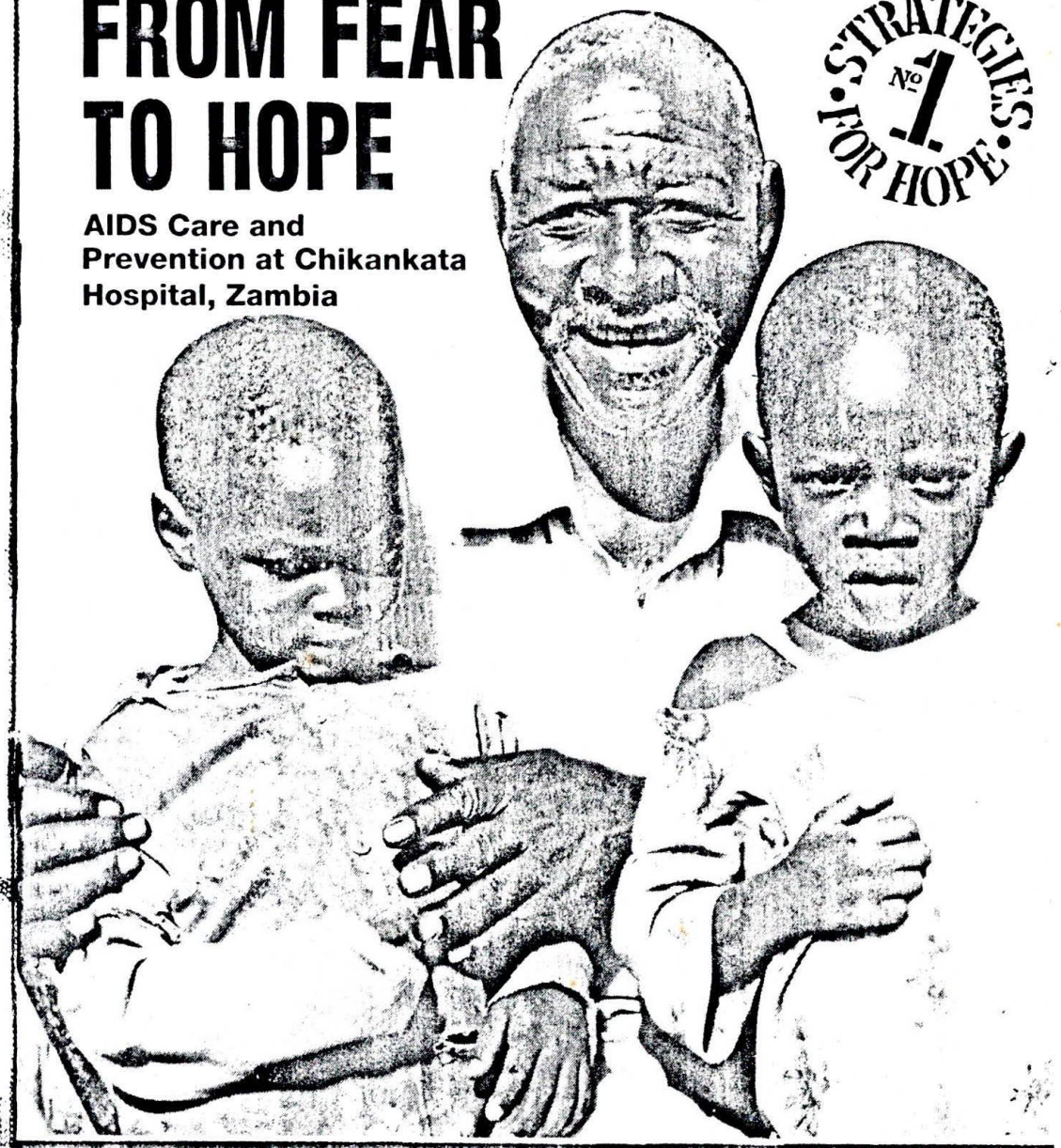
FROM FEAR TO HOPE

AIDS Care and Prevention at Chikankata Hospital, Zambia

STRATEGIES FOR HOPE No. 1



by Glen Williams

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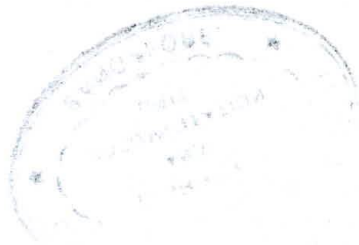

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NOTE

The names of all hospital patients and persons visited by the Chikankata AIDS home care team have been changed.

Introduction

Only a decade ago, AIDS was completely unknown.

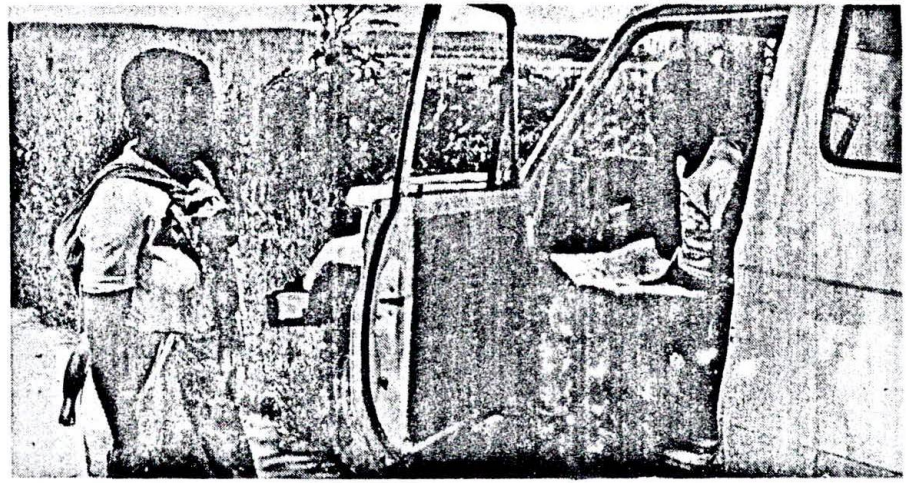
Today, no nation on earth can escape its consequences. The World Health Organization estimates that 5 to 10 million people in over 150 countries are infected with HIV, the virus which causes AIDS. Most, if not all, will develop AIDS and will die prematurely. Meanwhile, the numbers of people infected with the virus continue to increase.

AIDS, or 'acquired immune deficiency syndrome', was identified only in 1981. HIV, or 'human immunodeficiency virus', was isolated two years later. The virus is remarkable in its behaviour and its effects on human health. It can live in a person's body for several years without causing any ill effects. The person may feel perfectly normal, but can transmit the virus to someone else through sexual activity or blood. A mother can also pass it on to her baby during pregnancy or childbirth.

HIV infection weakens the body's defences, or immune system. As the virus begins to take effect, the infected person suffers from repeated illnesses – infections of the skin, the respiratory system, the genitals, the gastro-intestinal tract, or the central nervous system. Recovery is increasingly slow and painful. The body's defences are finally weakened to the point of collapse, followed by death.

There is no cure for AIDS, and no vaccine to prevent it. But this does not mean that people with HIV or AIDS should be neglected by the health services, rejected by their families and friends, and abandoned by society.

There is hope for people with HIV/AIDS, for their families, and for their communities. That is the message emerging from the work of the Salvation Army Hospital at Chikankata in southern Zambia, in caring for people with HIV/AIDS and their families. This book is about that hope, and how it can be created and sustained. Only in a climate of hope – not in one of fear and panic – can the threat of AIDS be confronted and overcome.



The Chikankata Hospital's AIDS home care team brings medical care, counselling and material support to people with AIDS, their families and communities.

In Africa, AIDS is primarily a family disease.

AIDS in Africa

Africa is in the frontline of the worldwide AIDS epidemic. The full dimensions of the epidemic in Africa are still uncertain, but it is already a grave public health problem in many countries, especially in East, Central and Southern Africa. Its impact is certain to grow at an alarming rate during the 1990s, even in countries which so far have reported only a few cases of HIV infection or AIDS.

Recent surveys in Zambia, for example, have identified HIV infection in about 10% of pregnant women, 10-15% of healthy blood donors, and 23-30% of persons with sexually transmitted diseases[1]. In rural areas the rate is probably lower than in towns and cities. At Chikankata Hospital, which serves a mainly rural population in one district of Zambia's Southern Province, 8% of blood donors have been found to be infected with HIV. Most of these people are likely to develop AIDS within the next five years.

HIV infection and AIDS are by no means unique to Africa. But the way in which the disease affects Africa differs in several important respects from the situation in the industrialized world, where most of the confirmed cases of AIDS have been reported. In particular:

- HIV infection in Africa is spread primarily by *heterosexual intercourse*. It affects sexually active men and women in equal numbers, rather than sub-groups of the population such as male homosexuals or intravenous drug users. (Homosexuality and intravenous drug use are rare in Africa.) High-risk sexual behaviour therefore consists of sexual intercourse with more than one partner.
- HIV infection in Africa is primarily a *family disease*, rather than a disease affecting mainly single people. Although it enters the family through one parent, it also affects the health, social, psychological, economic and spiritual wellbeing of other members of the nuclear family and often those of the extended family as well.
- The presence of HIV makes it easier for some *common infectious diseases* to spread and increases their severity. Diseases such as tuberculosis, some forms of cancer, and some parasitic diseases – already more widespread in Africa than in industrialized countries – behave in this way.
- AIDS comes on top of Africa's already intolerable *burden of economic, social and health problems*. In the past decade, virtually all African nations have seen their economies shrink as a result of falling commodity prices, economic recession, crippling foreign debts and declining international aid.

