patient and relatives, whereas an AIDS patient was given no hope of survival.²⁷ Some traditional healers took advantage of the vulnerability of AIDS patients and claimed that they cured AIDS when in the actual sense it was *kafunga*.²⁸ Since AIDS came at a time when most people had already been influenced by western ways of life and medicines, the young generation and the educated tended to disassociate themselves from such beliefs as *kafunga* as they considered them to be barbaric and outdated.²⁹ However, when modern treatment failed, most young and educated people secretly ran to traditional healers for help.

Zambians' Response to HIV and AIDS

Initial reactions to HIV and AIDS across the African continent were characterised by rumours, denials and myths about the disease. Reports from newspapers also gave the African people some relief as it was believed only homosexuals in America had the disease. Churches also thought HIV and AIDS were only for sinners because it was associated with promiscuity. Worse still some completely denied the existence of the disease. In short, people tended to disassociate themselves from the disease by thinking it was for a particular group of people. Tuju saw denial and rationalization as a way in which human beings tried to cope with stressful situations.³⁰ The rumors, denials and rationalization soon developed into myths.

²⁶ Dover, "Morality and Misfortune", p.166.

²⁷ Dover, "Morality and Misfortune", p.166.

²⁸ Dover, "Morality and Misfortune", p.166.

²⁹ Dover, "Morality and Misfortune", p.166.

³⁰ Tuju, *AIDS: Understanding the Challenge*, p.19.

Myths and misconceptions about HIV and AIDS have been in existence since the very beginning of the pandemic. There were many myths and misconceptions associated with various aspects of HIV and AIDS originating from many parts of the world. The first category of myths stemmed from the lack of information on the relatively new disease. Later, myths associated with the prevention, transmission and cure of the disease developed.

Evidence from *Outreach Programme on HIV/AIDS and Other Related Issues*, shows that many people in Zambia were worried about contracting HIV and AIDS through such casual contacts as mosquito bites, sharing cups and plates, knives and forks, shaking hands, having your hair cut, through eating and drinking, wearing second hand clothes, sitting next to an inflicted person, sharing a toilet or bathtub, playing with an infected person, coughing, sneezing or talking, swimming in a pool or river or through animals.³¹ Some people even started fearing eating meat because of some claims that AIDS originated from animals. Ndhlovu expressed his fears for AIDS and stated;

...I am an avid meat eater. Each time I buy meat from the butchery; I have that blood in mind. Could it by some chance contain the AIDS virus? What of that pork, what of that chicken I love so much, what of the goat? I also have in mind my cousins in the Northern part of Zambia. That delicacy of theirs, the monkey...could its blood not contain that deadly AIDS? Man today is reaping his sins. Man with his 'thirst' for fresh bloody food has now found himself in this rot. It is too late to come out of it. We shall all perish.³²

One of the popular myths claimed that only promiscuous people contracted HIV and AIDS. When HIV and AIDS just appeared on the scene the only method of transmission people were

³¹ *Outreach Programme on HIV/AIDS and other Related Issues*.

³² Nyambo Ndhlovu, "AIDS SCARES ME" *Zambia Daily Mail Friday*, May 22, 1987.

familiar with was through sexual intercourse with an infected person. Because of this, some people felt that people with HIV and AIDS were immoral and therefore deserved the consequences.³³ In Zambian tradition, issues of sex were highly confidential and not to be discussed openly. As a result, discussing issues of HIV and AIDS openly was shunned. This period was also characterized by shame and stigma. Epstein testifies that everywhere she went in Southern Africa, HIV and AIDS-related shame seemed to hang over the region like a spell.³⁴ She goes on to state that some people chose to die rather than admit that they had the disease. In the late 1980s and early 1990s, people adopted different euphemisms for HIV and AIDS when speaking of kin or close associates or even someone from the same village: they had a long illness, they were very thin, and they had swollen legs and so on. Colson notes that, by mid-1990s, to admit that AIDS was sexually transmitted was something that was likely to be denied publicly, but admitted privately.³⁵

The misconception that witchcraft caused HIV and AIDS was one of the defense mechanisms that people came up with in order to disassociate themselves from sexual roots of HIV and AIDS. Ndubani's work describes witchcraft as it relates to HIV and AIDS among the Goba of Chiawa chieftaincy.³⁶ He indicates that Zambia was in the middle of social and cultural transition where the dominance of beliefs in witchcraft was slowly being replaced by the beliefs in modern science. As such the two co-existed. Ndubani argues that the people of Chiawa continued to look

³³ Binold K. Sahu, (O.E.S) *AIDS and Population Education* (New Delhi: Sterling Publishers), p.8.

³⁴ Hellen Epstein, *The Invisible Cure: Africa, The West and the Fight against AIDS* (London: Penguin Books Ltd, 2007), p.xiv.

³⁵ Elizabeth Colson, "AIDS and Behavioural Change: Gwembe Valley, Zambia", *African Social Research*, 51 (2005), p.5.

³⁶ Phillimon Ndubani, "Death, Witchcraft, and AIDS", *African Social Research*, 51 (2005), p.62.

to witchcraft for an explanation for the many HIV and AIDS related deaths in the area.³⁷ However, there was now a shift from total dependency on traditional medicines to a combination of both traditional and modern medicines. Ndubani therefore, suggests that, if education and prevention campaigns were to be successful, the government needed to pay special attention to the traditional beliefs in witchcraft as those beliefs impeded the assimilation of new values and perceptions about the disease and death causation.

Another popular myth that led to certain sexual abuses and child molestation was the myth of ‘virgin cure’. In parts of Africa including, Zambia, it was widely believed that having sexual intercourse with a virgin would cure HIV and AIDS. The belief was so wide spread that the government launched campaigns to dispel it. In Zambia, billboards depicting small girls stating that ‘sex with me does not cure HIV and AIDS’ were stack in many places. Virgin cleansing as a myth has a long history in the world. In the early 2000s, most Europeans believed that they could rid themselves of sexually transmitted diseases by transferring it to a virgin through sexual intercourse.³⁸ The myth gained considerable notoriety as a perceived reason for certain sexual abuse and child molestation. Recent myths included speculations that showering after intercourse would prevent someone from contracting HIV and AIDS.³⁹

Conclusion

The chapter has examined the Zambian traditional beliefs about the causes of disease and death, the question as to whether HIV and AIDS was an old disease or not, how Zambians viewed HIV

³⁷ Ndubani, “Death, Witchcraft, and AIDS”, P.62.

³⁸ B.I. Meel, “The Myth of Child Rape as a Cure for HIV/AIDS in Transkei: a case of report”, *Med.sci.Law* 43, 85-88 PMID 12627683, 1 (2003), p.43.

³⁹ Interview, D. Manda, Solwezi Day High School, Solwezi, 03/02/ 2011.

and AIDS, and their responses to the scourge. It has been contended that people's perceptions and reactions to HIV and AIDS were rooted in their traditional beliefs about the causes of disease and death which included witchcraft and pollution illnesses such as *kafunga*. The chapter has demonstrated that due to the stigma surrounding HIV and AIDS, beliefs in witchcraft and pollution diseases provided AIDS patients an alternative explanation for the disease. Zambia's responses to the scourge were characterised by myths and misconceptions resulting from fear, ignorance of the origin of the disease and stigma. Myths such as the virgin cure which led to child molestation prompted the government to come up with measures to curb such a vice.

CHAPTER THREE

TRADITIONAL CULTURAL BELIEFS AND PRACTICES *VIS-À-VIS* HIV AND AIDS

Introduction

The mode of life displayed by a given society is always influenced by the traditions of that particular society. This is because human socialisation process takes place in a particular culture and therefore it is directly linked with different facets of life. With the coming of HIV and AIDS in the 1980s, certain traditional practices need to be examined.¹ In Africa, as in other parts of the world, cultural norms and values intermingled with HIV and AIDS epidemic in various ways. However, the situation in Africa was a bit unique in the sense that many of the cultural factors influencing the epidemic and response to the disease were specific to the continent. Therefore, an in-depth study of these particular determinants and norms is critical. In short, a clear line between helpful and risky practices in the light of HIV and AIDS must be drawn. With respect to this assertion, the chapter explores the cultural factors and beliefs that accelerated the spread of HIV and AIDS in Zambia. Some of the high-risk practices and beliefs that influenced the spread of HIV and AIDS include; widow/widower cleansing, dry sex, gender and girls' initiation ceremonies.

HIV and AIDS and Widow/Widower Cleansing

Widow/widower cleansing was a traditional ritual which was used as a means of getting rid of the ghost from the widow or widower after the death of a spouse. Cleansing took different forms such as sexual cleansing, symbolism and using traditional medicine. It was widely believed in Zambian communities that when a person lost a spouse due to death the spirit of the dead spouse

¹ Youth Alive Zambia Education for life Manual, 2004. P.103.

would haunt the surviving spouse.² The belief was that, in order to prevent the spirit of the dead from haunting the surviving spouse, relatives of the deceased had to cleanse the survivor. ‘Cleansing’ or ‘purification’ among the Tonga of Gwembe valley was called *ku-salazya*,³ *ukupyanika* among the Bemba,⁴ *buswanyi* among the Kaonde⁵ and *kunjila chokolo* among the Tumbuka of Lundazi.⁶

Prior to the HIV and AIDS era, cleansing took different forms such as sexual cleansing, symbolism and blessing.⁷ Although the three forms of widow/widower cleansing were present from time in memorial, the most common in most parts of Zambia was sexual cleansing. It is also important to note that one form of cleansing also had divergent ways in which it was conducted. Sexual cleansing for instance could involve the surviving spouse having intercourse with a close relative to the deceased or parents or close relatives to the deceased having sexual intercourse with their own spouses.⁸ Among the Tumbuka of the M’nyanjagha, the Chewa, and the Balowoka, when a man or woman died, the widow or widower was expected to choose from the late spouse’s family someone to marry her or him.⁹ If they accepted another woman or man the cleansing process was initiated. The two were then asked to have sexual intercourse as a way of cleansing the widow or widower.

