Social Welfare Interventions for AIDS Affected Households in Zambia

Report of a Consultancy Commissioned by the GTZ Back Up Initiative in Cooperation with the GTZ Assisted Social Safety Net Project at the Ministry of Community Development and Social Services, Lusaka, March 2003

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Dr. Bernd Schubert,
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1. Introduction

The GTZ BACKUP Initiative assists partner countries to create knowledge and form alliances in the fight against HIV/AIDS and its impact. While the Government of Zambia (GRZ), the Zambian Civil Society and a number of donor agencies have been and are carrying out numerous activities on sensitisation, awareness, prevention, treatment and care, the issues of social impact, of coping strategies and of social assistance to AIDS stricken households, families and communities has not yet been sufficiently addressed.

In order to fill this gap the National Aids Council (NAC) and the Ministry of Community Development and Social Services (MCDSS) /GTZ Social Safety Net Project have requested a BACKUP Initiative consultancy to address the following issues:

1. Which households in Zambia require urgent social welfare interventions in order to ensure the survival of the members of these households? What are the criteria by which the most needy households can be identified?

2. To what extent is the critical state of these households caused by AIDS and to what extent do these households include orphans and vulnerable children?

3. Which assistance reaches the most needy households through formal and informal safety nets and who provides this assistance?

4. What is the organisational landscape on village, sub-district and district level through which interventions to assist the most needy (most vulnerable/most food insecure) households are channelled or could be channelled?

5. What is the policy on national level with regard to strengthening the social protection and risk management or simply with regard to ensuring the survival of the most needy households with special emphasis on AIDS affected households, orphans and vulnerable children?

6. What would be a realistic vision for the social protection of the most needy/Aids affected households in Zambia?

7. What are the main constraints which have to be overcome and the main windows of opportunity which could be exploited in order to move progressively towards realising this vision in terms of

    - Political will?
    - Realistic concepts based on appropriate information and experience?
    - Funding?

8. Recommendations for Action.

The Consultancy contributes to the development of a comprehensive Social Protection Strategy for Zambia. It also serves to back-up a request by the Ministry of Community Development and Social Services to the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) for funding a pilot scheme for Social Transfers to AIDS Affected Households (see annex 3). The detailed Terms of Reference of the consultancy are documented in Annex 1.

The consultancy has been conducted in a short period of time. The results would not have been achieved without the support and advise of Dr. Jörg Goldberg, the GTZ Advisor to the Social Safety Net Project and his secretary and driver. The logistical support of the GTZ Country Office and the field support from the GTZ assisted Reproductive Health Project, Southern Province, especially from Mr. Mbulwe Mwiimba, the GTZ HIV/AIDS Task Force Advisor, was also very effective. The consultant feels indebted to the large number of persons and organisations contacted (see Annex 2) that generously provided their time, advise and data during interviews and also during the debriefing workshop which was moderated by the GTZ Director Zambia, Ms. Martina Bergschneider. Finally the consultant thanks the GTZ BACKUP Initiative for funding the consultancy.

2. Households Urgently Requiring Social Welfare Interventions

The information documented in Table 1 and 2 is mainly based on data from a Participatory Impact Monitoring (PIM) conducted in April and November 2002 by the Choma HIV/AIDS Task Force and by Multi Teams. The Task Force activities are integrated in the GTZ assisted Reproductive Health Project (REH), the Agricultural Support Project Southern Province (ASSP) and the District Development Project (ddp-sp). Detailed results of the PIM activities are contained in a consultancy report available at all GTZ project offices. (Engelhardt-Wendt, December 2002).

For the purpose of this consultancy the PIM data were supplemented by additional data collected by the consultant, assisted by a team of officers from Choma District. The team was organised by the GTZ Task Force Advisor, Mr Mbulbe Mwiimba, and consisted of the Social Welfare Officer Choma, Mr. C. Sikwibele, a Zambia Information Service Choma Officer, Mr. Moffat Chazingula, and two Multi Team members, Ms. Mary N. Phiri and Ms. Jennie Mambo, both nurses at the Pemba Clinic. Data collection was greatly facilitated by the fact that Mr. Mwiimba and the two nurses are well known in the communities visited and are experienced in participatory data collection.

Table 1 contains data from the 292 households that form 6 villages in Pemba Area, Choma District. It shows which types of households carry the burden of caring for orphans. The main conclusions from this analysis are:

- 39% of all households are caring for orphans
- 55% of all households caring for orphans are female headed
- 38% of all households caring for orphans have household heads older than 60 years of which 63% are female
- 23% of all households caring for orphans have household heads older than 65 years of which 58% are female.

In summary female headed and elderly headed households together have a share of 69% of all households caring for orphans.

Table 2 shows in which types of households the 277 orphans of the 6 villages are cared for. The main conclusions are:

- 58% of all orphans live in female headed households
- 39% of all orphans live in households headed by over 60 years old heads of which 60% are female
- 23 % of all orphans live in households where the head is over 65 years old.