Zambia's export earnings, for example, fell by 56% between 1980 and 1986. Countries such as Uganda, Mozambique and Angola have had their health and social infrastructure devastated by war. Most African nations have had to slash their health and education budgets because of falling government revenues. The capacity of government services to respond to the urgent needs of people with AIDS and their families is therefore extremely limited.

Collective responses

In Africa, as in other parts of the world, there is a pattern of official and public responses to the AIDS epidemic. Dr Jonathan Mann, former Director of the World Health Organization's Global Programme on AIDS, describes these responses as occurring in three stages: first, 'denial and minimization of the problem'; second, 'reluctant acceptance'; and third, 'constructive engagement'[2].

In the first stage, political leaders and policy-makers dismiss AIDS as a problem of 'others' – of foreign countries, or of small, marginal sections of their own populations. The fact that AIDS threatens the health and wellbeing of their societies *as a whole* is denied or ignored.

But as the numbers of AIDS cases mounts and begins to attract public attention, the government feels obliged to respond in some way. AIDS control activities (e.g. blood screening in hospitals) may now be carried out on a limited scale.

Finally, when the scale of the problem can no longer be ignored, policy and decision-makers start to move into the stage of 'constructive engagement'. In Zambia a decisive factor in reaching this phase was the announcement by President Kenneth Kaunda, in December 1987, that one of his sons had died of AIDS. The President's courageous statement ushered in a new era, in which it is now possible for Zambians to address the AIDS issue more openly.

Photo : Carlos Guarita / ActionAid

Blood screening in hospitals is often one of the first official responses to the threat of AIDS.

The 'fear' approach

The year 1988 saw a dramatic increase in the coverage of AIDS by the Zambian mass media. Radio, television and the newspapers informed millions of people about AIDS and its dangers. But while media coverage has helped to sensitize the public to the issue of AIDS, its educational impact has been only limited. Misconceptions and fears about how AIDS is transmitted are, if anything, greater than ever before (even among some health professionals). By taking a 'fear approach' to AIDS education, the mass media may well have contributed to the stigmatization of people with HIV/AIDS. Increasingly, there are reports of people suspected of having AIDS being ostracized by their neighbours, friends or workmates.

Because of its associations with sex outside marriage, AIDS is also seen as something for which the victims themselves are to blame. It is a 'shame' disease, a cause for moral judgement and condemnation. Many people diagnosed as HIV-positive are understandably reluctant to tell their friends, workmates or neighbours about their condition, for fear of condemnation and ostracism.

But judgmental public attitudes will not stop transmission of HIV. On the contrary, they will result in a climate of secrecy and fear, in which the problem is driven underground rather than addressed openly with all the seriousness it deserves.

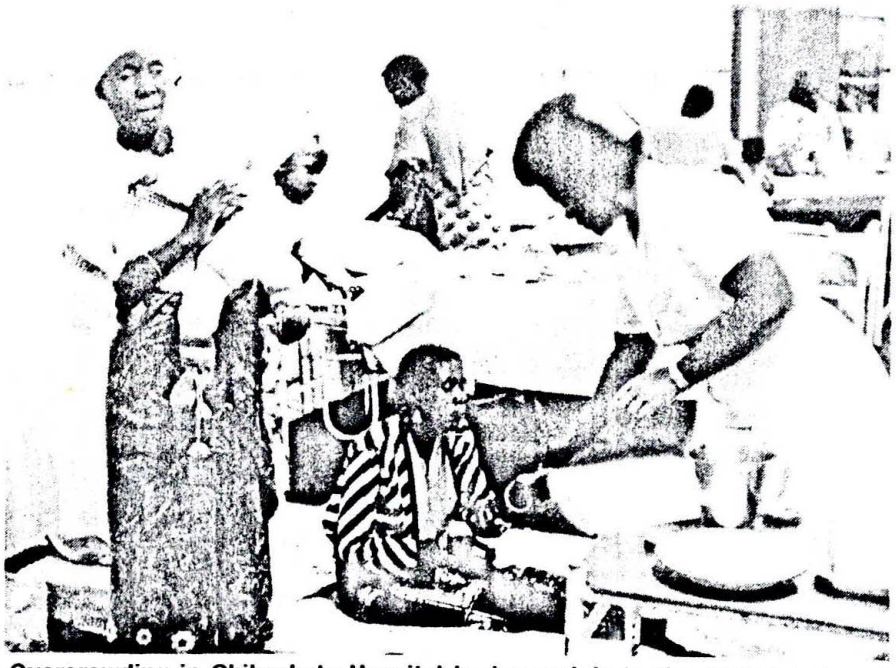
On an international level, the World Health Organization now advocates that public education campaigns should move away from the 'fear' approach to AIDS. "We want positive campaigning," says Eric van Praag, WHO's AIDS team leader in Lusaka. "We want to move away from fear to hope." In February 1989, WHO's Geneva Headquarters withdrew its controversial AIDS logo featuring a skull and two hearts, which had been criticized by AIDS patients worldwide because of its vivid association with death.

Alternative strategies

Although in Zambia AIDS is no longer such a taboo subject, many health professionals still view the problem with a mixture of resignation and uncertainty. It is clear that the health system cannot possibly deal with the rapidly escalating number of AIDS patients who need medical and nursing care, as well as social, psychological and material support. The scale of the problem is so vast that the health services, on their own, will be completely overwhelmed.

In addition, AIDS raises a number of highly controversial medical and ethical issues, which are still unresolved in many African countries. For example, should hospitals screen all ante-natal patients for HIV? And if the result is positive, should the woman be informed? Should blood donors be informed if their HIV tests are seropositive? Should everyone whose blood is to be tested for HIV be asked for their consent beforehand? Continued controversy over these issues gives rise to uncertainty, indecision, and delayed programme development[1].

Although these issues are now being addressed in Zambia, the number of



Overcrowding in Chikankata Hospital is due mainly to the recent influx of patients with HIV/AIDS.

people infected with HIV continues to increase every day. Urgently needed - not only in Zambia but throughout Africa – e strategies for diagnosing, counselling, caring for and supporting people with HIV/AIDS and their families. These strategies must take account of local constraints, but they must also build on the strengths of the community – in particular that of the family.

The experience of the Salvation Army Hospital at Chikankata, in the Mazabuka District of southern Zambia, demonstrates that a family-based strategy of AIDS care and prevention is both appropriate and feasible. This is not to suggest that the 'Chikankata model' should be replicated in every respect in other places. Strategies and programmes must obviously be tailored to local potentials and constraints. But the underlying principles of the Chikankata approach are relevant for many other African hospitals, clinics and health institutions, especially those operated by non-governmental organizations.

The setting

Thirty kilometres of dirt road, criss-crossed by ditches and gullies scoured out by the rains, link Chikankata to the main highway between Lusaka and Livingstone. Situated about 130 kilometres southwest of Lusaka, the Salvation Army Hospital serves a population of about 100,000 in the heart of one of Zambia's most fertile agricultural regions. Crops of maize, wheat, sunflower, potatoes and soya beans are grown on the rolling hills, and beef and dairy cattle are reared on the grasslands. To the south, the hospital's catchment area is bordered by Lake Kariba on the mighty Zambezi River.

Founded in 1946, the Chikankata Mission now consists of a 240-bed hospital and four rural health centres, a nutrition centre, a homecraft centre, a secondary school for 600 girls and boys, a multipurpose training centre, a broadcasting studio and a community development programme. The hospital also operates training schools for nurses, midwives and laboratory technicians. A new ward under construction will increase the number of hospital beds to 265.

The hospital is staffed by five physicians, 67 qualified nurses and midwives, 29 paramedical staff, and 81 trainee nurses and midwives.

In 1988 the average bed occupancy rate was 98%, about 20% higher than during the previous seven years. In several wards patients lie on mattresses on the floor. In some, beds are also put up on the verandah, shielded from the wind and rain only by flimsy screens. More than one-third of all beds are occupied by patients with leprosy, malaria or tuberculosis. But the present state of overcrowding is due mainly to the recent influx of patients infected with HIV. There are patients with HIV in each of the hospital's twelve wards. When all patients throughout the hospital were tested for HIV in July 1988, one in every five was found to be HIV-positive. The prevalence rate was highest in the two tuberculosis wards, where almost half the patients were infected.

Origins of the AIDS programme

The first AIDS patient at Chikankata Hospital was a 35 year-old man admitted in May 1986, suffering from a distinctive skin disease known as Kaposi's Sarcoma. During the latter half of 1986, blood samples from other patients were also sent to the laboratory of the University Teaching Hospital in Lusaka for HIV testing: 37 of these were found to be positive.