² Securing our Future, *Commission on HIV/AIDS and Governance in Africa* (CHGA), 2008, p.18.

³ Interview, Maureen Mwanza Kyembe, Zambia Compound, Solwezi, 02/02/2011. See also Elizabeth Colson, “AIDS and Behavioural Change: Gwembe Valley, Zambia”, *Africa Social Research*, 51 (2005), p.10.

⁴ Interview, Irene Chisambwe, Josephine Nsama and Mary Mulenga, marketeers at Solwezi main market, Solwezi, 02/02/2011.

⁵ F.H.Melland, *In Witchbound Africa, an account of the Primitive Kaonde Tribe and their Beliefs* (London: Seeley Service and Co. Ltd. 1923), p.97.

⁶ Yizenge Chondoka, *A History of the Tumbuka and Senga in Chama District, 1470-1900: Chiefs without a Kingdom*, (Lusaka: Academic Press, 2007), p.

⁷ Colson, “AIDS and Behavioural Change”, p.9.

⁸ Colson, “AIDS and Behavioural Change”, p.10.

⁹ Chondoka, *A History of the Tumbuka and Senga in Chama District*, p.

In Luapula province, the man selected to perform the sexual cleansing ritual went to the house of the widow at night without giving her any notice.¹⁰ He entered the house and made love with the widow without talking to her. Immediately after the act, the man left again silently. In case of a widower, the selected woman was taken to the widower's house at night and left her on his bed without informing him. He was expected to make love with her without talking to her. If the man failed to ejaculate, he went back to the family members of the deceased for blessings. After receiving blessings, the man repeated the ritual the following day. If the act was successful, the following morning, the family members to the deceased spouse came to congratulate him and ask for blessings from the deceased on his behalf. Once this was done, the ritual performer was assured of total freedom from the spirit of the deceased relative. What was shocking about the whole ritual was the 'touch and go' nature in which it was conducted. The man or woman who conducted the ritual never married the widow or the widower.¹¹ The relationship ended with the ritual. It was this temporal nature of the ritual that became a factor in the spread of HIV and AIDS. If one of the people involved in the sexual act was infected, he/she infected the partner. If the man or woman who was assigned to perform the ritual was married, they transferred the virus to their spouses at home. There is however evidence that, often times, the widow or widower was given a deceased's relative as a wife after the cleansing process with that relative.

Before the advent of HIV and AIDS, the efficacy of widow inheritance went beyond that of simply getting rid of the dead person's ghost. It was also an indirect way of taking care of a widow's sexual, spiritual as well as social-economic needs by a selected relative to the deceased. Clan identities were maintained in the process. It was therefore immoral for any person other than a relative to the deceased to take up this responsibility.

¹⁰ Interview, Ireen Mwelwa, Solwezi Day High School, 07/01/2012.

¹¹ Interview, Mwelwa.

By 1990, most Zambians had been converted to Christianity as such; this characteristic funeral ritual came under a great test as it was often condemned by the Christian faithfuls. Evidence shows that only the most devoted Christians were prepared to forego it and the kin would insist that it be carried out even without their consent. The coming of HIV and AIDS did not change their perception either. The ritual was still observed with such passion that the use of a condom was a taboo. In an event that a cleanser used a condom, he was ordered to repeat the ritual without it. Death taboos such as prohibition of intercourse were upheld too during this ritual. By virtue of losing a relative and spouse, the living kin and more especially the surviving spouse, carried death pollution (*caando*) and were, therefore, expected not to indulge in any sexual activities until the ritual was over. The violation of this taboo had very serious consequences as the living spouse risked ‘the vengeance of the spirit angered by failure at being reintegrated properly with the on-going community of both living and dead’.¹²

Unlike other ethnic groups which only conducted cleansing when a married man or woman died, the Tonga of Gwembe valley conducted this ritual at all the funerals. The only difference was that when a child or an unmarried adult died, the cleansing ritual was carried out by some members of their lineage or the parents.

It is important to note that when a married man died, the cleanser did not only assume physical duties of the deceased family but also spiritual duties. The spirit of the dead relative was seemingly attached to the cleanser at the time when the ritual took place. As such he had a duty to remember it by providing it with offerings. He became the successor and guardian of the spirit. Apart from that he acquired some rights over certain things. As long as bride price was paid, the cleanser if he so wished became the heir to the dead man’s property which included his

¹² Colson, “AIDS and Behavioural Change”, p.7-12.

widow and children as well as land, stock, agricultural equipment, and other assets. Since he had now acquired the status of father to the children of the dead, he had the right over them and everything that pertained to their lives including bride wealth of the daughters and some share of the estates of the sons.¹³ He also had the right to claim the widows as wives as long as he had their consent and that of their lineages.

In circumstances where the cleansing ritual did not take place due to one reason or the other, a substitute cleansing, was done. The Tonga called this substitute cleansing *ku-chuuta*. It involved someone from the dead spouse's lineage having intercourse with his or her own spouse, after which the widow/widower was placed across their thighs in a symbolic form of intercourse. Later *ku-chuuta* was widely accepted as the best way of cleansing a man when his wife was dead for at times her lineage had no woman available as a replacement wife. However, when *Ku-chuuta* was adopted, the surviving spouse was entitled to a payment in form of a cow, or an equivalent sum of money. This served as compensation to any new spouse against the risk that the spirit of the dead might have not accepted the alternative cleansing as adequate. Alternatively, the money was used to buy herbs for protection against the anger of the dead.¹⁴

When the reality of HIV and AIDS began to unfold in the early 2000s, widow and widower cleansing had undergone a great transformation. Prior to the HIV and AIDS era, widow/widower cleansing focused on getting rid of the ghost of the dead spouse from the widow or widower, but it was now being used in the prevention of HIV and AIDS. Substitute cleansing ritual of *ku-chuuta* was now promoted by some traditional rulers in Gwembe valley. *Ku-salazya* was slowly being abandoned as it involved sexual intercourse which was also a tool in the spread of HIV and

¹³ Colson, "AIDS and Behavioural Change", p.10.

¹⁴ Colson, "AIDS and Behavioural Change", p.10.

AIDS. They found *Ku-chuuta* to be safer than *ku-salazya*.¹⁵ As opposed to the earlier period, the cleanser's wives had the right to object with the backing of the whole community if a man insisted to undergo *ku-salazya*. In the light of HIV and AIDS, this is very significant as it is an indication that the message of HIV and AIDS had been appreciated by the people. However, it is evident that some people doubted the effectiveness of *ku-chuuta* or treatment with medicine. Besides, a surviving spouse who used *ku-chuuta* was highly stigmatized because they feared she or he was still carrying death pollution. Similarly, if the surviving spouse and the cleanser fell sick during this period, their illness was blamed on death pollution which they claimed continued to cling to them because the spirit of the dead spouse did not recognize the cleansing.

The trend of using substitute cleansing rituals became a common feature among most ethnic groups of Zambia. The Kaonde of North Western Province, for instance, also upheld substitute cleansing rituals, although it only applied when an old widow was involved. The heir did not need to cohabit but simply cut her abdominal string of beads and placed his hand lightly on her private parts.¹⁶ The Bemba also adopted the use of beads. The relatives to the dead spouse had to look for a couple from among the relatives to perform the ritual. On a chosen day, the couple was given a string of white beads which they placed on the bed and made love (*ukupisha ubulungu*). The following morning, the string of beads was placed on the hand of the widow or widower. The widow or widower was expected to wear these beads until the string broke on its own. Ireen Mwelwa notes that, in recent years, sometimes the beads were merely tied on the wrist of the widow or widower without any sexual intercourse.¹⁷ At this point, the widow or widower was free to find another partner to marry. Money was also given to the widow or widower to give the

¹⁵Colson, "AIDS and Behavioural Change", p.11.

¹⁶ Colson, "AIDS and Behavioural Change", p.11.

¹⁷ Interview, Mwelwa.

would-be husband or wife. The money was a symbol of blessings from the dead person's relative. Thus in the absence of money after marriage the couple went back to the relatives of the deceased to bless them. But if the surviving spouse used to ill-treat his/her in-laws, the ritual was manipulated so that the ghost of the deceased could continue haunting his or her partner. The selected couple would pretend that they slept on the string of beads and give it to the widow/or widower to wear it on his/her wrist. According to Bemba tradition, if the beads were not ritually burnt, the surviving spouse continued being haunted by the dead person's ghost.

As observed by Chisambwe, Nsama and Mulenga, widow/widower cleansing was slowly dying away because of modernity and that those practicing it were doing so simply as a means of assuming wealth in ones' family.¹⁸ When a woman was married to a wealthy man the parents would not want to lose this link even when their daughter was dead. They gave an example of a family in their community which gave the widower (despite his confirmed HIV/AIDS status) the young sister to the dead spouse just to maintain the link. Zambia was at crossroads vis-à-vis traditional culture and westernization. Thus, this family did this as a way of preserving traditions. Another transformation in this practice came much later. In 2005, a Penal Code was amended to make it illegal for any person to engage in risky cultural practices such as widow cleansing.¹⁹

HIV and AIDS and Dry Sex

Dry sex was another HIV/AIDS risk factor that was practiced by a large number of women in African societies.²⁰ There is evidence, however, that the practice was very common in Zambia.

¹⁸ Interviews, Chisambwe, Nsama, and Mulenga.

¹⁹ Securing our Future, Commission on HIV/AIDS, P.18.

²⁰ Zambia Health Information Digest, Dry Sex in Zambia, vol.5, 3 (July- September 1998), p.21 See also J.M. Nyirenda, "An Investigation of the Behavioural Aspects of 'dry sex' in Lusaka Urban" *HIV/AIDS BIBLIOGRAPHY: An Annotated Review of Research on HIV/AIDS in Zambia* UNICEF, 1996, P.101.

Dry sex involved the use of vaginal drying agents or micro abrasions or irritation of the vaginal lining.