In summary female headed households and elderly headed households together care for 74% of all orphans.

The results from Table 1 and 2 show that three quarters of all orphans are cared for by the most vulnerable and weak households.[1]

In order to get more specific information on households urgently requiring social welfare interventions the key informants in each community were asked to identify the 5 most needy (poorest, destitute, most food insecure) households in their village and to rank them starting with the worst cases. The households identified in this participatory process were then interviewed with regard to their structure, problems and assistance received. Tables 3 to 8 contain the data collected from the worst off households. The main conclusions with regard to the structure of those households are:

- 20 households (63%) are female headed
- 19 households (59%) are elderly headed, of which 14 are over 65 years old
- Of the 13 household heads younger than 60 years, 7 are either disabled, chronically sick or in other forms unfit for work
- Only one household was classified as child-headed; however the "child" was a 20 year old young man living alone
- Altogether 45 fit adults (of which 17 are only 16 to 19 years old and mostly still schooling) have to care for 22 elderly, 21 under 60 years but unfit for work, and 114 children under 16.

In summary the average dependency ratio[2] of the 32 destitute households is 349. If the 17 persons between 16 and 19 are not considered to be adults, the dependency ratio is 621. The average demographic dependency ratio for rural areas of Zambia is 122 according to the Living Conditions Monitoring Survey of 1998. The large difference between the average dependency ratio and the much higher dependency ratio of the destitute households indicates a high correlation between the degree of poverty and the degree of labour scarcity. In other words: Households needing urgent social welfare interventions are to a large extent labour scarce households. The most extreme cases were 9 households that do not have a single household member between 16 and 60 years and fit for work.

[1] A recent study using the results of the 1998 Living Conditions Monitoring Survey confirm these findings with respect to the national level. Ministry of Community Development and Social Services, April 2003

[2] The dependency ratio is the number of household members, which are normally not economically active (children under 16 years, elderly over 60 years and all members aged 16 to 60 which are unfit for work) divided by the number of economically active household members (all persons aged 16 to 60 years and fit for work) multiplied by 100.

Table 1: Number of Households with Orphans by Sex and Age of Head of Household in 6 Villages of Choma District, Zambia, March 2003

Name of Village	Total number of households by sex of head			**Households with orphans by sex of head of household**			**Households with orphans by age and sex of head of household**								
	All	**Male**	**Female**	**All**	**M**	**F**	up to 60 years			Over 60 years			Over 65 years		
							all	M	F	all	M	F	all	M	F
1. Chuulu	25	18	7	15	8	7	10	7	3	5	1	4	4	1	3
2. Hajuunza	47	32	15	17	4	13	11	2	9	6	2	4	2	-	2
3. Haluumba	40	31	9	16	8	8	9	5	4	7	3	4	3	3	-
4. Hamachila	69	52	17	15	6	9	12	6	6	3	-	3	1	-	1
5. Manyepa	45	29	16	23	12	11	14	7	7	9	5	4	6	3	3
6. Yalila	66	55	11	27	13	14	14	8	6	13	5	8	10	4	6
TOTAL	**292**	**217**	**75**	**113**	**51**	**62**	**70**	**35**	**35**	**43**	**16**	**27**	**26**	**11**	**15**
Share of male and female headed households	100%	74%	26%	100%	45%	55%	100%	50%	50%	100%	37%	63%	100%	42%	58%
Share of different types of households as % of all households	100%			39%	17%	22%	24%	12%	12%	15%	5%	10%	9%	4%	5%
Share of different types of households as % of all households with orphans				100%			62%			38%			23%		

Bernd Schubert, Consultant for GTZ Social Safety Net Project in Ministry of Community Development and Social Services, Government of Zambia.

Table 2: Number of Orphans by Sex and Age of Head of Household Caring for the Orphans in 6 Villages of Choma District, Zambia, March 2003

Name of Village	Total number of Orphans by Sex of Head of Household			Number of Orphans by Age and Sex of Household								
	All	Male	Female	*Up to 60 years*			*Over 60 years*			*Over 65 years*		
				All	M	F	All	M	F	All	M	F
1. Chuulu	**27**	11	16	15	10	5	12	1	11	10	1	9
2. Hajuunza	**57**	20	37	34	8	26	23	12	11	3	-	3
3. Haluumba	**45**	24	21	27	16	11	18	8	10	8	8	-
4. Hamachila	**20**	6	14	14	6	8	6	-	6	2	-	2
5. Manyepa	**71**	32	39	52	21	31	19	11	8	13	6	7
6. Yalila	**57**	24	33	26	12	14	31	12	19	27	10	17
TOTAL	**277**	**117**	**160**	**168**	**73**	**95**	**109**	**44**	**65**	**63**	**25**	**38**
Share of orphans in male and female headed households	**100%**	42%	58%	100%	43%	57%	100%	40%	60%	100%	40%	60%
Share of orphans in different types of households as % of all orphans	100%			61%	26%	34%	39%	16%	23%	23%	9%	14%

Bernd Schubert, Consultant for GTZ Social Safety Net Project in Ministry of Community Development and Social Services, Government of Zambia.