It was clear that AIDS was becoming a major health problem in the Chikankata area, threatening to overwhelm the hospital's limited resources. The question was: how to meet the challenge posed by the threat of AIDS, without sacrificing the hospital's work in other vital areas? There were no precedents, no ready-made answers, no tried-and-tested models for African conditions. Everything would have to be learned through a process of experimentation.

Events came to a head when, in March 1987, a British charitable trust, World in Need, approached Chikankata with the offer of funds for a hospice-type institution to care for terminally ill AIDS patients. It would be separate from the hospital, utilizing a group of old buildings previously used by leprosy patients. At first glance this might have seemed a sensible and attractive proposal. But from Chikankata's point of view it had certain limitations. First, it did not take full account of the potential impact of AIDS on hospital bedspace. A hospice would provide beds for only 20 to 25 persons at a time. Given the likely scale of the AIDS epidemic, this would be totally inadequate. (Indeed, by 1988 the hospital was caring for 30-40 AIDS patients at any one time, with an average length of stay of 16 days.) It would be simply unacceptable for the hospital to care for a small group of AIDS patients on an indefinite basis, but at the cost of turning away even more patients also in need of care.

Second, the hospice proposal did not take account of the inherent strengths of Zambian society, particularly the family support network. For generations, Zambian families have cared for their loved ones at home when ill. In this respect, AIDS need not be any different from other illnesses. A way therefore had to be found to link the hospital to the family and the community, rather than trying to graft onto the hospital a new - and unsustainable – facility serving only a

small fraction of those [illegible] support.

The donor organization [illegible] arguments put forward by [illegible] and it was agreed to test the idea [illegible] the management of AIDS in Africa [illegible] of *home-based care*. The basic idea was not the hospital, would be the most effective means of caring for people with AIDS. But this would not mean discharging AIDS patients from hospital and then leaving them and their families to fend for themselves. The hospital would have to decentralize and visit AIDS patients in their own homes, providing medical, nursing, psychological and pastoral care through a small mobile team.

Such a concept had never before been tried with AIDS in Zambia and probably not in Africa. A rural area seemed an unlikely place to try it out. In an urban area a mobile team would be able to visit large numbers of patients in a relatively short time. But in a rural area, with poor communications and a widely scattered population, it might not be so effective.

A small team was hastily assembled to give the home based care idea a try. Without special funding, and borrowing a vehicle from another hospital programme,

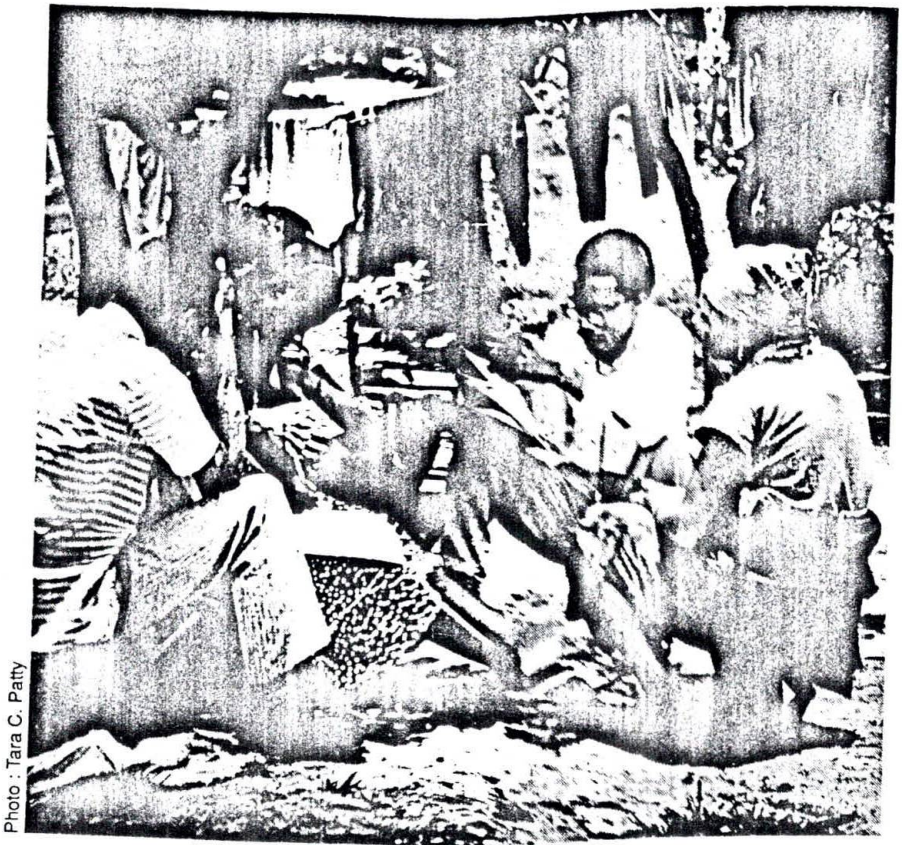


Photo : Tara C. Patty

The Chikankata AIDS home care team meets with a patient under a tree.

Doris

Doris is working in the maize fields when the Chikankata AIDS team arrives at the farm, bringing the result of her 18 month-old daughter's HIV test. Last month she brought the child to hospital after three weeks of diarrhoea, cough and fever. The child failed to improve, and a blood sample was taken. The result was HIV-positive.

Doris arrives, carrying her baby, who is coughing and looks poorly. She insists on her mother being present, and the two women climb into the back of the land-cruiser with clinical officer Zebron and nurse Christine. Gently, Zebron explains that Doris's daughter will need a lot of care because she will often be ill. The hospital staff will keep visiting her to give whatever treatment is possible. But she might not live long enough to go to school. Zebron also explains how HIV is transmitted and that Doris is probably a carrier. He suggests that the child's father should also be tested.

The problem is that Doris is not married to the child's father, a worker on the farm who already has one wife. He has promised to marry Doris as well, and has already paid the dowry (polygamy is still common in rural Zambia). Doris says she will try to persuade him to come to the hospital for a blood test, but she does not seem hopeful. As a single mother she is in a weak bargaining position with the child's father, whom she wants to marry.

Christine takes a sample of Doris's blood for testing. (It is almost certainly HIV-positive.) She also gives Doris a bottle of cough medicine and a kilo of milk powder for the baby. Zebron promises to return next month. He will try to speak with the child's father if he has not yet come to the hospital for a blood test, but only if Doris agrees.

the team began making twice-weekly visits to AIDS patients within 20-30 kilometres of the hospital. The results were encouraging. The team was generally able to visit five to eight patients a day, and were almost invariably well received. The team also realized that home visits were an opportunity for 'contact tracing' - following-up a patient's sexual contacts in order to reduce the chances of the infection being transmitted still further. In addition, home-based care could also create new possibilities for educating family members about AIDS. It should also be possible, the team believed, to start trying to dispel the many misconceptions, fears and rumours about the disease, which were beginning to spread within local communities.

Two months later the donor organization agreed to provide funds for a vehicle, running costs, AIDS testing kits, medical supplies and other expenses. Meanwhile, the AIDS unit was formally established with five staff, all of whom also had other responsibilities in the hospital.

The advent of AIDS also had important implications for hospital staff. Safety procedures were revised in order to minimize the risks of HIV infection, for

example when taking blood, assisting childbirth, or working in the laboratory. A meeting of all nursing, medical and laboratory staff was held to explain the nature of AIDS and the need for the new safety procedures. These were important steps in reassuring hospital staff that their health and safety would not be placed at risk by HIV-infected patients.

Dimensions of the epidemic

In June 1987 the hospital's own laboratory began testing blood for HIV rather than sending samples to the University Teaching Hospital in Lusaka. During 1987 and 1988 a total of 3,861 blood samples were tested, of which 28% were positive, 67% negative and 5% indeterminate.

Chikankata is now one of 35 Zambian hospitals which routinely screen all blood donors for HIV. Patients with a combination of certain conditions commonly associated with HIV infection are also tested at Chikankata. These include weight loss of 10% or more, swollen lymph glands around the neck, persistent diarrhoea, coughing, skin rash, body pains and oral thrush.