In traditional Zambian societies, both men and women were socialised by elders that a woman should not have any “water” in the vagina.²¹ Most men were fully aware and comfortable with the fact that women used herbs to dry the “water” and tighten their vagina as it enhanced their mutual relationships. The presence of “water” was considered an illness and a hindrance to a man’s sexual performance and pleasure. Thus, men demanded a tight and dry vagina from their wives and women who had “water problems” were advised to seek help or treatment from elders who were well vested in such issues. A tight vagina, on the other hand, enhanced sexual pleasure and enabled men to ejaculate within a short time and so increased the number of rounds, which was traditionally a signal of a man’s strength. Traditionally, manhood was measured by the number of rounds a man had with his spouse during sexual intercourse. The fewer the rounds the weaker the man was considered to be.²²

Ironically, dry sex was practiced even in modern urban communities. A study by J. M. Nyirenda indicates that dry sex was practiced by 86 percent of women in Lusaka urban alone for a number of reasons.²³ Agents used for drying included herbal porridge and vaginal mopping (using a piece of cloth or inserting herbs). It is understood that in the early 2000s, some women began to use even more sophisticated methods to dry the vagina including such things as Mosi beer, salt, cold water, tea leaves, and ginger. These drying agents sometimes caused great damage such as

²¹ V, Bond, “What are Young Women Looking for in a Sexual Relationship in and around a Migrant Labour Camp?” *HIV/AIDS BIBLIOGRAPHY: An Annotated Review of Research on HIV/AIDS in Zambia* UNICEF, 1996, P.106.

²² Zambia Health Information Digest, Dry Sex, p.21. See also Nyirenda, “An Investigation of the Behavioural Aspects of ‘Dry Sex’, p.101.

²³ Zambia Health Information Digest, Dry Sex, p.21. See also Nyirenda, “An Investigation of the Behavioural Aspects of ‘Dry Sex’, p.101.

genital ulceration resulting from excessive tightness and friction during sexual intercourse, as well as irritating effects of some herbs they applied. In such circumstances, bruises in the genitals due to friction were not uncommon. The number of cases with adverse effects with sores on the penis and inside the vagina totaled 35 percent while 17.6 percent were recorded as having erosive effects of intra-vaginal insertion.²⁴ Another research on dry sex conducted in 1994 noted that there was no strong link between dry sex and HIV and AIDS infection. However, the study acknowledged the fact that it was those same effects of dry sex that increased women's likelihood of contracting HIV and AIDS especially if they had sexual relations with an HIV and AIDS infected person.²⁵ Men have a high concentration of T4 cells at the fore skin of the penis which attracts viruses. Thus, if a man is bruised on the penis during dry sex with an infected woman, he could easily contract the virus because the T4 (receptors) would have been exposed to the virus. An infected man also carries HIV viruses in the sperms which are transmitted to a woman during dry sex if she developed bruises. In this way, dry sex becomes a factor in the transmission of HIV/AIDS.

According to Nsama and Chisambwe, most men preferred dry sex especially in villages because they enjoyed difficult penetration which in turn enhanced sexual enjoyment. They further noted that a woman with a watery birth canal was highly stigmatised by men and even divorced if she did not take precautions to improve her condition. As a result, women were in a habit of using vaginal tightening stuff in order to dry up the vaginal fluids for fear of losing their marriages. An investigation of what young women in Chiawa expected in a sexual relationship was carried out by Bond in 1995 and he found that women also enjoyed dry sex as very few complained that it

²⁴ Zambia Health Information Digest, Dry Sex, p.21. See also Nyirenda, "An Investigation of the Behavioural Aspects of 'Dry Sex'", p.101.

²⁵ National HIV/AIDS/STI/TB Council, *Zambia Country Report: Multisectoral AIDS Response Monitoring and Evaluation Biannual Report 2006-2007* (May 2008), p.10.

was painful.²⁶ The idea of a condom was in fact not welcomed by these women because of its lubricating action which annulled the aims of dry sex. Dry sex became a factor in the transmission of HIV and AIDS. This is because the CD4 cell present in the fore part of the penis has a very high affinity for HIV and AIDS virus. Thus, if a man had sex with an infected woman the virus penetrated easily through the bruises he sustained during dry sex.²⁷

HIV, AIDS and Gender

Gender was another major determinant in the spread of HIV and AIDS in Zambia. There existed among the indigenous Zambian societies certain aspects of gender which were considered normal and yet risky in the context of HIV and AIDS transmission. Gender favoured men more than women. Men had an upper hand in decision-making including sexual relations. Gender roles that were deeply ingrained in culture constituted the major component of gender that perpetuated male dominated interests and lack of 'self-assertiveness on the part of women'.²⁸

From time immemorial women from different ethnic groups in Zambia were taught to be submissive and obedient to men especially those that commanded power such as a father, uncle or husband. This was based on the premise that a man was the head of the house and therefore could never be equal to a woman. A woman was expected at all costs to satisfy her male partner sexually. Among the Ngoni of eastern Zambia, when a man came home late the wife was not supposed to question him but instead welcome him normally and serve him with meals and allow him to sleep until at an opportune time when they had a peaceful discussion.²⁹ If he demanded

²⁶ Bond, "What are Young Women Looking for in a Sexual Relationship", p.106.

²⁷ Abraham Muma, CM Volunteer, Solwezi Urban Clinic, 03/02/2011.

²⁸ National HIV/AIDS/STI/TB, *Zambia Country Report*, p.9.

²⁹ Maxima Nyasulu Mwale, "Education Aspects of Girls' Initiation Ceremony in Ngoni Society" *Long Paper* (July 1989), p.61.

for sex that night, the woman was supposed to comply. This trend was expected to be the same even when the wife was fully aware of her husband's extra-marital relationships.

In other Zambian societies, there were traditions in which husbands used the excuse of culture to exercise sexual control and sexually exploit their wives. The Bemba, for instance, had a saying that "*ubuchende bwa mwaume tabutobe ing'anda*"³⁰ meaning; 'the infidelity of a man does not cause divorce'. Culture demanded that a woman be at home taking care of her home and children. A woman who left her home and indulged in sexual activities with other men was a disgrace and challenged her husband's authority and therefore risked instant divorce. A man, on the other hand, was free to have extra-marital affairs and yet their marriage remained intact because no one questioned him. This justified the unfaithfulness of men and at the same time taught women not to compete with men. Thus, from childhood girls were made to understand that a husband was a dominant figure on the subject of sex.

Male dominance negatively affected condom use in most Sub-Saharan African countries. Gosh and Kalipeni's analysis of condom use in Malawi found that men were in control of condom use too.³¹ This trend was similar to that of Zambian men. Gosh, Kalipeni and Lesley Doyal indicated that most women were worried of contracting HIV and AIDS and aware of their husbands' promiscuous behaviour but could not request for condom use.³² They explained that doing so brought suspicions of infidelity which often resulted in women being abandoned or abused. This does not rule out the fact that some women did not want condoms to be used on them because

³⁰ Interview, Jacqueline Katongo, Ng'ombe Compound, Lusaka, 18/05/2011.

³¹ Jayati Gosh and Ezekiel Kalipeni, "Women in Chisapo, Malawi: vulnerability and Risk of HIV/AIDS", in Muna Ndulo and Margaret Grieco (eds.), *Power, Gender and Social Change in Africa* (Cambridge: Cambridge Scholars Publishing, 2009), p.172.

³² Gosh and Kalipeni, "Women in Kasapo", p.172. See also Lesley Doyal, *What Makes Women Sick: Gender and the Political Economy of Health* (London: Macmillan Press, Ltd, 1995), p.78.

they associated them with prostitution. The issue of divorce was the last thing married women could think of no matter the abuse for culture did not permit it.

In his book *What Makes Women Sick: Gender and Political Economy of Health*, Doyal noted a link between culture and income as well as wealth.³³ She observed that cultural domination of heterosex was strengthened by wider gender inequalities in income and wealth between men and women. She further noted that many women were so dependent on their male partners for economic support without which they would not make it on their own. Thus, sexual intercourse was a commodity the woman paid in exchange for that financial support. The man demanded his payment at any time and in any way he desired. It was this financial dependence that limited women's ability to control their exposure to HIV and AIDS.

In some cases, some men abandoned their wives and children for years and even stopped providing economic support and yet when they came back sick their wives welcomed them. It was observed though that women who did not have children were more likely to leave a promiscuous husband if he became violent than a woman who had children.³⁴ Women held on to their marriages not because they were enjoying but simply because they wanted to protect the interests of their children. There were also instances where some women continued having children even when their husbands had the disease. African traditions made women powerless and vulnerable to HIV and AIDS transmission.

Forced sexual intercourse was common in many marriages in Zambia. Sexual violence was a vice that increased HIV and AIDS infections because a female partner was not given a chance to negotiate for safer sex. A sexual behaviour survey carried out in 2005 indicated that 15.1 percent

³³ Doyal, *What Makes Women Sick*, p.78.

³⁴ Interview, Lizzy Mwanaute, Zambia Compound, Solwezi, 02/02/2011.

of women in Zambia experienced forced sex.³⁵ There was a slight drop from the 16.3 percent recorded in 2003. According to the 2005 report, forced sex was higher in urban areas (17.7 percent) than in rural areas (13.3 percent). The percentages might not represent the actual picture on the ground because very few women reported such cases. Married women in traditional society in Zambia seemed to enjoy ‘forced sex’. For them it was part of romance and they were proud about it. For men it was a symbol of strength and therefore mutual consent was not a prerequisite for sexual intercourse to occur.³⁶

It was becoming increasingly popular in Africa, America and Europe to ascribe the main cause of HIV and AIDS pandemic in developing countries to poverty and other ills associated with poor health conditions. To the contrary, studies from several developing countries observed that HIV and AIDS infections were not confined to the poorest of society but that prevalence rates tended to be even higher among the doctors, lawyers, teachers and other professionals.³⁷ This was because these could afford to have more sexual partners than unemployed day labourers. Although, poverty may have been the major cause of HIV and AIDS, African traditions also played an influential role in men’s sexual behaviour. The level of education and knowledge about HIV and AIDS did not do much in changing inherent African traditions. An analysis of men’s extramarital relationships shows that men left their educated women at home for uneducated women because those women were believed to have traditional skills that enhanced sexual satisfaction.³⁸

³⁵ National HIV/AIDS/STI/TB Council, *Zambia Country Report*, p.10.