Table 3: Household Structure of the 5 most Needy Households in Chuulu Village of Choma District, Zambia, March 2003

No.	Head of Household			Household Members (incl. Head)							Depen-dency Ratio[1]	Main Problems of the Household	Type and Source of Assistance provided to Households in last 3 months
	Sex	Age	Health		Age 16 to 60		Over 60		Under 16				
				Total	*Fit for work*	*Unfit*	*Fit for Work*	Unfit	*Parents alive*	Orphan			
1.	F	56	Disabled	7	3 (F28,26, M 22)	1	-	-	-	3	133	Disabled widow with 2 widowed daughters and grand children - no resources due to property grabbing	50 Kg sorghum World Vision 20 Kg beans Red Cross 50 Kg mealie meal Red Cross 5 Kg maize neighbours
2.	F	61	Asthmatic	10	1 (F17)	-	-	1	7	1	900	Chronically sick widow with one 17 years old grand daughter and 8 young children	50 Kg maize World Vision
3.	M	61	fit	12	4 (F20,M22, 20,17)	1	1	-	5	1	140	One daughter in law just died, one son chronically sick. Spent all resources caring for the sick and only little on cultivation	50 Kg maize World Vision 10 Kg beans World Vision
4.	F	72	fit	9	-	-	1	-	4	4	Over 1000	Old women, no other adult household member, 8 children	20 Kg maize World Vision seeds son
5.	F	63	sick	6	-	-	-	1	-	5	Over 1000	Sick old women. Son in law and daughter died from chronic disease and left her with 5 orphans	100 Kg maize World Vision sporadic support son

1) Dependency Ratio:(Household members aged 0-15 plus over 60 plus those aged 16-60 but unfit for work/household members 15-60 fit for work) X 100

Table 4: Household Structure of the 5 most Needy Households in Hajuunza Village of Choma District, Zambia, March 2003

No.	**Head of Household**			**Household Members (incl. Head)**						**Depen-dency Ratio[1]**	**Main Problems of the Household**	**Type and Source of Assistance provided to Households in last 3 months**
	Sex	**Age**	**Health**		**Age 16 to 60**		**Over 60**		**Under 16**			
				Total	*Fit for work*	*Unfit*	*Fit for Work*	Unfit	*Parents alive*	Orphan		
1.	F	90	Sick	5	2 (F22, M 28)	-	-	1	2	-	150	Chronically sick old widow, no assets due to property grabbing. Granddaughter (22) with 2 children unmarried.	50 Kg sorghum World Vision 10 Kg beans World Vision 50 Kg maize World Vision
2.	M	52	Disabled	8	2 (F45, M18)	1	-	-	5	-	300	Man unable to work with wife, 18 year old son and 5 children	100 Kg maize World Vision 100 Kg sorghum World Vision 50 Kg mealy meal Red Cross 20 Kg beans Red Cross
3.	F	71	Chronic. sick	4	-	-	-	1	1	2	Over 1000	Old widow with small children. Did not plant anything because chronically sick	100 Kg maize World Vision

4.	M	73	Partial Paralysis	6	1 (M18)	-	-	2	3	-	500	Sick old man with chronically ill wife, one 18 years old grandson and 3 grandchildren supported by son (watchman, Pemba)	100 Kg maize World Vision 20 Kg beans World Vision money son
5.	F	61	Chronic. sick	4	1 (M19)	-	-	1	-	2	300	Chronically sick old widow. 3 sons died, left with grandchildren	50 Kg maize World Vision 50 Kg sorghum World Vision 10 Kg beans World Vision

1) Dependency Ratio:(Household members aged 0-15 plus over 60 plus those aged 16-60 but unfit for work/household members 15-60 fit for work) X 100

Table 5: Household Structure of the 7 most Needy Households in Haluumba Village of Choma District, Zambia, March 2003

No.	**Head of Household**			**Household Members (incl. Head)**							**Depen-dency Ratio[1]**	**Main Problems of the Household**	**Type and Source of Assistance provided to Households in last 3 months**
	Sex	**Age**	**Health**		**Age 16 to 60**		**Over 60**		**Under 16**				
				Total	*Fit for work*	*Unfit*	*Fit for Work*	Unfit	*Parents alive*	Orphan			
1.	F	72	Lame	1	-	-	-	1	-	-	Over 1000	Lame old widow living alone. Unable to work, no food, no clothing, no bedding. Depends on neighbours.	20 Kg maize World Vision maize, salt, clothes neighbours
2.	M	20	fit	1	1 (M20)	-	-	-	-	-	0	Orphan. Cared for father and sister until they died. Now tries to complete school (grade 11) but has problems with school fees, food, bedding, clothing	20 Kg maize World Vision some food neighbours
3.	M	27	Chronic. sick	4	-	1	-	-	-	3	Over 1000	Chronically sick widower with 3 children. Unable to do farming	50 Kg maize World Visbn 5 Kg beans World Vision food and blanket mother