Chikankata also screens all TB patients, pregnant women, and patients with sexually transmitted diseases. The results of these tests, carried out over a two-year period (1987-88), present a grim picture of the dimensions of the AIDS epidemic in the Chikankata area, and probably in other parts of rural Zambia as well:

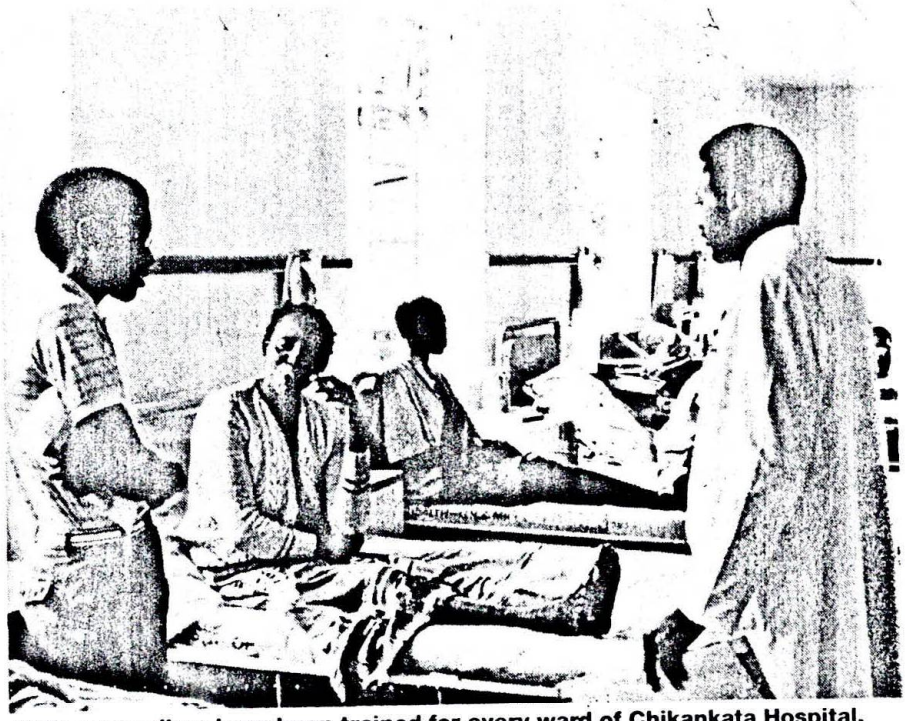
- Among patients with sexually transmitted diseases, 37% were found to be infected with HIV.
- Among pregnant women coming to the hospital for ante-natal check-ups, 12% were found to be HIV-positive. (It is reported that babies born to women infected with HIV have a 25-40% chance of also being infected. If so, they will frequently be ill and will almost certainly die by the age of three.)
- Among TB patients, 49% were found to be HIV-infected.
- Among healthy blood donors, 8% were found to be infected with HIV.

Patient and family counselling

Every person who returns an HIV-positive blood test is informed of the result as soon as possible. But it would be irresponsible to simply tell someone: "You have HIV and you will probably get AIDS, but there is nothing we can do to help you." Patients and their families need skilled help in coping with the potentially devastating news that they are infected with HIV. Counselling is therefore an essential part of the Chikankata approach to AIDS management. At Chikankata it is carried out by the 'AIDS counsellor' assigned to the patient's ward. (Blood donors are counselled by the laboratory supervisor.) Nine AIDS counsellors have so far been trained: three nurses, two clinical officers, two social workers, one doctor and the laboratory supervisor. Counsellor and patient meet in a room outside the ward for a session which may last from 20 minutes to an hour.

The counselling process aims to help individuals and families to understand the nature of HIV and AIDS, and to cope with the implications for their behaviour and lives. The counsellor provides information, guidance and psychological support, but also encourages the patient to ask questions and to express his or her fears and anxieties.

Wherever possible, patients are counselled before being tested. Usually, however, counselling takes place only after the results of the test have been received. However desirable it may be to counsel all patients before testing, this is not usually possible in a busy hospital where staff already have an extremely



AIDS counsellors have been trained for every ward of Chikankata Hospital.

heavy workload.

Counselling in hospital is done in confidence. The counsellor tells the patient the result of the blood test, and then explains how the disease is transmitted and the stages of the infection.

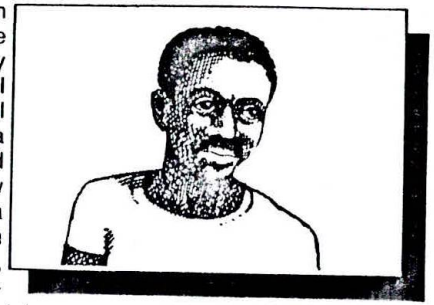
Particular care is taken to dispel myths about how the disease is transmitted. Common misconceptions include shaking hands or sharing cups, cutlery, plates or furniture with an infected person.

The focus of the counselling process varies according to the stage of HIV infection. People who have no symptoms (for example, healthy blood donors or pregnant women) are encouraged to avoid sexual behaviour which could transmit the virus to another person. The emphasis is on the importance of living in a positive but responsible manner, and avoiding other infections (which could hasten the progress of the virus) through healthy behaviour – for example by abstaining from alcohol.

Patients with HIV who have symptoms such as a persistent skin rash, weight loss or a recurring cough are usually anxious about how much longer they are likely to live. The counsellor's response must be absolutely honest: the number of years or months they have to live cannot be predicted with certainty. In the meantime, they should take a positive attitude to life, working and taking part in family and community activities as normal, but avoiding sexual behaviour which would risk transmitting the virus to others, and cutting out unhealthy habits. The patient may also ask the counsellor for advice or direct help in dealing with his or her employers, workmates or neighbours, which opens up the possibility for

Lawrence

"My name is Lawrence Mabelo and I'm 40 years old. I have two daughters, aged six and ten. My wife died the day after she gave birth to our second child. I was born in Zimbabwe but I've lived most of my life in Zambia. I was a professional soldier, then a truck driver, and for the past few years I've been a farmer. I've been growing maize, soya beans, sunflower and a few potatoes.



About six months ago I began having trouble with a skin rash. It started as a spot on my back, then it spread all over my body. You should have seen my skin – it was covered in great big red flakes, and it was all cracked and coarse. The itchiness was driving me mad.

I live near Lusaka but I decided to come to Chikankata for treatment because this hospital has a good reputation. The staff here really care about you. They took my blood and did tests, and they told me my blood has the AIDS virus. They explained what that means. At first I couldn't accept that such a thing could happen to me. It seemed unfair really. After my wife died I didn't go with any women at all for five years. That's a long time, five years. And then I had a girlfriend, only one, and only for about six months. So I suppose I must have picked it up from her.

What can I say? I can't do anything about it now. It's just something that has happened to me. But I won't be the first person to die. Everyone has to die some time. All I hope is that I can live another five or six years, till my children are bigger. That would be enough.

The other day I read an article that said some American scientists had found a cure for AIDS. I cut it out and gave it to the sister on our ward. She said she didn't know anything about it but she would ask the doctor."

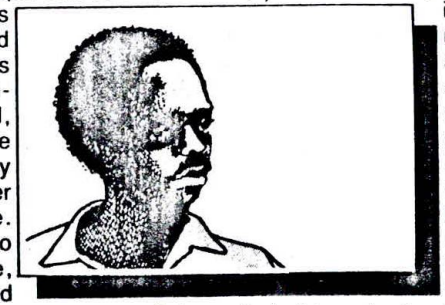
what the Chikankata team call 'community counselling' (see page 18).

The counsellor may also become involved in discussing and sharing religious concepts. The Chikankata team find that most patients accept the idea of a spiritual life, and expect those who provide health care - especially if from a mission hospital such as Chikankata - to provide pastoral care as well. This is done in a non-intrusive manner, taking into account each patient's spiritual background and wishes. The team takes great care not to impose religion on any patient, since this would destroy the vital relationship of mutual trust and respect. Through pastoral care, many patients and their families have been helped to greater serenity in coping with AIDS, especially as they approach the point of death.

With all people who are HIV-positive, the counsellor also initiates the process of contact tracing. The person is encouraged to ask his or her sexual partner (or partners) to come to the hospital for counselling and a blood test. The counsellor, in most circumstances, may not inform a sexual partner or family member of the

Abel

Abel was admitted to hospital suffering from fever, weight loss, coughing, night sweats, diarrhoea, and abdominal pains. A blood sample was taken to be tested for HIV. His condition remained stable for five days but then deteriorated. He died, aged 30, on the night of February 16, with his mother by his bedside. One of his two wives, Florence, was being treated for malaria in another part of the hospital on the night he died. Three of his eight children were in the children's ward, also receiving treatment for malaria.



Two days after Abel's death, Sister Elly Kalichi received the result of his blood test from the hospital lab. It was, as expected, positive. Someone would have to inform his family soon. His wives were probably infected with the virus as well, and their blood should be tested. If the test was positive, they should be advised not to remarry because of the risk of infecting their future husbands. Neither should they proceed with the 'ritual cleansing' ceremony through sexual intercourse with one of Abel's brothers. Normally this ceremony would take place within five days of the death.

Elly was not a member of the AIDS team but she knew Abel's village and was anxious to help his family. She had a word with Thebisa Chaava, head of the AIDS counselling team, and it was decided that Elly should visit Abel's family in the afternoon.

When she arrived at the village the mourners were still singing hymns, but the atmosphere was tense. Elly found one of Abel's brothers and asked to speak with him in private. The brother insisted on another man being present as a witness, and all three sat on the ground by the roadside. Elly now learned that two days earlier, after the body had been buried, Abel's relatives had gone to the local 'witch-finder' to ask about the cause of his death. They were told that a neighbour had put poison in Abel's beer. A bitter quarrel had broken out between Abel's family and that of the accused, and the threat of violence still hung in the air.

Elly now told the two men that the cause of Abel's death was AIDS. The men accepted this explanation, but asked Elly to put it down on paper, in English, so it would be official. On a piece of paper torn out of a school exercise book she wrote:

"Abel Munjobe, who died in Chikankata Hospital on February 16, 1989, was diagnosed as having AIDS. This was the cause of his death. Signed, for the Doctor, and on behalf of the AIDS team, Sister Elly Kalichi."