³⁶ National HIV/AIDS/STI/TB Council, *Zambia Country Report*, p.10.

³⁷ Gosh and Kalipeni, “Women in Chisapo”, p.172. See also Daniel Halperin and Arther Allen, “Is Poverty the Root of Cause of African AIDS?” *AIDS ANALYSIS AFRICA* vol.11, 4 (December 2000/ January 2001), p.3.

³⁸ Interview, Kyembe and Mwanaute.

HIV, AIDS and Initiation Ceremonies

Initiation ceremony was an important event in Zambian tradition that introduced young men and women to adult life. It was a transition from childhood to adulthood. Once the girl or boy had undergone the ceremony, he/she was able to perform duties of a mature person in society. The focus of this analysis is the one on girls. The event took place just after the girl had her first menstruation. During initiation, the girl was taught a number of things by elderly women who had knowledge about the culture of a given society. The syllabus covered such topics as personal hygiene, character building, home management, sex education, and respect for elders and her future husband, respect for her future husband's family members, sexual taboos and food taboos.³⁹

The girls' initiation ceremony was a very good practice because the initiates were taught many things that were important in one's life. Some of these lessons acted as preventive measures for certain diseases. Among the Tonga of Monze district in Southern province and the Ngoni of Chipata district in Eastern province the novice was taught how to be hygienic during her menstruation period and how to keep herself healthy during pregnancy.⁴⁰ At initiation ceremonies, girls were taught good sexual intercourse in marriage and how it was to be done. These initiation ceremonies were rooted in deep conservative traditions. In addition, the girl was encouraged to begin behaving like a mature person and leave behind her childish and carefree way of life. In this way societies were able to curb immoral behaviors which helped in the prevalence of sexually transmitted diseases like HIV and AIDS.

³⁹ Mwale, "Educational Aspects of Girls' Initiation Ceremony", p.54.

⁴⁰ Mwale, "Educational Aspects of Girls' Initiation Ceremony", p.54. See also Mary Mambo, "The Effects of Nkolola Initiation Ceremony on Women of Southern Province: A case study of Monze District", 2007, p.12.

In her 2007 study, Mary Maambo expressed concern over the knowledge women disseminated to the girls during initiation ceremonies.⁴¹ She noted that some girls were taught how to please their future men/husbands sexually. Among the Tonga the *mooye* (the initiate) was even taught how to seduce a man. A girl was taught how to wear a special string of beads loosely about her hips as a visual gift to her husband.⁴² The teaching was appropriate in the past in the sense that after an initiation ceremony the next thing a girl was waiting for was marriage. As a result, a number of them married at a very tender age.

Things began to change with the introduction of western education during the colonial period. Girls spent more time at school after the initiation ceremony resulting in extended time gaps between initiation and marriage.⁴³ During this period a girl was keen to experiment what she was taught.

Mambo's works on *nkolola* (initiation ceremony for girls) among the Tonga demonstrates that most women who went through *nkolola* were vulnerable to prostitution.⁴⁴ This behaviour was in most cases driven by the great desire these initiated girls had to experiment what they were taught during the ceremony. Their curiosity influenced them in having more than one sexual partner which was not the case with girls who were not initiated. Maambo noted that if initiation was to remain meaningful in the HIV and AIDS era, those topics that influenced girls into risky behaviors should be changed. Although initiation ceremonies were dynamic in nature and were evidently on the decline in Zambia, the deep-rooted conservative traditions remained intact.

⁴¹ Mambo, "Effects of Nkolola", p.15.

⁴² Mambo, "Effects of Nkolola", p.16.

⁴³ Douglas Webb, HIV and AIDS in Africa (London: Pluto Press, 1997), p.125.

⁴⁴ Mambo, "Effects of Nkolola", p.iv.

Conclusion

The chapter discussed the cultural beliefs and practices that fueled the spread of HIV and AIDS in Zambia. It is evident from the discussion that some beliefs and traditional practices that exacerbated the spread of HIV and AIDS still existed in Zambia amidst the many awareness campaigns. Among the high-risk cultural factors were widow/widower cleansing, dry sex, gender and girls' initiation ceremonies. It has been noted that though some of these practices were on the decline, the deep-rooted conservative traditions remained intact. Education or knowledge about HIV and AIDS did not change people's behaviour because of strong traditional cultural influences.

CHAPTER FOUR

GOVERNMENT AND NON-GOVERNMENTAL ORGANISATIONS' RESPONSE TO HIV AND AIDS

Introduction

General government response to the HIV and AIDS crisis was on the whole, slow and inefficient in Africa. John Iliffe and Edward Green attributed the slow response to the fact that most governments were preoccupied with immediate problems ranging from war or political crisis to financial insufficiency.¹ In addition, many governments felt admitting a generalised HIV and AIDS epidemic in the country would threaten their dignity. Countries like Zambia saw public announcement of HIV and AIDS prevalence figures as a threat to the potentially lucrative tourist market.² As a result much of what was known about HIV prevalence in the early days of the pandemic was kept secret by the authorities. However, as the realities of HIV and AIDS began to unfold in the late 1980s, the government responded by putting in measures to prevent, halt and reverse HIV infections. Initially, HIV prevention methods focused primarily on preventing the sexual transmission of HIV through behavioural change. Abstinence, condom use and faithfulness (the ABC) was the approach used for several years. However, in the mid-2000s, it became evident that the ABCs alone were not effective in the prevention of HIV and AIDS. As a result, the government and its various stakeholders began to engage a combination of programmes that needed to take into account underlying socio-cultural, economic, political, legal

¹ John Iliffe, *The African AIDS Epidemic: A History*, (Oxford: James Curry Ltd, 2006), p.65. See also Edward Green, *Rethinking AIDS Prevention: Learning from success in Developing Countries* (London: West Port, 2003), p.23.

² Douglas Webb, *HIV and AIDS in Africa*, (London: Pluto Press, 1997), p. 85.

and other contextual factors.³ This chapter therefore, discusses government and non-governmental organization's response to HIV and AIDS. It will specifically discuss the four pillars around which government response evolved. The four pillars included; prevention, treatment, care and support, impact mitigation and response management. The study further demonstrates how and why these programmes changed over the years.

Government Response and Interventions

In Zambia, government response began to take shape in 1987 after former President Kenneth Kaunda announced to the world that his son Masuzyo had died from AIDS. Zambia was credited by international observers for having started HIV and AIDS awareness campaigns early. Much of these early campaigns included pamphlets and posters that warned of the dangers of HIV and AIDS such as “sex thrills, but AIDS kills” and promoted abstinence before marriage, fidelity and the use of condoms (ABCs).⁴ Over the years however, campaigns took different forms. A wide range of media which involved drama, adverts, peer education and so on, were employed in the campaign against HIV and AIDS.

In 1986, the government of the republic of Zambia established the National AIDS Prevention and Control Programme (NAPCP), with assistance from the World Health Organisation (WHO) Global Programme on HIV and AIDS.⁵ Several national plans also followed as a response to the emerging epidemic. The emergence Short Term Plan was the first plan to be developed in 1987. The sole aim of this plan was to ensure safe blood and blood product supplies. Later, two more plans were advanced. The Medium Term Plans (MTP1 and MTP2) covered the years 1988-1992

³ UNAIDS, ‘Combination HIV prevention: Tailoring and Co-ordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections.’

⁴ Johns Hopkins Bloomberg School of Public Health, ‘AMHR Research Projects’ and National HIV/AIDS/STI/TB Council, *National HIV/AIDS/STI/TB Monitoring and Evaluation Plan* (2006-2010), p.1.

⁵ National HIV/AIDS/STI/TB Council *National HIV/AIDS/STI/TB Monitoring*, p.1.

and 1994-1998, respectively.⁶ The first MTP prioritized eight operational areas: TB and leprosy; information, education and communication; counselling; laboratory support; epidemiology and research; STD and clinical care; programme management; and home based care. The second MTP on the other hand was multi-sectoral in design and incorporated a mechanism for inter-sectoral co-ordination and collaboration.

Stephen Lewis notes that, by the early 1990s, HIV and AIDS infections were accelerating at a fast rate such that as many as one in five adults were infected with HIV and AIDS and observed that there was now need for concerted efforts.⁷ The situation must have been precipitated by the economic problems the country experienced in the 1990s, the Structural Adjustment Policies imposed by the International Monetary Fund (IMF) and the World Bank (WB), the 1992-1993 droughts across the Sub-Saharan region and other shortcomings such as cholera. The turn of events prompted the World Health Organization to call for the establishment of a National HIV/AIDS Advisory Council in Zambia.

Between 2002 and 2005 the Zambian government began to run the National HIV/AIDS Intervention Strategic Plan and the National Monitoring and Evaluation Plan.⁸ These comprehensive plans were mainly concerned with the national level decision making and coordination. The said plans were later updated to form the Zambia HIV/AIDS Strategic Framework between 2001 and 2003. The framework had three main objectives which included: reducing the spread of HIV/AIDS/STI transmission with children, youth, women and situations providing risks for HIV transmission being the focus; reducing the social impact of HIV/AIDS on individuals and families in homes, in work places, and in the whole of Zambian society; and

⁶ National HIV/AIDS/STI/TB Council, *National HIV/AIDS/STI/TB Monitoring*, p.1

⁷ Stephen Lewis, "Zambia, 'A Constellation of Change and Commitment' in response to AIDS."