4.	F	82	disoriented	1	-	-	-	1	-	-	Over 1000	Mentally confused old women, lives from begging from neighbours	10 Kg maize World Vision 5 Kg beans World Vision food, tobacco neighbours
5.	M	38	fit	7	2 (M38,17)	1	-	-	4	-	350	Large family with disabled wife who cannot walk	50 Kg maize World Vision 10 Kg beans World Vision food family and neighbours clothing SDA Church
6.	F	78	sick	3	1 (M21)	-	-	1	-	1	200	Sick old widow unfit for work with 2 grandchildren	50 Kg maize World Vision 10 Kg beans World Vision
7.	M	38	Chronic. sick	8	1 (M17)	2	-	-	5	-	700	Both parents chronically ill. Smallest child severely malnourished. All stopped schooling. No food, no medicine	270 Kg maize World Vision 250.000 K. medical exp. Brother

1) Dependency Ratio:(Household members aged 0-15 plus over 60 plus those aged 16-60 but unfit for work/household members 15-60 fit for work) X 100

Table 6: Household Structure of the 5 most Needy Households in Hamachila Village of Choma District, Zambia, March 2003

No.	**Head of Household**			**Household Members (incl. Head)**							**Depen-dency Ratio[1]**	**Main Problems of the Household**	**Type and Source of Assistance provided to Households in last 3 months**
	Sex	**Age**	**Health**		**Age 16 to 60**		**Over 60**		**Under 16**				
				Total	*Fit for work*	*Unfit*	*Fit for Work*	Unfit	*Parents alive*	Orphan			
1.	F	73	Asthmatic	5	1 (F32)	-	-	1	-	3	400	Asthmatic old widow with widowed daughter and 3 orphans. No resources due to property grabbing	10 Kg maize World Vision 2 Kg beans World Vision blouse, skirt Church
2.	F	70	Weak due to age	2	1 (M16)	-	-	1	-	-	100	Old widow, all her children died from chronical disease. Lives with 16 year old grandson who is still schooling	15 Kg maize World Vision food neighbours

3.	F	67	sick	2	-	-	-	1	-	1	Over 1000	Old widow. Seven children died after sickness of about one year. Now left with one 10 years old orphan	15 Kg maize World Vision 21/2Kg beansWorld Vision T-shirt, soap SDA Church
4.	F	82	sick	6	2 (F44,32)	-	-	1	2	1	200	Sick old widow with daughter, widowed grand daughter and 3 children	60 Kg maize World Vision
5.	M	42	Handy-capped	9	2 (F36, M18)	1	-	-	6	-	450	Handicapped farmer, many children. Father used to support him but died.	35 Kg maize World Vision 5 Kg beans World Vision

1) Dependency Ratio:(Household members aged 0-15 plus over 60 plus those aged 16-60 but unfit for work/household members 15-60 fit for work) X 100

Table 7: Household Structure of the 5 most Needy Households in Manjepa Village of Choma District, Zambia, March 2003

No.	**Head of Household**			**Household Members (incl. Head)**							**Depen-dency Ratio[1]**	**Main Problems of the Household**	**Type and Source of Assistance provided to Households in last 3 months**
	Sex	**Age**	**Health**		**Age 16 to 60**		**Over 60**		**Under 16**				
				Total	*Fit for work*	*Unfit*	*Fit for Work*	Unfit	*Parents alive*	Orphan			
1.	F	73	Leg problems	7	1 (F19)	1	-	1	3	1	700	Old widow with leg problems, one daughter died and left an orphan, one daughter disabled. Only one grand daughter (19) fit for work.	100 Kg maize World Vision 20 Kg beans World Vision
2.	F	74	sick	5	1 (FM16)	-	-	1	2	1	500	Sick old widow unable to work with small children. 16 years old grandson is the only fit person in working age.	100 Kg maize World Vision 20 Kg beans World Vision mealy meal, relish son

3.	F	71	Weak due to age	4	-	1	-	1	2	-	Over 1000	Old widow. First son died after 2 years chronically sick. Now granddaughter also chronically sick. No food, no cloth, no bedding.	50 Kg maize World Vision
4.	M	50	fit	19	7 (F40, 36, M50, 23, 20,19,16)	-	-	1	11	-	271	Farmer 7 small and 4 grown up children of whom 3 are still schooling. Oxen died through corridor disease.	100 Kg maize World Vision 10 Kg beans World Vision
5.	M	47	fit	4	2 (F46,M47)	1	-	-	-	1	100	Farmer and wife with an epileptic son (18) and a mentally ill daughter (9). Spent much time on caring for the sick and have no oxen.	100 Kg maize World Vision

1) Dependency Ratio:(Household members aged 0-15 plus over 60 plus those aged 16-60 but unfit for work/household members 15-60 fit for work) X 100

Table 8: Household Structure of the 5 most Needy Households in Yalila Village of Choma District, Zambia, March 2003