The note would probably heal the quarrel between the two families over the cause of Abel's death. Abel's brother also promised to show it to the relatives of Abel's two wives. They would try to arrange for ritual cleansing by a means other than sexual intercourse. They would also suggest that the wives should go to Chikankata Hospital for a blood test.

patient's HIV-positivity without his or her consent. Confidentiality, however, does not extend beyond the grave. If a patient dies of AIDS-related causes without the immediate family knowing the diagnosis, a member of the AIDS team will share this information with them.

Women of child-bearing age who test HIV-positive are strongly encouraged not to have any further children. Not only is there a 25-40% chance of the baby being born with the virus, but pregnancy and childbirth may also accelerate the development of the virus and increase the chances of the mother herself developing AIDS. This places many women in an agonizing situation, where whatever decision they make is fraught with risks. For a young couple without children, the pressures from parents and relatives to have children may well be irresistible. (Indeed, if the woman fails to produce a child the husband's family can press for divorce.) At Chikankata about one in every three HIV-positive women tell the counsellor that it will not be possible for them to refuse to become pregnant again[4].

Home-based care

The hospital's responsibility for a patient with HIV or AIDS does not end after counselling and discharge. Patients are offered the choice of either reporting back regularly to the hospital's outpatient department, or being visited at home by the hospital's home care team. The great majority opt for home visits. For patients, home care is generally more convenient and more personal than coming to hospital. For the hospital, home care costs less and releases beds needed by other patients. It is also a more appropriate setting for emotional and pastoral support, and brings the AIDS team into contact with the patient's family, relatives and members of the community.

Chikankata Hospital screens the blood of all women who come to the hospital for ante-natal check-ups.

The home care team consists of one clinical officer, two nurses, a schools educator, and a driver. All are Zambian nationals. Two or three team members travel on three days a week to patients within an 80 kilometre radius of the hospital, visiting five to eight patients on each trip. They are often joined on these visits by an additional nurse, a social worker, a health educator, or the project manager. In 1987-88 the team carried out over 1,000 visits to 276 patients

A day with the home care team (morning)

8.30 a.m., and the AIDS team's yellow landcruiser is about to leave on a day trip. Clinical officer Zebron makes a quick check that nothing has been forgotten: files on every patient, equipment for taking blood, a box of basic drugs and medical supplies, a sack of powdered milk, a thermos of hot tea, bread, hard-boiled eggs, a jar of golden syrup, plates, cups, and a large bread knife. Nurse Christine helps to load everything on board.

First stop is the Post Office in a small town about 45 minutes drive away. The Post Master, 50 year-old Patrick, was diagnosed HIV-positive four months ago, when he came to Chikankata for treatment of an anal ulcer. He takes us to his house. His wife, Grace, welcomes us effusively and we chat at great length. They have nine children, aged between two and twenty. Grace is now six months pregnant and seemingly blooming with health. Her blood has been tested for HIV but the result was indeterminate. We take another sample of her blood for testing. Patrick says he is feeling alright now. He wants the team to keep visiting regularly.

Second stop is Sanderson farm. We drive round in circles in the long grass, but patients Angelina and her husband Joseph are nowhere to be found. There is news of another AIDS patient, Esther Monga, but it is bad. She left the farm last month and returned to her home village.Her workmates heard yesterday that she died there ten days ago.

At Lees farm, the team has to break the news to 39 year-old Amon that his blood has been found HIV-positive. Last month he was treated at the hospital for a genital ulcer. He knows that HIV is transmitted sexually, and also through blood. He also thinks it can be caught by using the same cups, spoons and plates as a person carrying the virus. He thinks he might have picked it up from razor blades: both he and his wife have undergone ritual scarification by a traditional healer in order to have more children. (They have only one child, a 14 year-old boy.) He sweats a lot at night but otherwise feels alright. He wants the team to keep visiting him on the farm. His wife Emily comes to the landcruiser and her blood is taken for testing.

At midday we break for lunch by the edge of a stream. The 'Chikankata special' consists of hard-boiled eggs with syrup on thick wadges of brown bread, washed down with tea.

A day with the home care team (afternoon)

On Gooch farm, we find 25 year-old Mary crouched on a mat in a dark corner of her mud hut. Diagnosed HIV-positive in May 1987, she now has AIDS – with diarrhoea, fever, weight loss, vomiting, general weakness and body pains. Unable to work and scarcely able even to walk, Mary is cared for by her mother. She knows she is dying, and feels bitter towards her ex-husband (who has moved out of the Chikankata catchment area) for having infected her with the virus. Her two year-old son has a cough and a high temperature. Christine takes his blood, despite loud protests. We give Mary a supply of medicines, and have a word of prayer with her before leaving.

We also enquire about George, another worker on Gooch farm, diagnosed HIV-positive 18 months ago. A group of workers tell us he has gone back to his home village. He has often been ill during the past few months.

On to Smithson farm, where we find 60 year-old Urity stretched out on a mat in his mud hut. He is feeling miserable today, with a cough, fever, weight loss and a constant headache. He was diagnosed HIV-positive when he donated blood for his two year-old daughter, who died nearly a year ago of AIDS. Urity has 12 other children and two wives. He knows that the AIDS virus is spread through sexual intercourse. Apart from his wives he has three or four other sexual partners. But they are other men's wives so he doesn't want to suggest that they be tested for the virus. He says there is a lot of sleeping around on the farm: "I'm not the only one. There are plenty of others." But he regrets it now and says he'll just stick to his wives from now on. He seems to mean it.

Urity's neighbour, 25 year-old Martin, was diagnosed HIV-positive nine months ago after his six month-old daughter died of AIDS-related causes. His wife, Florence, is not at home. She is also infected with HIV. Both her children have died in infancy. They would like to try for another child. "Just one more time", says Martin. Christine asks whether they know that pregnancy would be bad for his wife's health and that there is a strong chance of the baby developing AIDS. Yes, they realize that. ... She suggests that if they really want children, perhaps they could 'adopt' one of his brothers' children. He says he'll think about it. In the meantime, could he please have some condoms? We give him 25.

Driving back to Chikankata, we discuss the day's events. What if Grace's blood sample is positive (as it probably will be)? What about the baby in her womb? Will Urity really give up sleeping around? What about the other farm workers? Will Martin and Florence try for another child? Probably. How does one influence people's behaviour anyway?

(representing 176 families), two-thirds of whom were the family's primary breadwinner.

The home care team provides medical and nursing care, gives powdered milk, and sometimes provides clothes, blankets or other forms of material assistance. Couples may also be provided with supplies of condoms to reduce the chances of HIV infection during intercourse. Wherever possible, the team also traces the patient's sexual contacts and takes their blood for testing.

The team also continues the process of counselling begun in the hospital. In the course of time, the process often widens to include other members of the family – parents, brothers and sisters, aunts and uncles – as well as neighbours and friends. In this way, home care can develop into an entry point for educating members of the extended family and the wider community in what they can do to prevent the further spread of the AIDS virus. 'Care *and* prevention' is the Chikankata definition of AIDS management.

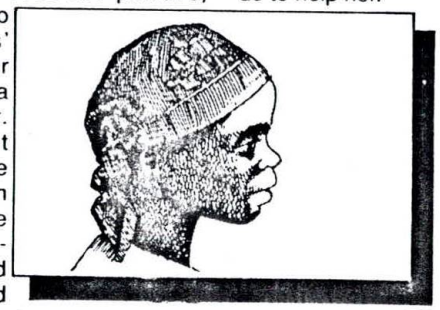
Most terminally ill patients prefer to die at home. Since the start of the programme in March 1987, a total of 79 patients on the home care register have died, of whom only 10 were readmitted to hospital before death.

Among the difficulties faced by the home care team are the poor state of the roads and the scattered nature of settlement in the catchment area. Patients are often difficult to find: addresses are

Eunice

The bullock cart outside the hospital is for Eunice, who is dying of AIDS.

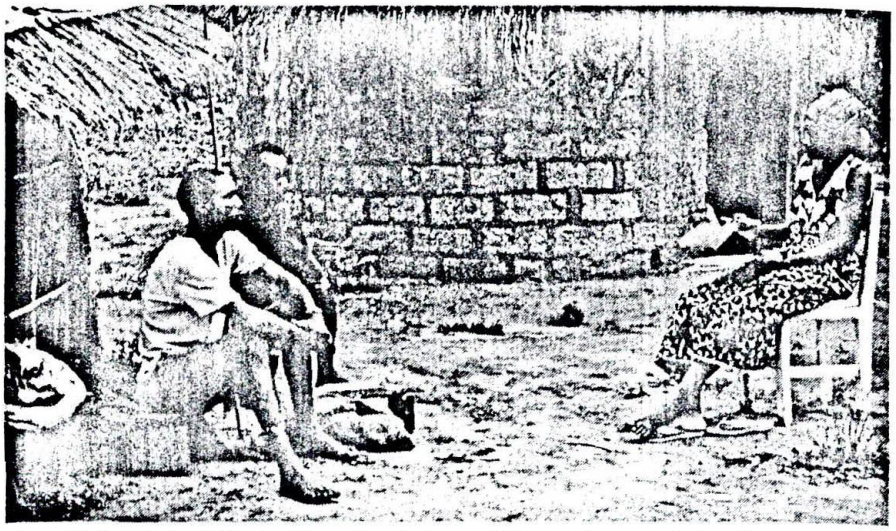
A year ago Eunice and her husband Philip were diagnosed HIV-positive, after Philip came to the outpatients' department for treatment of a genital ulcer. During the next four months the home care team visited them three times. Philip's condition deteriorated rapidly and he died in September. Eunice and her three children then moved back to her parents' village and she began using her maiden name again. The home care team lost contact with her.