⁸ National HIV/AIDS/STI/TB Council, *National HIV/AIDS/STI/TB Monitoring*, p.1

local and external resource mobilisation to fight the epidemic through concerted efforts of all stake holders.

According to the National HIV/AIDS Policy, these initial responses to HIV/AIDS “were inadequate to contain a problem that was more than just medical in nature.”⁹ As a result the subsequent Programmes and strategies that were developed sought to foster political commitment at the highest level, develop inter-sectoral approaches encompassing all Government Line Ministries, the private sector and civil society, while fully involving people living with HIV and AIDS.

Stephen Lewis demonstrates that, following this observation, the new millennium came with a ‘renewed political attitude and a completely new level of determination’¹⁰ to confront the epidemic. As such, at the close of 2002, the National HIV/AIDS/STD/TB Council (NAC) was established by an Act of Parliament No. 10 of 2002.¹¹ NAC became a single, high-level institution responsible for coordination and development support, prevention and mitigation of HIV and AIDS, STIs and TB. It was also in charge of guiding the implementation of the National HIV/AIDS Strategic Framework (2006-2010). In addition to this development, the government formulated the National HIV/AIDS Policy in 2005 to provide direction and mandate for the national response.

There is also evidence that around the same period, Government officials at all levels were now much more willing to talk about the epidemic. For instance, in 2004, the then President of the Republic of Zambia, Levy Patrick Mwanawasa declared HIV and AIDS a national crisis and

⁹ Republic of Zambia, *National HIV/AIDS/STI/TB Policy* (2005), p.8.

¹⁰ UNAIDS, ‘Report on Global AIDS Epidemic,’ (Geneva:UNAIDS,2008)

¹¹ UNAIDS, ‘Report on Global AIDS Epidemic.’

pledged to provide free antiretroviral drugs to 10,000 people by the end of the year. The government extended free treatment to more than 100,000 people by the end of 2005.¹² People like the former republican President Kaunda changed and became a fulltime HIV and AIDS activist. In 2008 UNAIDS noted a stabilizing HIV and AIDS situation in Zambia and some evidence of favorable behavior change.

The new millennium also saw increased HIV and AIDS donor funding. Neo Simutanyi notes that millions of dollars were poured into the health campaign programmes, counselling, treatment and care from various donor sources which included The Global Fund for HIV/AIDS, TB and Malaria (GB), US President's Emergency Programme for AIDS Relief (PEPFAR), Bill and Melinda Gates Foundation and the William J. Clinton Foundation and bilateral and multilateral donors.¹³ It was this goodwill from various stakeholders and the legal status it had, that the NAC was strengthened. However, the Joint-Mid-Term-Review Report published in 2013 notes that, although NAC had a strong legal status and goodwill of various stakeholders, it still had no legal authority to register, inspect, enforce or penalise any agent operating in the HIV and AIDS response arena.¹⁴ The report further goes on to state that, NAC had inadequacies in terms of structure, communications, human resources and finances for it to fully execute its mandate. In addition, Self-coordinating Groups meant to foster coordination among various key stakeholders were also not operating at their best. The Central Statistics in particular CSO competes for resources and does not adhere to national guidelines and standards. As a result, many parallel coordinating mechanisms and programmes within and outside Government could operate

¹² AIDS Care, "The Epidemiology of HIV infection in Zambia," 7 August, 2008.

¹³ Neo Simutanyi, "Pitfalls of HIV/AIDS Policy in Zambia," *Zambia Analysis*, Issue NO. 03 (August 2007), p. 28.

¹⁴ NASF, *Joint Mid-Term Review Report* (2011-2015, 2013), p. 136.

without NAC's consent, oversight, or knowledge.¹⁵ The major concern had been that despite increase in donor funding the prevalence rates were still increasing in some parts of the country and certain groups of people especially among women between the ages of 24 and 49.

Once the platform had been set, the government and other stake holders began to run various HIV and AIDS programmes that focused on prevention, treatment, care and support, impact mitigation and response management. Of these four pillars, prevention was key in government response. In line with prevention, the government employed the Abstinence, be faithful and use a condom also known as the ABC strategy. Barnett Tony and Parkhurst Justin have observed that, the usefulness of the ABC approach, is highly debated and interpreted differently by different actors.¹⁶ For instance, abstinence in the religious circles meant avoidance of vaginal sex until marriage. The circular world on the other hand interpreted abstinence as an approach that encouraged young people to delay "sexual debut" (age of first sexual intercourse) as used by countries like Uganda. In addition to abstinence, was the 'be faithful' approach which encouraged people to eliminate casual or other concurrent sex partners and practice fidelity within marriage and other sexual partners. The third and most effective component of the ABC approach is the 'use a condom' strategy. This component emphasised the correct and consistent use of a condom.

Garret notes that, although condoms were a proven and highly effective tool in preventing sexual HIV and AIDS transmission when used correctly and consistently, they were in conflict with religious beliefs which associated the use of condoms with moral decay.¹⁷ She demonstrates that

¹⁵ NASF, *Joint Mid-Term Review Report*, p. 136.

¹⁶ Barnett Tony and Parkhurst Justine, "HIV/AIDS, Sex, Abstinence, and Behaviour Change" *Lancet Infectious Diseases*, 5 (9: 590-593).

¹⁷ *The Times of Zambia*, "The Church's Uncompromising Stance on Condom" (8 January, 2006).

both Muslims and Christians favored abstinence which was less effective as very few people were able to control their sexual desires in spite of their religious affiliations. Worse still, some top government officials also condemned condom use.¹⁸ Frederick Chiluba (former president of Zambia), for example, because of his strong belief in Christian values, he saw condom use as a sign of weak morals. Rural areas were another place where condom use was usually shunned. People both in rural and urban areas felt condoms reduced sexual pleasure. However, issues of availability and affordability were very crucial. Many villagers found it difficult to access condoms as they lived far from the main outlets. Other factors such as stigma, lack of knowledge, and gender inequality were also major obstacles to condom use. As a result the use of condoms remained infrequent especially in rural areas and in Christian and Muslim circles despite total condom sales increasing from 4.7 million in 1993 to 10.6 million in 2002.¹⁹ The UNAIDS report on combination HIV prevention published in 2010 states that, by mid-2000s it became clear that ABCs alone were not enough for effective HIV prevention and that effective interventions needed to take into consideration underlying social-cultural, economic, political, legal and other contextual factors.²⁰ Besides, the ABC approach only focused on the sexual transmission of HIV and AIDS and over-looked other ways such as through mother to child, unsterilised needles and sharp instruments and so on. It was observed for example that, the mother to child HIV transmission alone accounted for 40 per cent HIV and AIDS infections of all babies born to HIV-positive mothers in Zambia. Therefore, programmes like Prevention of Mother to Child Transmission (PMTCT) were a direct response to this observation.

¹⁸ L. Garret, 'Prosperity's Fatal Side Effect: New Urban Lifestyle Spurs Virus,' News Day (27 December 1988). See also *Times of Zambia*, "The Church's uncompromising Stance on Condom."

¹⁹ Bay Area Report, "Zambia's President Questions the use of Condoms" 11 January, 2001.

²⁰ UNAIDS, 'Combination HIV Prevention: Tailoring and Co-ordinating Biomedical.'

PMTCT began as a three-year pilot programme in the Copperbelt province in 1999. Within four years it had expanded to four more provinces with 74 health facilities offering antiretroviral drugs (primarily niverapine) to expectant mothers and newborn infants. With a high antenatal HIV and AIDS prevalence, estimated at 16.4 percent in 2008, approximately 80,000 infants born annually were at risk of acquiring HIV from their mothers.²¹ It was also concluded that, reducing the number of women newly infected with HIV would reduce HIV exposure to their children. Following these observations, the Ministry of Health (MOH) recommended that PMTCT be integrated into Maternal, Newborn and Child Health (MNCH) services throughout the country in order to reduce the transmission of HIV and the subsequent child morbidity and mortality. Other services that were carried along with the integrated PMTCT included couple counseling and disclosure of test results. It was hoped that once couples were counseled together during MNCH services it would be easier to disclose their status to each other and it would lead to behaviour change. Dr. Lawrence Marun from CDC and the panelists during the National convention held in Lusaka in 2009 also alluded to the fact that, involvement of men was critical in reducing MTCT.²² They argued that, targeting couples was much more effective in PMTCT than targeting mothers alone because involvement of fathers had proved effective in adherence to both drug and feeding regimes. However, concerns were raised at the low levels of male involvement in antenatal care. The low male involvement was attributed to ‘‘ante-natal clinics that were not male-friendly, and deference to traditional attitudes about male roles.’’ The fact that men had begun to respond to this cause is a great milestone in as far as prevention of HIV and AIDS was concerned. This is because in traditional Zambian society, maternal health was predominantly a feminine issue. It also shows that tradition was not static but that in difficult times it could be

²¹ Ministry of Health, *2010 National Protocol Guidelines: Integrated Prevention of Mother-to-Child Transmission of HIV*, (September 2010), pp. 1-3.

²² NAC, *National Prevention Convention: Securing Zambia’s Future* 3-5 November, 2009.

manipulated to adapt to the current situation. It was a sure sign that people were beginning to appreciate the importance of counseling in prevention of HIV and AIDS. Towards the end of 2010, the MOH in conjunction with both local and international Organisations formulated the 2010 guidelines to help in the implementation of the PMTCT programme.²³ Considerable improvements have been recorded in terms of the percentage of women testing for HIV and receiving ARVs and the proportion of pregnant women put on prophylaxis to prevent HIV transmission to infants.