No.	**Head of Household**			**Household Members (incl. Head)**						**Depen-dency Ratio[1]**	**Main Problems of the Household**	**Type and Source of Assistance provided to Households in last 3 months**
	Sex	**Age**	**Health**		**Age 16 to 60**		**Over 60**		**Under 16**			
				Total	*Fit for work*	*Unfit*	*Fit for Work*	Unfit	*Parents alive*	Orphan		
1.	F	57	unfit	6	1 (M 18)	1	-	-	3	1	500	Sick elderly women. Daughter died from chronical disease. Lives with 18 years old grandson (still schooling) and 4 small grandchildren. Lack of everything.	100 Kg maize World Vision 20 Kg beans World vision mealy meal family members

2.	M	47	fit	11	3 (F43, M47, 29)	1	-	1	6	-	367	Farm family with one adult son, disoriented grandmother, chronically sick daughter and children.	100 Kg maize 10 Kg beans	World Vision World Vision
3.	F	74	fit	6	-	1	-	1	4	-	Over 1000	Old widow with disabled unmarried granddaughter having her third pregnancy but no father to support.	70 Kg maize 10 Kg beans	World Vision World Vision
4.	M	48	disabled	12	3 (F20,16, M18)	4	-	-	5	-	233	Disabled farmer, both wifes and one daughter (22) sick.	130 Kg maize 10 Kg beans seeds (maize, cow peas)	World Vision World Vision GTZ
5.	F	54	fit	8	2 (F54,20)	3	-	-	-	3	300	Widow with one fit daughter (20), 2 sick and one chronically ill daughter and 3 orphans.	100 Kg maize 100 Kg maize	World Vision Food for Work (GTZ)

1) Dependency Ratio:(Household members aged 0-15 plus over 60 plus those aged 16-60 but unfit for work/household members 15-60 fit for work) X 100

3. The Role of AIDS as a Cause of Destitution and of Vulnerability with Special Emphasis on Orphans and Other Children

AIDS is by far the most important cause of the destitute situation of the 32 households documented in Tables 3 to 8. AIDS has caused the death of breadwinners, of sons and daughters, of brothers and sisters and of fathers and mothers. Before they died they needed many months of care and caused medical expenses and expenses for extra food. Some household members including heads of households are presently chronically ill and have to be cared for, leaving their children in the care of the other household members.

However, AIDS is not the only cause for labour scarcity and destitution. Other chronical diseases like epilepsy and asthma as well as disabilities and weakness due to old age also cause labour scarcity. Often destitute households are hit by AIDS and in addition by these other causes.

Of the 202 persons living in the 32 household 114 are children of which 34 are orphans. All these children – orphans and non–orphans – are extremely vulnerable. They suffer in varying degrees from the lack of food, beddings, and clothes. Some are severely malnourished. However, only few have stopped schooling. It is impressive how even the worst off caretakers try to keep children at school. The recent introduction of free schooling may have contributed to this positive achievement in an otherwise desperate environment.

In summary: There are other factors causing labour shortage and destitution in addition to AIDS. More than half the persons living in the worst off households are orphans and other vulnerable children. In terms of vulnerability there is no difference between the 34 orphans and the 80 other children living in these households.

4. Type and Source of Assistance reaching the most Needy Households

Due to the food crisis situation in Southern Province and the huge Relief Programmes operating in the area, Food Aid channelled through World Vision and to a lesser extent through Red Cross has reached all destitute households except for one which has moved into the area only 2 weeks ago and was not yet registered.

While the Food Aid organisations have to be commended on achieving 100% coverage, very little assistance from other sources has been reported:

- 8 cases of assistance from family members, mostly from sons
- 6 cases of assistance from neighbours
- 3 cases of assistance from churches
- 2 cases of assistance from GTZ.

Maybe there was more assistance before Food Relief started and it will pick up again after Food Relief ends. This could not be verified. Most likely the majority of destitute households including orphans and vulnerable children receive no significant assistance from outside except for food relief in times of crisis. Nobody had ever heard of the Public Welfare Assistance Scheme.

In summary: Apart from relief food some of the most needy households received limited assistance from family members, neighbours and churches. Most reported that relief food is the only assistance they receive from anybody. For these households the food crisis that triggered off the relief food programs is a blessing. But what will be their fate once relief food stops to flow?