Two weeks ago her parents and two brothers brought her to hospital, complaining of fever, a stiff and painful neck, abdominal pains, and a constant headache. She had pressure sores on both sides from lying on a mat at home for the previous two months. She was diagnosed as having malaria and AIDS. She is now emaciated and practically bald. Her body is wracked with pain and every movement is a supreme effort. She can no longer take food. Her blood pressure is falling. There is nothing more the hospital can do to help her.

Dr Clement Chella asks the nurses to put screens around Eunice's bed. Her mother, an aunt, and her two brothers arrive. Clinical officer Roy Mwilu, who is the AIDS counsellor for this ward, invites them to gather round the bed.

He explains that Eunice has AIDS, for which there is no cure. Eunice will not get better in hospital, and it would be better if she now went home. Eunice's mother says they know about this disease. Her husband died of it last year. Other people in the village have also died of it. They have never heard of anyone recovering from AIDS, but they want to take her to a traditional healer in case he can work some miracle cure. Roy encourages Eunice and her family to put their trust in God, and concludes the meeting with a prayer.



The Chikankata AIDS home care team continues the process of counselling begun in hospital.

vague, and they may be out working or travelling when the team arrives. In the future, it may be possible to work more closely with rural health centres and community health workers, and to give patients advance warning of when the team plans to visit. Some may be prepared to come to the nearest health centre rather than be visited in their homes.

It might be thought that people with HIV/AIDS would prefer not to attract attention to themselves through the regular visits of the distinctive yellow landcruiser of the Chikankata AIDS home care team. So far, however, this has rarely been the case. The team is almost invariably made welcome by patients and their families. Perhaps even more important, in the longer term, is the way in which home visiting has also created opportunities for entering into a dialogue with other members of the community.

Counselling communities

In December 1987 the chief of Sinadambe, on the northern shores of Lake Kariba, called a meeting of all the village heads in his area to discuss the problem of AIDS. He did this at the suggestion of a health worker from the local health centre, which is part of Chikankata Hospital's primary health care network. For several months, the home care team from Chikankata had been visiting three AIDS patients in the area. One, the son of a village headman, had died only a few weeks earlier. Surprisingly few people, however, were aware of the seriousness of the AIDS threat to themselves and their families. Some had not even heard about AIDS, despite frequent radio broadcasts.

Held in the local primary school, the meeting was attended by about 20 village headmen, as well as three members of the Chikankata AIDS team. The discussion demonstrated how little the great majority of community leaders understood about AIDS. Most believed it was spread by shaking hands, sharing utensils, or standing in the shadow of someone with the disease. Few could accept that there was really no cure: if the hospital had no remedy, there must surely be a traditional healer who did. And was it really such a new disease? Perhaps it was just another form of *kayanga*, a disease with which local people had long been familiar. Finally, the father of the young man who had recently died of AIDS stood up and made an impassioned plea:

"Look, you all saw how my son suffered before he died. You all saw how he was. Have you ever seen anything like that before? There is no cure for this disease. It's something completely new. We have to do something now to stop it spreading any further."

This meeting marked the start of a gradual process of raising community awareness of the gravity of the AIDS problem, and of the need for changes in sexual behaviour which reduce the risk of HIV transmission. The Chikankata AIDS team describe this process as 'community counselling'. As in the counselling of individuals or families, the team members spend a great deal of time listening and learning before giving information or trying to guide the discussion in a particular direction. The emphasis is on helping people develop a sense of collective responsibility for dealing with the threat of AIDS.

"We believe," says Thebisa Chaava, social worker and head of the AIDS counselling team, "that the only long-term hope for prevention is for communities themselves to feel a sense of responsibility for dealing with the problem of AIDS. They are the only ones who can change their behaviour and stop the spread of the virus."

The Chikankata team are convinced that the most sustainable form of safe

Agnes and Roda

Agnes is aged 26 and her sister Roda is 21. Both have HIV infection. A few months ago Agnes was very ill. She could not eat, was vomiting frequently, and had chronic diarrhoea. After treatment in Chikankata Hospital she improved and returned home, where she is now cooking, eating well, and generally taking part in community life.

Her sister Roda was also admitted to hospital after suffering persistent diarrhoea and weight loss. She has returned home but is still unwell, suffering from continued weight loss and weakness, but is able to participate in most community activities.

Both women are unmarried. Before falling ill they often visited the nearby rural bar, where they sold chicken cooked at home. They also sold sexual favours, and in so doing became infected with HIV. They are now potential transmitters of the virus to their sexual partners.

The two women are regularly vistied by the Chikankata AIDS team in their home village, where they are fully supported by their parents and relatives. They have given up visiting the bar and say they have had no sexual partners since being discharged from hospital. The loss of income is causing them some hardship. Both are managing to earn some money, however, by knitting and selling sweaters, using wool supplied by the Chikankata AIDS team.

sexual behaviour is faithfulness to one partner for life. Given the current high levels of sexual activity outside marriage, that ideal may seem unattainable for many. But only two decades ago extra-marital sex was far less widely practised in Zambia than it is today. The Chikankata strategy is to encourage communities to reactivate traditional values and norms of sexual behaviour, which have been lost in the recent wave of 'modernization'. These include not only chastity before marriage and monogamy within marriage, but stable polygamy as well.

The Chikankata AIDS team is now involved in community counselling in four different types of communities: traditional villages, commercial farms, a peri-urban farming settlement, and an urban area. The team usually enters the community through patients coming to hospital for treatment.

Gilbert, for example, worked as a labourer on a commercial farm about 20 kilometres from Chikankata. He had been diagnosed HIV-positive when he sought treatment at the hospital for a genital ulcer. His workmates, noticing that he had been unwell for several weeks, suspected that he had AIDS and were afraid of contracting the disease from him at work. They brought him to Chikankata Hospital and demanded that he take a blood test. The hospital staff explained that the results of such a test were confidential and could not be disclosed to anyone else without the person's permission.

The AIDS team also offered to visit the farm to discuss the problem with the local community. The meeting created enormous interest, and was attended by over 50 workers and their families. Initially the mood was fairly tense, as speaker after speaker expressed their fears about contracting AIDS from someone at work, but without referring to Gilbert by name. The Chikankata team explained that it was not possible to contract AIDS simply by working with someone. They could contract the disease only if they had sexual intercourse with the person or with his or her sexual partners. The most effective way of avoiding AIDS was by having only one, mutually faithful sexual partner for life. The meeting defused the tension in the community, at least temporarily. Several months later Gilbert left the farm and returned to his home village.

The longer term importance of community counselling is its potential multiplier effect. It will never be possible for the Chikankata AIDS team to meet with more than a small handful of individuals, families and community groups. What is needed is for communities to identify individuals who can become 'AIDS communicators' - local leaders who can speak about AIDS with groups such as church congregations, trade union branches, women's groups, youth clubs, sporting and cultural associations, political parties, and schools.

"What we have to aim at," says Chief Medical Officer Ian Campbell, "is to move beyond counselling individuals, their families, and community groups. We have to get to the point where communities are counselling communities. That is the key ingredient in changing behaviour on a national scale."

This process is starting to take shape. In Nega Nega, a farming settlement near the railway line between Lusaka and Livingstone, the Chikankata team took the initiative of asking the local community leader to organize a meeting to discuss AIDS. (The team had already been visiting HIV/AIDS patients in the area for several months.) Two meetings have been held so far, and the community has decided that local church leaders should take the lead in educating people about AIDS. They will first attend a two-day training course in AIDS care and prevention at Chikankata, where they will meet AIDS patients and learn basic counselling skills. It is hoped that this will be the first of many such training courses for local community leaders who can take the lead in the long-term process of AIDS education and prevention.

Maxwell

Maxwell used to work as a painter for the state electricity company, ZESCO, in the town of Kafue. He is in his mid-thirties, married, and has five children. Three previous marriages ended in divorce.

In August 1987 he was admitted to the TB ward at Chikankata Hospital, where a blood test revealed that he was HIV-positive. On Maxwell's request, two members of the Chikankata AIDS team met with the company's personnel officer and explained why he was likely to need time off work to receive medical treatment on a fairly regular basis. The personnel officer responded in a very understanding way.

Maxwell's wife was also tested and found to be HIV-positive. She is still feeling in good health.

After several months of weight loss and poor health, Maxwell sought help from a traditional healer who claimed to be able to cure AIDS. While waiting, he met three of his workmates, all of whom were amazed to discover that the others were also HIV-positive. After undergoing treatment, Maxwell had his blood re-tested at Chikankata, but the result was again positive.