Voluntary Counseling and Testing (VCT) came later in 2004 and it became a very important component in the prevention of HIV and AIDS. Unlike couple counseling which only targeted couples, VCT strategy covered all types of population groups. Evidence shows that only 28 percent of Zambian adults aged 15-49 knew their HIV and AIDS status.²⁴ Many people would wait until they fell ill for them to be tested because they feared stigma and social rejection, or felt it was a waste of time knowing their status especially if they were unlikely to receive antiretroviral therapy.²⁵ For example the 2001 anonymous and the 2004 mandatory HIV and AIDS testing introduced by Konkola mine and the government respectively received so much criticisms from human rights activists and people living with HIV and AIDS. Many people feared that anonymous testing would lead to discrimination of miners. Mandatory testing on the other hand was seen as a violation of human rights. These criticisms prompted the government to replace the two types of testing with voluntary Counseling and Testing in 2005. The number of Counseling and Testing (CT sites also increased from 450 in 2005 to 1,023 by end of 2007. As of 2009, all 1,563 private and public health facilities in the country offered VCT services. In that

²³ Ministry of Health, *2010 National Protocol Guidelines*, pp. 1-3.

²⁴ FHI, 'Corridors of Hope II,' 2009.

²⁵ WHO/UNAIDS/ UNICEF, 'Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector', 2009.

year many people were tested for HIV and AIDS as compared to previous years.²⁶ In 2010 the counseling sites increased further. NAC observed that, the increase in testing sites in 2007 and 2010 did not translate into an increase in the number of people accessing CT services like in 2009.²⁷ The increase in the number of people accessing CT in 2009 may have been precipitated by the government campaigns such as the declaration of June 30 as the national voluntary counseling day and the issuance of the National HIV CT guidelines in 2006.

Other prevention programmes that government introduced focused on social and behavioural change (SBC). The SBC interventions had two main objectives and these were: firstly, to improve the level of comprehensive knowledge about HIV and AIDS to an extent where people are able to assess their own lifestyles; and secondly, to promote social and behaviour change interventions that would result in the adoption of key and prevention behaviours.²⁸ The target groups for these interventions included; the young people, the general population and the key population or the Most at Risk Population (MARPS). The SBC interventions were in form of school clubs, the media, music, drama, group discussions and role play exercises. Anti-AIDS clubs mainly operated in schools where members were encouraged to spread messages about safer behaviour and compassion for those living with HIV and AIDS. The first Anti-AIDS club to be opened in Zambia was in the late 1980s and possibly the first in the world. By 1992 there were 1,150 registered clubs in Zambia.²⁹ Television, radio and the newspapers raised awareness

²⁶ Republic of Zambia, *National HIV/AIDS/STI/TB Policy*, (January, 2005).

²⁷ NAC, 'HIV Prevention Strategy' p. 18.

²⁸ NASF, Joint Mid-term Review Report (2011-2015, 2013), p. 27.

²⁹ WHO/UNAIDS/UNICEF, 'Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector', 2009.

to 71 percent of urban and 37 percent of rural youth. Through the HAART television campaigns in 2000, some behaviour change was noted among some youths.³⁰

On the Copper-belt, a project called Copperbelt Health Education Project (CHEP) was initiated. The project began to employ music, drama, group discussions and role play exercises to raise HIV and AIDS awareness, particularly in rural areas. School youth programme and Peer-centered education also reached school children, sex workers, street children and soldiers. CHEP also established youth-friendly health services, in which trained peer educators worked alongside clinic staff.³¹ Later CHEP activities were evident all over the country. The Mid-Term-Review of National HIV/AIDS Framework published in 2009, shows that the general knowledge of HIV and AIDS had consistently increased from 97% in 2005 to 99% in 2007. Among the youths aged (15-24 years) knowledge about how to prevent HIV had also increased from 40.5% to 65% for females and from 46.1% to 67% for males between 2007 and 2008. In 2006, 4567 (out of 7611), schools were providing life skills-based HIV education. By 2007, 1,102,637 young people were reached with life-skills based HIV education. There is evidence that knowledge of HIV and AIDS among the youth aged 15-24 years had remained stagnant and reduced. From this scenario, it is doubtful as to whether the information acquired through these campaigns was translated into behaviour change.

As earlier stated, the SBC programme also catered for the MARPS. Therefore, particular attention was also directed to the truck drivers as they were among key players in the spread of HIV and AIDS due to the high levels of mobility along main transport routes. Prevention programmes targeting this high-risk group proved to be very effective in changing the behaviour.

³⁰ K. Baker, 'Anti-AIDS Clubs in Zambia', *International Conference on AIDS*, (19-24: 8 July 1992).

³¹ C. Underwood, "Impact of the HEART Campaign, Findings from the Youth Surveys 1999 and 2000", (November 2001).

This was evidenced by increase in condom use from around 50 percent in 2000 to almost 70 percent in 2006.³² The exercise was spear headed by “Corridors of Hope”, a project funded by USAID and implemented by RTI International and Family Health International. It aimed at reducing HIV and AIDS transmission among transportation corridor communities in Zambia, Burundi, the Democratic Republic of Congo, Djibouti, Ethiopia, Kenya, Mozambique, Rwanda, South Sudan, Tanzania, and Uganda.

Given the complexity of the disease, the Ministry of Health saw the need to collaborate with other line ministries. At its genesis, HIV and AIDS was viewed by ministries such as Education, as an exclusively health issue. By the time it dawned on them that HIV and AIDS affected everyone, it was somewhat late. The Ministry of Education had “the capacity to equip learners with knowledge, skills, attitudes and values that would reduce the likelihood of acquiring or transmitting HIV infection”³³ and yet unaware of its potential. Since the education sector had the potential to attract youths who also made more than half of Zambia’s population, it was the best platform through which HIV and AIDS messages could be transmitted. According to Kelly, it was saddening that by as late as 2007, a number of young people aged 15-24 still held on to the major misconceptions about HIV and AIDS transmission and ignorant of ways of preventing sexual transmission of HIV and AIDS.³⁴

Apart from the issue of HIV and AIDS, the government was also faced with the challenge of addressing problems that came with youths’ developing sexuality at adolescent age. Sexuality and interpersonal relations if not checked left youths in a vulnerable position to HIV and AIDS

³² WHO, ‘Education and HIV: A Sourcebook of AIDS/AIDS Prevention Programs’, (Vol.1 of 2), (Geneva: WHO, 2004).

³³ M.J. Kelly, *Education for an African without AIDS*, (Nairobi: Paulines Publications 2008), p. 143.

³⁴ UNAIDS, ‘UNAIDS Report on Global AIDS EPIDEMIC’, (Geneva: UNAIDS) 2010.

infections among most youths. In view of this, the Ministry of Education was prompted to integrate HIV and AIDS, sexuality and interpersonal relations issues in the school curriculum at all levels of the education strata.³⁵ Through integration the MOE aimed at not only empowering youths with the skill of resisting negative peer pressure and other sources, but also providing the youths with the facts about the dangers of drug and alcohol abuse, HIV/AIDS and sexuality and above all providing the knowledge needed for prevention of infection. To intensify HIV and AIDS awareness among youths, additional strategies were initiated and these included: anti-AIDS clubs, peer education programmes, outreach for out-of-school youths, introduction of school guidance and services for psychosocial counseling and so on.

Joseph Chita notes that although the Ministry of Education may have been successful at planning level, implementation of these plans was not that easy in some subsectors like schools. Some of the factors that hampered the implementation of school-based HIV and AIDS education were: lack of specific teaching and learning methods and materials; untrained teachers; limited time due to overloaded curriculum and delay in training of in-service and pre-service teachers. These coupled with cultural factors became barriers in the mitigation of the HIV and AIDS pandemic. Of all the challenges stated above, culture remained a crucial issue in as far as mitigation of the scourge was concerned. This was because culture like religion defined a way and approach to life for individuals and society as a whole.³⁶ Therefore removing these deeply enshrined cultural values was not easy. For instance, discussing sexuality and condom use in public to children usually attracted criticisms from society because this was a taboo according to African tradition. Even teachers themselves tended to shun handling HIV and AIDS education because it involved

³⁵ Ministry of Education, *Educating Our Future*, (Lusaka: MoE, 1996), P. 38.

³⁶ Joseph Chita, "Children's Rights of Information and HIV Education: A Study of School Based HIV Education in Two Catholic Secondary Schools in Zambia ". MIED Thesis, University of Oslo, 2008, p. 50.

issues of sex that were shaped by social, cultural and religious attitudes. Thus, the government and the Ministry Education in particular needed to address the issue of culture in order to provide information and education on the subject.

While the government was making headways in providing a safe environment through prevention programmes, those that had already contracted the disease were becoming helpless. There was therefore, need for the government of Zambia to look into the rite of this vulnerable group by providing treatment. State provision of antiretroviral therapy began in Zambia in the late 2002. Initially very few people could afford ARVs as they were mainly found in the private sector and to some extent in public institutions where patients procured their own medicine.³⁷ Moreover this treatment was limited to treating HIV and AIDS patients with opportunistic Infections such as Tuberculosis and STIs. Although the private sector provided these services, they were hampered by lack of laboratory facilities. Provision of free treatment only began in June 2004 after receiving an unprecedented amount of funding from the Global Fund and U.S. President's Emergency Plan for AIDS Relief (PEPFAR). As for the delivery of the programme, the government entirely relied on NGOs, churches and communities. By the end of 2009, 64 percent of the 440,000 people in Zambia needing ARV treatment were receiving it and a third of all health facilities in the country were able to offer treatment.³⁸

The ultimate goal of the Zambian government was to provide treatment that could accessible universally and eventually make ARV therapy equally available to everyone who was clinically eligible.³⁹ However, some schemes tried to make it easier for particular groups to have access to ARVs such as civil servants, teachers, university students and mothers and children (through

³⁷ WHO/UNAIDS/UNICEF, 'Towards Universal Access', 2010.

³⁸ Stephen Lewis, "Zambia: A constellation of Change and Commitment' in response to AIDS".

³⁹ HIV/AIDS in Zambia (<http://www.avert.org/aids-htm>).

"PMTCT Plus"). Mining companies had private schemes. However, these services only benefited the city dwellers and not those in rural areas.