5. Organisational Landscape on Village, Sub-District and District Level that does or could provide Social Protection

Taking the example of Choma District and excluding the interventions in the Health Sector, most interventions aiming at social protection and food security are targeting the "capacitated poor" or "viable poor". These interventions aim at increasing the productivity and self-help capacity of households but by-pass the majority of labour scarce and destitute households. Social welfare interventions reaching the "incapacitated poor" are very few:

- The Choma Welfare Department was allocated 27 million Kwacha in 2002 that it used for food, blankets, school fees and repatriation of stranded people. It has a list of 1000 beneficiaries staying mostly in Choma's urban and sub-urban areas. This means that less than 0.5% of the population receive on the average 27.000 Kwacha (5 US Dollar) per year. The reorganisation of the Public Welfare Assistance Scheme (PWAS) has not yet resulted in any tangible improvements for the beneficiaries. So far no funds have arrived for the year 2003. The situation in other Districts of Southern Province (Monze, Kalomo, Kazungula, Livingstone) was similar.
- World Vision has Relief Food Distribution Centres and Village Food Relief Committees covering all areas of Choma District. As long as the Relief Programme is operational they target all destitute households, partly in coordination with Red Cross and other NGOs. Apart from temporary food relief they run a livelihood program mainly aiming at capacitated households. They also run a foster child program through which, persons from industrialised countries, regularly support Zambian orphans financially.
- As far as relief food is concerned Care International and Catholic Relief run similar programs in other Districts of Southern province. They together form the USAID assisted Csafe program which coordinates their relief food activities.
- Kara Counselling is concentrating on awareness creation, HIV testing, home-based care and a hospiz for AIDS patients. Integrated in their home based care activities they supply about 100 AIDS affected households with food and second hand clothes which are donated by a Canadian NGO.
- Churches are helping here and there with whatever they can afford. Tables 3 to 8 show that in addition to family and neighbours, churches are reaching some destitute households in rural areas, but on a small scale.

In summary: Organisations on village, sub-district and district level are preoccupied with relief food operations, AIDS prevention, health care related activities and development activities targeting capacitated households. Assistance targeting labour scarce AIDS affected households or other incapacitated households urgently requiring social welfare interventions are insignificant.

6. Social Protection and Risk Management Concepts for AIDS Affected and other Incapacitated Households on National Level

On national level a large number of organisations are involved in HIV/AIDS related activities. Coordinated by the National AIDS Council (NAC), which has close ties to the Ministry of Health (MOH), these organisations work in five areas:

- **HIV/AIDS prevention** through awareness creation, HIV testing and counselling and through social marketing.
- **Providing medical care** in various ways to AIDS affected patients through hospitals, clinics, health posts, and hospices and by supporting home based care.
- **Supporting AIDS orphans** partly directly (orphanages, street children projects, nursery schemes, health cost exemption schemes, bursary schemes) and partly indirectly by e.g. giving priority to households caring for orphans when targeting relief food programmes.
- **Encouraging income-generating activities** for AIDS affected households. These programmes mostly target individual households and assist them to engage e.g. in small livestock production (chicken, goats) or try to empower communities in order to be able to generate income for supporting needy households. None of the 32 households interviewed in Choma District (Table 3-8) had benefited from such activities.
- **Broad scale social transfer** programmes through the Public Welfare Assistance Programme (PWAS) of the Ministry of Community Development and Social Services do exist in theory but are insignificant in practice (see box). Social transfers through NGOs and churches in the form of food and/or clothes do exist here and there but only in an uncoordinated patchwork like fashion, covering only a small fraction of the households needing social welfare interventions.

In summary: HIV/AIDS related programmes in Zambia are concentrating on prevention and on health care. The need to assist AIDS orphans is recognised and respective programmes do exist, but are overwhelmed by the magnitude of approximately 1 million OVCs. Social transfer schemes that target female and/or elderly headed households which care for more than 50% of all orphans, do not exist. In other words: Social welfare interventions by government or NGOs to systematically assist AIDS affected household in order to at least ensure their survival are non-existent.

The Public Welfare Assistance Scheme (PWAS)

While the National Pension Scheme Authority (NAPSA), the Public Service Pension Fund, the Local Authority Superannuating Fund, and two small private insurance schemes provide a minimum of social protection to formal sector employees, the PWAS under the Ministry of Community Development and Social Services is the programme to provide social protection to vulnerable households in the informal sector. As the livelihood of 90% of households in Zambia depends on the informal sector, the task of the PWAS is enormous.

The importance of PWAS is also underlined by the fact, that social protection schemes like extended family networks, urban reciprocal social networks, church based charity, savings clubs (Chilemba) and market associations have been weakened by a combination of rural-urban migration, poverty and AIDS (see Makuka, pp.67).

In order to be able to fulfil its role of alleviating the social problems, especially of the poorest and most vulnerable households, the MCDSS has been assisted by the European Union in reorganising the PWAS since 1999. The first phase of the reorganisation concentrated on 9 Districts of which 3 are in Southern Province (Kalomo, Monze, Siavonga). In the second half of 2002 another 27 Districts where included. This means that the scheme now covers more than 50% of all Districts in Zambia. The remaining Districts will be included in the forthcoming third phase.

The concept of the reorganized PWAS has a number of merits:

- It is decentralised: Community Welfare Assistance Communities (CWACs) on village level are coordinated by Area Coordination Committees (ACCs) on Ward level which in turn are coordinated by the District Welfare Assistance Committee (DWAC) and the District Social Welfare Officer (DSWO).
- It is participatory: Targeting is done by the CWACs using a Matrix with Social and Economic Qualifiers provided by the PWAS.
- It integrates NGOS and CBOs: Existing organisations providing social welfare interventions on community, ward or district level are integrated in the scheme.
- It is Self-Help oriented: Self-Help activities on community level like forming widows groups, organising child care or starting income generating activities are encouraged.