By this time, his neighbours and workmates were starting to suspect that he might have AIDS and began avoiding him. He felt lonely and rejected, and decided to resign his job on health grounds. At his request, a doctor from Chikankata wrote a letter to the personnel officer supporting his application, and he has since retired with a decent pension. He has now started to build a new house for his wife and children, so that they will have some security in the future. Since quitting work he is feeling better and has even gained a little weight. But he still worries about how he will cope when his health starts to deteriorate. Two of the former colleagues he met while waiting to see the traditional healer have since committed suicide. The thought also crosses his mind at times.

The contact with Maxwell may also prove to be an entry point for the Chikankata AIDS team into the local community. On the invitation of the personnel officer, the team has already held meetings about AIDS with two groups of men and women at ZESCO, Maxwell's former workplace. Plans are now underway for follow-up meetings within the community, starting with church groups.

Ritual cleansing

Some traditional practices require particular counselling approaches. One of these is the 'ritual cleansing' of widows and widowers. In the Chikankata area, as in many other parts of Zambia, the family of the deceased has an obligation to prepare the bereaved spouse for another marriage. This is usually done by a member of the dead person's family having sexual inter-

course with the widow or widower. It is believed that failure to carry out 'cleansing' correctly will result in the bereaved person going mad. In an area with a high prevalence of HIV infection in the sexually active population, however, this practice obviously carries the risk of further spreading the virus.

The Chikankata counselling team tries to encourage safe alternatives to sexual intercourse as the preferred means of 'cleansing' after death. These alternatives have always been practised whenever sexual intercourse was not acceptable, for example if the widow was known to be pregnant. Three main alternatives are encouraged:

- The widow or widower sits undressed indoors, and a hoe is placed under his or her bent knees. The hoe is then presented to the bereaved person's family.
- The widow or widower is made to jump over a cow lying on its side. The cow is then killed and the meat distributed to the mourners.
- A member of the deceased's family sits on the widow or widower's lap. This is done indoors, no other persons being present.

In promoting safe alternatives to sexual intercourse as a means of 'cleansing' after death, the Chikankata team has been struck by the influence of the family unit on individual behaviour. In several well-documented cases, the bereaved person has wanted to be 'cleansed' through intercourse, but has been persuaded not to do so by other family members. This underlies the importance of counselling the whole family about AIDS rather than individuals [5].

The future

Training for health professionals and others involved in AIDS care and prevention will be an increasingly important activity for Chikankata. One-week courses have already been run for three small groups of district-level health workers from other parts of Zambia and abroad. When new training facilities have been completed it will be possible to handle groups of 25 at a time. The approach to training is 'hands on': participants meet AIDS patients in the hospital and accompany the home care team on visits. At the end of the course participants present their ideas for implementing what they have learned.

An important new development in the field of in-hospital patient care is also about to take place. A 25-bed hospital ward, currently under construction, will be used to care for patients with AIDS-related illnesses. An additional ward is necessary because of existing pressure on hospital bedspace and the expected influx of even greater numbers of AIDS patients in the near future. The main purpose of having a ward dealing exclusively with AIDS patients (to be called a 'special care' ward) is to facilitate the nursing and medical treatment of patients who are intensively ill. It will not function as an 'isolation' ward or as a hospice for terminally ill AIDS patients, but will be a normal part of the hospital. Patients with HIV will be free to walk around the hospital and socialize with other patients. And there will still be patients with HIV in other wards throughout the hospital.

The new ward will also serve as a training facility for people selected by the community for training in basic AIDS management skills. After training, they will work closely with Village Health Advisory Committees to promote the implementation of collective decisions arising from the process of community counselling.

External assistance

The Chikankata AIDS control programme has been fortunate to receive financial assistance from donor organizations such as World in Need (U.K.), NORAD, and the Australian Development Assistance

Patients with HIV/AIDS at Chikankata Hospital use the same eating utensils as other patients.

Bureau. This assistance has been used to fund a vehicle, a training centre, drugs, medical supplies, AIDS testing kits, laboratory equipment and reagents, a new hospital ward, an office building and staff accommodation.

No health institution in Zambia can afford to maintain a comprehensive AIDS control programme without some external assistance, particularly to cover transport costs. But this should not deter anyone from doing what is possible, now, within existing staff and resource constraints. In most cases much more could be achieved with the staff and resources already available – for example, by training nurses and doctors in AIDS counselling techniques, or by starting a 'pilot' home care scheme in communities that can be reached by bicycle or motorbike.

Chikankata has been extremely fortunate in having donor agencies who are prepared to 'listen and learn' before deciding on what type of assistance to give. Other organizations working in AIDS control in Africa, however, may come under pressure to implement programmes which reflect the views of donor agencies rather than their own priorities. Consciously or unconsciously, donors may seek to impose models of AIDS control which have limited relevance to the African situation. It is vital for donor organizations to realize that the social, economic and epidemiological features of AIDS in Africa are often different from those in industrialized countries. AIDS control strategies and programmes in Africa will therefore differ in important ways from those of the industrialized world.

A national strategy

The Chikankata AIDS control team advocates a three-stage 'strategy for national behaviour change', as follows:

1. *Care and counselling of individual patients and family members*, starting in hospital and continuing at home.

2. *Community counselling* through regular meetings between community leaders and the AIDS team.

3. *Communities counselling communities*, as part of a national effort involving every available means of social organization, communication, and community leadership, with the goal of promoting the changes in sexual behaviour needed to curb the spread of HIV/AIDS. Those who could help to make this vision a reality include:

- political leaders at all levels
- traditional leaders (chiefs, village heads, councillors)
- church leaders and organizations
- voluntary agencies
- teachers and schools
- farmers' organizations
- trade unions and employers
- service organizations (Rotary, Lions, Jaycees etc)
- artists and entertainers
- women's organizations
- youth movements
- sporting clubs and cultural associations
- community health workers and village health committees.

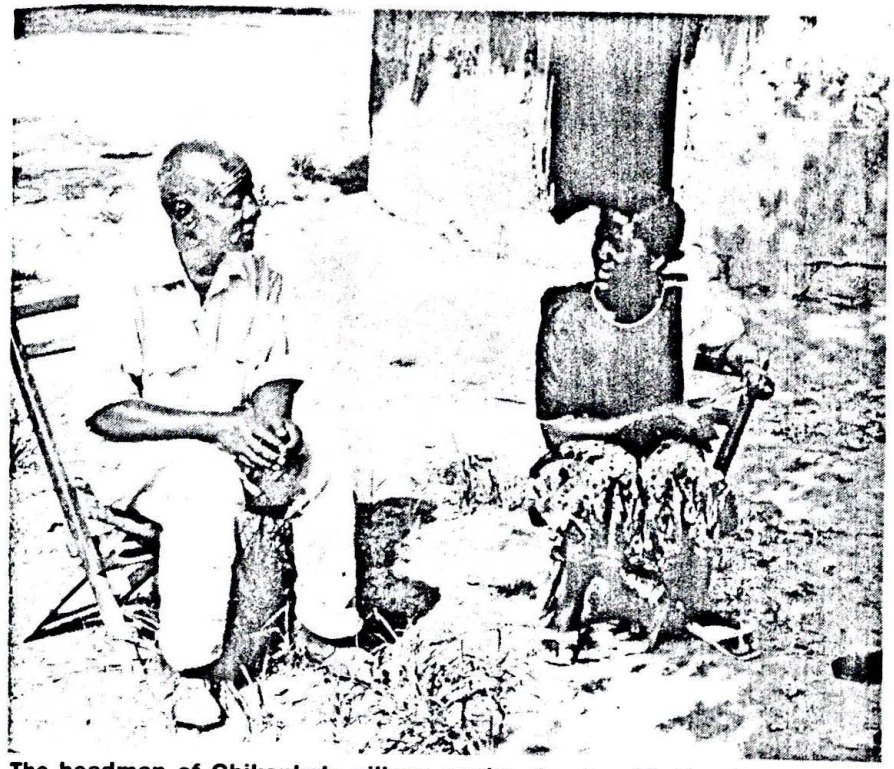
One particularly pressing need is for AIDS counsellors – people who can give psychological, social and spiritual support to AIDS patients and their families. Every hospital in the country should have a core of trained AIDS counsellors. But many counsellors need not be hospital-based. They can also be organized as small, community-based groups, consisting mainly of volunteers, some of whom may in fact be people with HIV. Such a group, known as The AIDS Support Organization (TASO), has been set up in Kampala, Uganda[6].

A climate of hope

Pioneering initiatives such as the Chikankata approach to AIDS care and prevention are invaluable because they blaze a trail for others to follow. But the fight against AIDS needs to become a broad-based social movement involving people from all walks of life. At national level, such a movement is starting to take shape in Zambia. The government's National AIDS Prevention and Control Programme promotes the message 'One man, one woman for life'. Cabinet Ministers, members of the Central Committee and members of parliament took part in two-day workshops on AIDS in August 1989. Four drama groups have reached large audiences through plays about AIDS. Anti-AIDS clubs have been started at over 100 secondary schools. Groups of traditional healers, media workers, teachers and hotel staff have taken part in AIDS workshops, talks and discussions.

The mass media have also helped to raise public awareness of the threat of AIDS. It is important that the mass media help to create a climate of hope rather than fear to dispel public misconceptions about how AIDS is spread, and to combat discrimination against people with HIV/AIDS.