Despite the many benefits, the treatment programmes were hampered by a number of factors which ranged from inadequate healthcare system to too few staff. There was a critical shortage of doctors, nurses, lab technicians and other health professionals. In 2006, for instance, there were only 646 doctors against 12 million people in the country. The doctor-patient ratio was less than a third as compared to that recommended by the WHO.⁴⁰ The problem was even more critical in rural areas resulting in people going to traditional healers for consultation and treatment. The sentiments of Solwezi Member of Parliament in one of the parliamentary debates in 1987 confirmed the state of staffing in health centres when he stated:

I followed with interest the ministry of health's staffing position. We have general and central Hospitals in Zambia. These Hospitals are poorly staffed. Take for example, Solwezi General Hospital, this hospital is supposed to have twenty- seven doctors on the establishment.... To my surprise, Mr. Speaker sir, at Solwezi, there are only three doctors out of twenty- seven that are supposed to be there.⁴¹

The problem of shortage of health workers persisted. The crisis was necessitated by a large-scale emigration of trained health professionals to other countries in Africa and abroad for greener pastures. To address these problems, the government increased health workers' recruitment and introduced a number of incentives to retain health staff and expanded the workforce.⁴² Certain health-care duties were delegated to lay people or community workers to reduce the workload of

⁴⁰ WHO/UNAIDS/UNICEF, *Towards Universal Access*, 2010.

⁴¹ Republic of Zambia, *Daily Parliamentary Debates*, 29 January 1987 Official Verbatim Report of the Debates of the fourth Session of the fifth National Assembly, (Lusaka: Government Printers, 1987), p. 630.

⁴² *The Lancet*, 'Zambia's Health – Worker Crisis', Vol.371, p. 639.

doctors and nurses. The 2010 report presented to UNAIDS noted that there "are no non-monetary incentives for overworked health providers in place or being planned for".⁴³ Most staff worked extended hours with no compensation. Thus, human resource challenges remained a major barrier to effective treatment programmes.

Another issue hampering the scale up of treatment in Zambia was the lack of funds. The problem of funding in the Ministry of Health in the country was not new and was to a large extent caused by misappropriation of funds by some officials in the ministry. The following statement by Mr. Borniface Shinga, Chinsali Member of Parliament, confirms this fact:

I would like the government to look into the problem of Health Facilities in Chinsali district. We have so many places where we require rural Health centres. Sir people in rural areas travel long distances in order to access medical services. Whenever we ask government to provide us with rural health centres ...The government cannot assist and yet a lot of money is being misused in this country.⁴⁴

The realities of embezzlement of funds began to unfold in 2009 when it was revealed that donor funding had been misappropriated in the Ministry of Health.⁴⁵ This led to the suspension of donor aid by a number of organisations and countries. Sweden and the Netherlands, for instance, suspended \$30 million in aid for health programmes, the Global Fund for HIV and AIDS, Malaria and TB also suspended more than \$137 million and the Canadian International Development Agency (CIDA) suspended \$14.5 million aid programme for the Health Ministry.

⁴³ *The Lancet*, 'Zambia's Health – Worker Crisis', p. 639.

⁴⁴ Republic of Zambia, *Daily Parliamentary Debates*, 22 January 1987 Official Verbatim Report of the Debates of the Fourth Session of the fifth National Assembly, (Lusaka: Government Printers, 1987), p.303.

⁴⁵ *Science Speaks, HIV & TB News*, 'Massive Gap in Funding Forecast for AIDS Treatment in Zambia' (August 2010).

A sum of \$7 million was reported to have been stolen in the Ministry of Health in 2010.⁴⁶ HIV and AIDS programmes were the worst affected by disruptions in donor funding. Almost three quarters of HIV and AIDS funding was coming from foreign donors and countries.

The Zambian government reimbursed the Swedish, Dutch and Canadian governments for the stolen funds. Despite the government's efforts to refund the stolen money, these countries did not resume their health aid to Zambia by August 2010. They insisted that funding would only resume after all queries were cleared. Those that resumed funding like the Global Fund began to channel it through sister Organisations such as the United Nations Development Programme (UNDP).

Non-Governmental Organisations' Intervention Measures

Government intervention measures were not adequate to cater for the escalating HIV and AIDS crisis. Like elsewhere in Africa many national programmes were corrupt, ill-equipped and poorly funded.⁴⁷ As a result, most of these programmes depended on the civil society, international and local non-governmental organisations for funding and implementation of programmes.

Like the various African governments, the WHO was slow to respond to the pandemic in Africa as it contended that HIV/AIDS was not the primary health concern in the region. However, when the organizations realised the intensity of the disease it began to put in place preventive measures. In 1987 WHO established a Global Programme for the Fight against HIV and AIDS to help in prevention and educational efforts in Africa. Since its formation in 1998, the Global

⁴⁶ Ann Danaiya Usher, 'Donors Lose faith in the Zambian Health Ministry' *the Lancet*, 376 (9739), (2010), pp.403-404. See also *Plus News*, 'Zambia: Health Funding Frozen after Corruption alleged'.

⁴⁷ IRIN Africa, 'Zambia: The Repercussions of Suspending aid' (September 2009).

Project on AIDS has led responsible discussion and planning at both international and national levels.⁴⁸

Efficient international community's action came with the formation of UNAIDS in 1996. It took up responsibility for coordinating international action against the epidemic. The UNAIDS showed commitment in reporting on various aspects of the HIV and AIDS pandemic ranging from behavioral change to prevalence rates. In one of its reports in 2008, for instance, UNAIDS reported some stability in the HIV and AIDS pandemic which was associated to positive behaviour change among the people of Zambia. In separate reports both the Ministry of Health and United Nations Development Programme (UNDP) also alluded to the fact that there was a drop in the prevalence rates from 19% in the 1990s to 14.3% between 2007 and 2008, and from 14.3% to 14% between 2008 and 2009 among 15 and 49 age group, respectively.⁴⁹ This brought some relief both to the Zambian government and the people.

However, this joy was short lived because in its follow up country report of 2010, UNAIDS indicated that about 76,000 adults were newly infected in 2009.⁵⁰ This entailed that one in every seven adults in Zambia were infected by the HIV virus with a further reduction in the life expectancy to just 39 years. The report was in line with the speech that the Minister of Health gave during a candlelight service on the eve of 2009 World AIDS day. In his speech, the Minister noted that the infection rate had risen from 70,000 in 2007 to 82,000 by 2009.⁵¹ These reports seem to contradict each other with the earlier reports which recorded a drop in the prevalence rates within the same period. However, there is a possibility that the decline may

⁴⁸ *The Global Mail*, 'Canada suspends Health aid to Zambia' (October 2009).

⁴⁹ UNAIDS, 'UNAIDS Report on Global AIDS Epidemic', 2010

⁵⁰ UNAIDS, 'UNAIDS Report on Global AIDS Epidemic', 2010.

⁵¹ UNAIDS, 'UNAIDS Report on Global AIDS Epidemic', 2010

have been caused by the high mortality rates. In other words, reduction of prevalence rate due to increased mortality rates may have been mistaken for a reduction in new infections. Whatever the case, the major concern is that if infections could rise in the midst of vicious campaigns about condom use, fidelity and abstinence then the pandemic was far from being contained.

Society for Family Health (SFH) was another organisation that contributed greatly in scaling up prevention in the spread of HIV and AIDS. It was established in 1992 to empower at –risk and underserved Zambians so that they lead healthier lives in line with the government’s health priorities. The organisation received funding from Population Services International Zambia to which it was an affiliate. SFH became a leading organisation in the sale and marketing of different types of condoms especially female condoms from its inception in 1992.⁵² The condoms were distributed through several channels, including pharmacies, drug stores, hair salons, barbershops, and VCT centres and in partnership with non-governmental organisations. In 2003 SFH began to offer Voluntary Counseling and Testing (VCT) services by opening a New Start centre in Lusaka Zambia’s capital city. Later it started operating in Kitwe, Chipata, Mansa, Solwezi, Ndola and Livingstone. With these centres in place SFH reached 10,000 clients per month through counseling and testing services. In 2009 SFH managed to launch a mass media campaign to encourage couples to seek VCT services. A research official at SFH office in the Lusaka branch disclosed that HIV and AIDS was spreading more among the couples because they refused to use condoms.⁵³ He added that the negative attitude to condom use was more in villages due to myths, ignorance and failure to use the condoms correctly.

⁵² Interview, Collins Munthanga, Research Officer, Society for Family Health, Lusaka. 18/05/2011.

⁵³ Interview, Munthanaga, Lusaka, 18/05/2011.

Following clinical trials in South Africa, Uganda and Kenya that estimated that a circumcised man was 60 percent less likely to contract HIV than an uncircumcised man, male circumcision (MC) began in Zambia in 2007.⁵⁴ SFH conducted this programme through a combination of fixed sites, private sector franchises and mobile male circumcision services through government hospitals and rural Health Centres. Although the response was overwhelming in the sense that men from different groups ethnic and all walks of life went for male circumcision, resistance was not unknown. Much resistance came from those societies that originally practiced it. Traditionally there were conditions that were to be followed during circumcision. Among the Luvale, women were not supposed to be present during circumcision, the initiates were not allowed to eat (salty) foods, it was supposed to be conducted during the cold season and above all, the one conducting the circumcision was supposed to be a person who had also undergone the same process.⁵⁵ Some men from other tribes also felt they were being acculturated into the Lunda and Luvale tradition hence shunned the exercise.

According to one male circumcision voluntary worker at Solwezi Urban clinic, the government put in place measures to overcome these challenges.⁵⁶ Some of these measures included; holding of workshops with traditional leaders, encouraging women to support their spouses and counseling. Despite all these efforts, there were concerns that some people were going to take male circumcision for granted and become careless thinking they were now safe.

Reaching HIV/AIDS Affected People with Integrated Development and Support (RAPIDS) was another organisation that made considerable contributions in the fight against HIV and AIDS. It was a multi-sectoral HIV and AIDS initiative in Zambia led by the World Vision and funded by

⁵⁴ UNAIDS Fact Sheet Sub-Saharan Africa.