Constraints of the PWAS are:

- It targets only 2% of the population while, due to the combination of extreme poverty and AIDS, at least 10% are in urgent need of social welfare interventions.
- It reaches only 0.5 of the population, mainly those in and near urban centres.
- It is supply–oriented: PWAS interventions are not triggered off by the needs on household level but by the arrival of resources at District level. It is a system for distribution of whatever resources may be available if and when they are available, that is at irregular intervals.
- Compared to its task the PWAS budget is small (USD 3 million per year) and of these, usually only 10% are actually released. In relation to its target group of 200.000 persons needing social welfare interventions (2% of a population of 10 million), the average amount per client is USD 1.5 per year.
- Welfare officers report that ACCs and CWACs are increasingly becoming inactive and loose interest because targeting efforts are meaningless if nothing can be transferred to the targeted households. Some officers see the whole scheme as a mockery.
- Assuming funds are made available – there is so far no proof that PWAS would be able to administer them effectively. A report on the distribution of German-Food-Relief maize to the vulnerable through the PWAS in Lusito, Siavonga, in December 2002, raises serious doubts on the effectivity of the reorganized PWAS.

In summary: Mainly due to extreme under funding, PWAS so far has no significant impact on the welfare of the households that are – due to AIDS or due to other reasons – in urgent need of social welfare interventions. However, there are also doubts with regard to the capacity of the PWAS, once appropriate funds for social welfare interventions are available. Therefore, before using PWAS on a broad scale for channelling welfare interventions to AIDS affected households, its capacity should be thoroughly tested in pilot areas.

7. Vision

Considering that social protection of the most needy AIDS affected households and other destitute and incapacitated households in Zambia is presently zero, and considering budget limitations, a vision of what should be achieved by the year 2015 has to be modest.

We have to assume that a significant number of households in Zambia (ca. 200.000 households) are in urgent need of social welfare interventions. These households are vital for the survival of OVCs. We further have to assume that in order to achieve a significant impact on their welfare these households require a regular social transfer. The amount to be transferred can only be established on the basis of additional research. Taking scarcity of resources into account it should be as small as possible but should at least amount to the value of the food relief, which is currently reaching the households (see tables 3 to 8).

Assuming that the minimum value of the transfers per household per month should be 6 USD (the equivalent of the average price of a 25 kg bag of maize in rural areas), the costs involved including administration expenses are 80 USD per household per year.[3] The total costs of a meaningful (though very small) social transfer to the 10% most needy and incapacitated households would therefore require total annual expenses of 16 million US Dollar (compared to the 0.3 million US Dollars released to the Public Welfare Assistance Scheme in 2002).

It may be ambitious but not completely unrealistic that by the year 2010 about 40% (80.000) of these households could be reached at costs of 6.4 million US Dollars and 80% (160.000) at costs of 12.8 US Dollars per year by 2015.

Assuming effective targeting and further assuming that according to the rapid appraisal results from Choma District (see table 1 to 8) these households mainly consist of elderly, widowed, sick, disabled and otherwise unfit people and that on the average each of these households cares for 3 orphans and vulnerable children (OVCs), the following impacts can be expected:

- By 2010 about 240.000 elderly, disabled and otherwise vulnerable people and the same number of OVCs directly benefit from the programme. By 2015 it would be 480.000 elderly, etc. and 480.000 OVCs.
- As a result of the transfers (assuming cash transfers) households will be able to meet some of their most urgent needs in terms of food, medical expenses and /or schooling expenses. Some would even invest part of the transfers in seeds, fertilizer, and hiring oxen for ploughing or in small livestock in order to improve their livelihood. This in term will significantly impact on child mortality, malnutrition, schooling rates and other welfare indicators.

[3] The Mozambique GAPVU scheme for urban areas operates a cash-transfer of US$1 per person/month for selected households without a member of working age. World Bank Institute, June 2002, p. 26

- The additional purchasing power which is immediately used by the beneficiary households to buy local products and services will stimulate economic activities of the productive households. It should not be underestimated how effective the economic multiplier effects of additional purchasing power can be in cash stripped rural economies that lack market outlets.

In summary: Limited expenditures on strictly targeted social transfers to 160.000 extremely needy and incapacitated households would significantly increase the welfare of 480.000 OVCs and of 480.000 other vulnerable individuals and would also indirectly benefit the capacitated households through economic multiplier effects. The long-term effects of avoiding malnutrition and school dropouts of OVCs are an investment in human capital. For these reasons the latest World Bank paper "Social Protection Sector Strategy: From Safety Net to Spring Board" (p.9) "…regards social protection as investments rather than costs."