The magnitude of the challenge ahead, however, should not be under-estimated. HIV infection is already so widespread that, in the absence of a cure, tens of thousands of Zambians will die prematurely of AIDS during the 1990s.



The headman of Chikankata village works closely with the AIDS team to inform and educate the local community about AIDS.

Only in a climate of hope can the threat of AIDS be confronted and overcome.

Thousands of children will be orphaned, families decimated, and old people left without social or economic support. Within five to ten years, virtually everyone in Zambia will have known someone who has died from AIDS. The economic consequences will also be grave, as many thousands of skilled people in their most productive years fall ill and die.

Tragically, most people are unlikely to alter their sexual behaviour until evidence of the need for change becomes overwhelming.

But the message emerging from Chikankata is that there *is* hope.

There is hope for people with HIV and AIDS: that they will not be rejected by their families, abandoned by the health services, and ostracized by society, but can still lead socially useful lives.

There is hope for the families of people with HIV and AIDS: that, in caring for their loved ones, they will receive the support of the nursing and medical professions, of religious and community organizations, and of their neighbours and friends.

There is hope for members of the community: that, through changes in their own sexual behaviour, they can protect themselves and their families from HIV infection.

There is hope for doctors, nurses, paramedics and social workers: that they can come to grips with AIDS by forging new working relationships with family members and community groups, rather than trying to deal with the problem on their own.

There is hope for community organizations, schools, employers, religious leaders, voluntary agencies, political parties, and all levels and branches of government: that they can help to combat AIDS by promoting responsible sexual behaviour and positive living.

And there is hope for society as a whole: that in a spirit of honesty and openness, people can be mobilized to confront and eventually overcome one of the greatest health threats of the twentieth century.

The Chikankata experience of AIDS care and prevention is an embodiment of these hopes, based on faith in God and in the capacity of human beings to act in the interests of their own survival.

FURTHER READING

1. **'AIDS Action'**, an international newsletter for information exchange on AIDS prevention and control. Distributed free to readers in developing countries. Available from AHRTAG, 1 London Bridge Street, London SE1 9SG, U.K.

2. **'WorldAIDS'**, a news magazine reporting on AIDS and development. Distributed free to readers in developing countries. Available from The Panos Institute, 8 Alfred Place, London WC1E 7EB, U.K.

3. **'AIDS Newsletter'**, a digest of recent developments in AIDS research, education, clinical care, counselling, and official policies worldwide. Available from Bureau of Hygiene and Tropical Diseases, Keppel Street, London WC1E 7HT, UK.

4. UNICEF Kampala, **Our Children and AIDS. A Guide to Child Survival**, 1988. Available from UNICEF, P.O. Box 7047, Kampala, Uganda.

5. Gill Gordon and Tony Klouda, **Talking AIDS. A Guide for Community Work**, International Planned Parenthood Federation and Macmillan, 1988. Available from IPPF, P.O. Box 759, Inner Circle, Regent's Park, London NW1 4LQ, U.K.

6. Gill Gordon and Tony Klouda, **Preventing a Crisis. AIDS and Family Planning Work**, IPPF and Macmillan, 1988.

7. Gill Gordon, **AIDS and Family Planning**, flannelgraph and book, Teaching Aids at Low Cost (TALC), 1988. Available from TALC, P.O. Box 49, St Albans, Herts AL1 4AX, U.K.

8. Wendy Holmes and Felicity Savage, **HIV Infection - Virology and Transmission**, slide set and script, TALC, 1988.

9. Wendy Holmes and Felicity Savage, **HIV Infection - Clinical Manifestations**, slide set and script, TALC, 1988.

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1. Carswell, J. Wilson, 'Impact of AIDS in the developing world', in: *British Medical Bulletin*, Vol. 44, No. 1, January 1988, p. 187.

2. Mann, Jonathan, 'Introduction' to *British Medical Bulletin*, Vol. 44, No. 1, January 1988, p. i.

3. Chikankata Hospital's policies on these and other issues of AIDS management are described in detail in *AIDS Management: an Integrated Approach*, by Ian D. Campbell and Glen Williams, No. 3 in the STRATEGIES FOR HOPE series.

4. Chaava, Thebisa Hamukoma, 'Approaches to HIV Counselling in a Zambian Rural Community', paper presented to the Third International Conference on AIDS and Associated Cancers in Africa, Arusha, September 1988.

5. See also Chaava, op. cit.

6. See No. 2 in the STRATEGIES FOR HOPE series, *Living Positively with AIDS: the AIDS Support Organization (TASO), Uganda*, by Janie Hampton.

STRATEGIES FOR HOPE

This series of case studies of innovative AIDS control and prevention programmes currently consists of:

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Reports on the work of the first AIDS support group in East Africa. Describes how people with HIV/AIDS and other volunteers provide care, counselling and support for people with AIDS and their families in hospitals and in their own homes.

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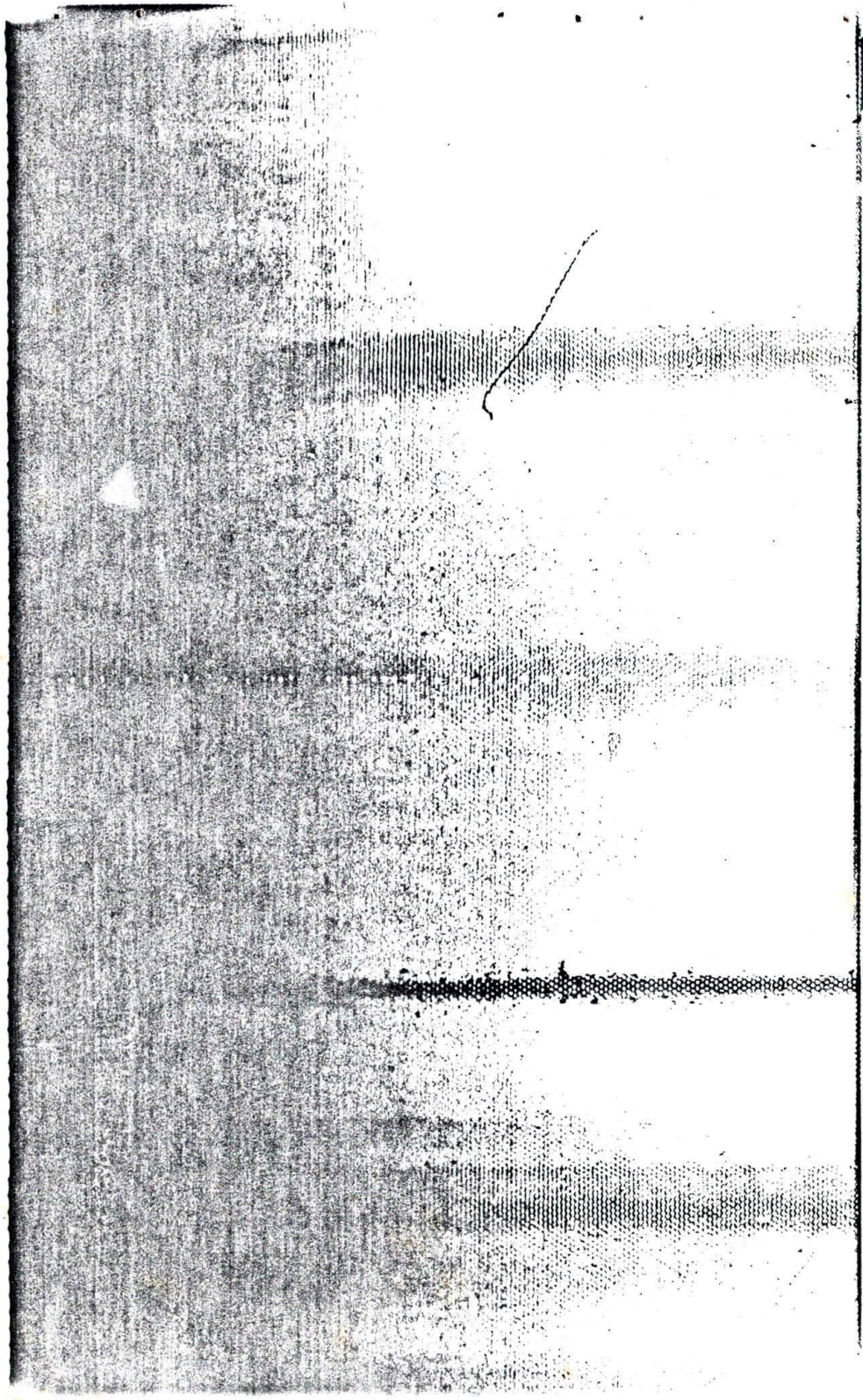

STRATEGIES FOR HOPE No 1

AIDS presents a major challenge to governments, health services and communities in many developing countries.

STRATEGIES FOR HOPE aims to promote informed, positive thinking and practical action, by all sections of society, in dealing with AIDS.

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STRATEGIES FOR HOPE describes these pioneering experiences, initially in several African countries, in a series of case study booklets and video programmes. These materials are being distributed with the support of the World Health Organization's Global Programme on AIDS, and in cooperation with national AIDS control programmes.

Series Editor: Glen Williams

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