⁵⁵ Interview, Abraham Muma, CM Volunteer, Solwezi Urban Clinic, 03/02/2011.

⁵⁶ Interview, Muma.

the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). It became one single project that brought together the proficiency and geographic coverage of six leading international and local NGO syndicate partners.⁵⁷ These included NGOs such as Africare, CARE International, Catholic Relief Services (CRS), Expanded Church Response (ECR), the Salvation Army, and World Vision. Through this strong alliance, RAPIDS began to work on the already existing service delivery activities for vulnerable communities. RAPIDS partners also strove towards improvement of the quality of work by sharing lessons and complemented each other's work. Its main activities included visiting vulnerable children and linking them to education, health, and protection services; providing care for PLWHA; facilitating youth groups; establishing community agriculture initiatives and creation of community coalitions that act as a community forum on HIV and AIDS. Its ultimate goal was to improve Zambia's quality of life by strengthening communities' institutional capacity to respond to HIV and AIDS.⁵⁸

Zambia Prevention, Care and Treatment (ZPCT) worked with the Ministry of Health (MOH) in Zambia to scale up HIV and AIDS clinical services in 35 districts in five of the country's ten provinces namely Central, Copperbelt, Luapula, Northern and North Western. Selected health facilities were then provided with technical and financial support, as outlined in a recipient agreement with a detailed scope of work. This agreement was executed within MOH systems and structures. Clinical HIV and AIDS services included prevention of mother to child transmission (PMTCT) of HIV/AIDS, counseling and testing, antiretroviral therapy (ART), clinical care, and HIV-related laboratory and pharmacy services.⁵⁹ Other local organisation such

⁵⁷ Bruce Wilkinson and Tony Frank, "Rapids Distribution Project" *World Vision International* (December 2005), p.2.

⁵⁸ Wilkinson and Frank, "Rapids Distribution Project", p.7.

⁵⁹ Interview, Beauty Lwando, ZPCT, Solwezi, 03/02/2011.

as the Churches Health Association of Zambia (CHAZ); traditional institutions such as Traditional Health Practitioners Association of Zambia (THPAZ) and Social Welfare Associations such as Tasintha which addressed specific issues associated with churches, traditional medicine and sex workers.

Conclusion

The work of the government and NGOs is worth noting. The chapter has demonstrated that government response to HIV and AIDS was slow and inefficient. This was the case not only in Zambia, but Africa as a whole. At the time, the tourism sector was flourishing and so public announcement of the pandemic was seen as a threat to the tourist market. As a result, much of what was known about HIV prevalence in the early days was kept secret by the authorities. However, when the realities of the pandemic began to unfold, the government failed to contain the pressure and thus put in measures to prevent its spread.

It is clear from the discussion that the Abstinence, Faithfulness and Condom use (ABCs) which was the earliest approach only focused on prevention of sexual transmission of the scourge through behaviour change. By mid-2000s the disease rose to alarming levels and it was now evident that ABCs alone were not enough to stop the spread of the pandemic. This situation prompted the government and other stake holders to engage a combination of programmes that took into account social-cultural, economic, political, legal and other contextual factors. The impact of some government and NGO programmes in response to the HIV and AIDS pandemic has been very minimal because of a number of factors. The major problem with government interventions was lack of funds, and inadequate staffing in health centres. Government programmes were too dependent on donor funding as a result the government failed to sustain

national programmes when NGOs pulled out of certain programmes. Organisations also worked outside the cultural context of given communities and ended up in conflict with their traditions.

CHAPTER FIVE

CONCLUSION

This study explored the relationship between Culture and HIV and AIDS in Zambia between 1984 and 2010. The study aimed at identifying cultural beliefs, practices, myths and misconceptions about HIV and AIDS in Zambia that had an impact on the fight against HIV and AIDS. It also aimed at examining the measures advanced by the government and non-governmental organisations in the prevention and treatment of the scourge. The study further set out to identify the challenges government faced in implementing these measures.

Various conclusions have been drawn in the study. The study discussed the question whether HIV and AIDS was a new disease or not, myths and misconceptions about HIV and AIDS, how Zambians viewed it and their response to the disease. Government and non-governmental interventions were also examined. It was noted that AIDS was seen by most Zambians as an old disease, *kafunga* which had adopted a new English name. The old illnesses related to breaking of taboos and careless behaviour that threatened the wellbeing of the community and those caused by witchcraft, had similar symptoms as those of TB and HIV and AIDS. The causes were also the same everywhere. As a result, when HIV and AIDS appeared, people did not see any difference. They continued to blame the disease on witchcraft and women's negligence of traditional values related to miscarriage, abortion, menstruation and sexuality. Besides, diseases resulting from sexual relations were kept secret in Zambian tradition because it was shameful or a taboo to discuss such issues as it involved private parts. It became equally difficult to disclose one's HIV and AIDS status because of the same reasons. Despite all this, a change had been noted in the way they responded to disease. Because of stigma, people developed euphemism when discussing issues related to HIV and AIDS. They realized they were dealing with disease

and could not avoid talking about it. Therefore, they developed their own language for communication. For example, when a relative died of AIDS, they would simply say; ‘they had a long illness, they were very thin, they had swollen legs’ and so on. As people became more enlightened about HIV and AIDS, stigma against those who were infected began to grow.

Owing to the stigma surrounding the disease, *Kafunga* and witchcraft provided an alternative explanation for AIDS patients. Many traditional Healers claimed that *kafunga* could be treated while HIV and AIDS could not. Thus, of the two, *kafunga* and AIDS, the diagnosis of the former gave some straw of hope and dignity to both the patient and relatives, whereas an AIDS patient was given no hope of survival. Initial response to HIV and AIDS was characterised by rumours, denials and myths about disease. Myths and misconceptions also developed. These myths came about mainly because of the lack of information on prevention, transmission and cure of the disease. Some of these myths and misconceptions led to sexual abuses such as child molestation. Incidents of child molestation and other abuses led the Zambian government to put in measures to prevent such vices.

At the centre of each society in traditional Zambia were certain norms and values that influenced the beliefs and practices of people in that particular society. Beliefs and practices such as widow/widower cleansing, initiation ceremony, and dry sex, gender and multiple sexual relationships were deep rooted in the lives of people and getting rid of them was not easy. These cultural norms and values intermingled with HIV and AIDS epidemic in various ways and as such became a factor in the spread of HIV and AIDS. People held on to these traditions even in the face of HIV and AIDS as getting rid of these traditions was a taboo and violation of society’s demands. Therefore, some beliefs and traditional practices that acerbated the spread of HIV and AIDS still existed in Zambia amidst the many awareness campaigns. It was also observed that

neither education nor knowledge about HIV and AIDS could change people's behaviour because of strong traditional cultural influences. It has been noted however that, although people held on to these traditions, they were now aware of the dangers of the new disease. As such, they manipulated some of the traditions in order to cope up with the new disease. For example, substitute methods which did not involve sex during the widow/widower cleansing, were increasingly used by most people in Zambia.

Due to the increasing rates of HIV and AIDS cases the government was prompted to come up with measures in order to prevent the further spread of the disease. Government response at the beginning was slow and not reliable, denying the presence of the disease and concentrated on immediate political and economic problems. The government's later response was unstable; from the late 1980s to 1993 due to economic crisis that followed International Monetary Fund (IMF) structural reforms in the 1990s along with the draught and the advent of cholera out breaks. Initial International Organisation interventions were propagated by the World Health Organisation (WHO) when they funded the Zambian government in 1987. Due to limited funds from the international organisations at the time, the government confined its measures to behavioral change; incorporating abstinence, faithfulness and condom use (ABCs). In the mid-2000s, it became evident that ABCs alone were not effective enough to fight this disease complex disease, but that rather interventions needed to take into account every aspect related to the scourge. It was also observed that HIV and AIDS were not only a healthy matter but something that affected all other aspects of life.

As such, the new millennium came with renewed political attitude and increased determination to confront the epidemic. This renewed political attitude saw the formation of important bodies like the National HIV/AIDS/STI/TB Council (NAC) and National Strategic Framework (NASF

co-ordinate and monitor responses to the disease. Donor funding increased. And the response broadened to include voluntary Counseling and Testing (VCT), Anti Retro-Viral Drugs/Therapy as well as the prevention of Mother to Child Transmission (PMTCT).

In the late 1980s non-governmental organisations came in to supplement government efforts in preventing the spread of HIV and AIDS. WHO was the first followed by the UNAIDS in 1996. Thereafter several other organisations both international and local emerged to address various aspects of the pandemic. Notable ones included Society for Family Health (SFH), Reaching HIV/AIDS Affected People with Integrated Development and Support (RAPIDS), Zambia Prevention, Care and Treatment (ZPCT), Churches Health Association of Zambia (CHAZ), Traditional Health Practitioners Association of Zambia (THPAZ) and Tasintha.

The impact of some government and NGO programmes was very minimal due to a number of factors. The major problem with government interventions was lack of funds, and inadequate staffing in health centres. Government programmes were too dependent on donor funding as a result the government failed to sustain national programmes. Another significant problem hampering the mitigation of the scourge was culture. Some cultural practices and beliefs although overlooked in both government and NGOs, had devastating effects on the efforts meant to prevent the spread of HIV and AIDS. This is because gender inequality, sexual practices such as widow/widower cleansing, multiple sexual relationships and initiation ceremonies were the founded nature of these societies. In addition to these traditional values, were the numerous myths and misconceptions related to HIV and AIDS that these traditional societies developed in the early 1990s. Stigma and opposition to condom use also became deeply rooted following knowledge on the existence of HIV/AIDS. Since a number of organisations worked outside the cultural context of given the communities they often clashed with their traditions. As a result,

despite increased donor funding and subsequent intervention measures, the general prevalence rates continued to escalate. It has been concluded that, given the complexity of the pandemic, government and Non-Governmental interventions have not remained static, but they have changed in accordance to the situation prevailing at that particular time.

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