8. Constraints and Windows of Opportunity

8.1 Political Will

The importance of political will for investing in social protection should not be underestimated. Political will is absolutely essential. Unfortunately, there are indications that this political will in Zambia is still weak. Indicators for lack of political will are:

- The chronic under funding of the Public Welfare Assistance Scheme (PWAS). In the last years only once, the PWAS received more than 600.000 US Dollars per year.
- The Zambian request for funding from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) does so far not include any request for funding social protection of AIDS affected households.[4]
- Most bilateral and multilateral donor agencies and programs as well as the big NGOs are not or only marginally involved in assisting activities that target households urgently needing social welfare interventions.

There is, however, some light at the end of the tunnel:

- The Human Development Network of the World Bank in cooperation with the MCDSS is funding a process that will lead to a "Comprehensive Social Protection Strategy for Zambia". If this Strategy will adequately address the specific social assistance needs of the incapacitated households and if the strategy will ever be implemented has still to be seen, but can maybe be influenced. One should see this process as one window of opportunity (MCDSS, Feb. 2003).
- ILO has developed the concept for a Global Social Trust (GST) that aims at providing "non-contributory pensions" to needy elderly–headed households (ILO, 2002).
- DFID commissions research, funds workshops and issues publications on options for targeting, delivering and monitoring "social transfers to work constrained destitute households that cannot avail themselves to opportunities offered by Cash for Work or Food for Work Programmes" (IDS/DFID, 2002). For Zambia DFID prioritised Social Protection as one of its 5 focal issues for the next 5 years.
- In the discussions held during this consultancies, it has become clear that the Management of leading stakeholder organisations like the National AIDS Council (NAC), the Church Health Association of Zambia (CHAZ), Kara Counselling, CARE Zambia as well as UNICEF are fully aware of the need to

[4] As an outcome of this consultancy a last minute request for funding of a pilot scheme for Social Transfers to AIDS Affected Households has been submitted by MCDSS to the GFATM Coordinating Committee (see Annex 3).

invest in social transfers to incapacitated destitute households and are willing to network in order to initiate appropriate social protection activities.

In summary, political will has been and is still weak. But there are a number of national and international stakeholders who, if they join hands, could form the critical mass required for mainstreaming social protection.

8.2 Realistic Concepts for Social Transfers

Once the political will to invest substantially in social protection has been generated, appropriate and well-tested concepts for broad scale application have to be in place. Essential components of such concepts are:

- Criteria and methods for strictly targeting the most needy households
- Identification of the most beneficial resources and their dimension to be transferred (food, blankets, free medical services, bursaries, etc. – or simply cash) and of the minimum amounts to be transferred
- Identification of the most appropriate beneficiary units (individuals, households, families, communities)
- Identification of the most appropriate organisations for administering the program
- Integration with complementary activities of other sector and sub sector programs
- Auditing, monitoring and evaluation.

Some experience has been accumulated already by PWAS and by Relief Food programs. This has to be supplemented by vulnerability assessments and by pilot schemes.

8.3 Funding

The scope of funds required for social transfers is roughly estimated at:

- Between 250.000 to 1 million US Dollars for a 3 year pilot phase, depending on the size of the pilot area
- A progressive increase in funding from annually 1 million in 2007 to 6.4 million in 2010 to 12.8 million in 2015.

The funding for the pilot phase could hopefully be made available by one or more aid agencies and/or by the GFATM. The MCDSS/GTZ supported Social Safety Net Project is prepared to support pilot activities through technical assistance and limited

funds for social transfers. For the subsequent financing of a progressive expansion of the scheme the following options should be explored:

- Request to the Global Fund for AIDS, Tuberculosis and Malaria (GFATM)
- Request to the Global Social Trust (GST)
- Integration into the next 3 years Poverty Reduction Strategy Paper.

A combination of two or more funding sources would be optimal.

9. Recommendations for Action

9.1 Strengthen the Political Will

This should be done by networking among stakeholders committed to social protection of incapacitated households in order to exchange information on research results, concepts and strategies and in order to pool resources.

Awareness and advocacy can be promoted through making information available, holding workshops, exposing decision makers to the reality of AIDS affected households and communities (exposure excursions) and by giving them access to the experience of countries which are operating effective social transfer schemes like the old age social pension scheme in Namibia (ILO, 2002).

First steps could be to form a task force or committee of interested agencies and/or a committee or sub-committee as part of the PRSP process.

9.2 Vulnerability Assessment

The rapid appraisal conducted during this consultancy has yielded only some preliminary information from a few villages in two wards of Choma District. In order to be able to design and test a social transfer scheme, more detailed and more representative information on household and community level is required.

This information is only partly available from the Living Condition Monitoring Surveys and from other surveys of the Central Statistical Office (CSO). Some of the problems when using CSO data for analysing the situation of extremely poor households are:

- CSOs lowest poverty line is “extremely poor”. Under this line are approximately 50% of all Zambian households. There is no disaggregation of the degree of poverty under this line. Meaningful analysis of the correlation of poverty with other parameters like household structure, etc. is therefore only possible in a limited way.
- CSO publications do not differentiate age groups over 60 years. However, for analysing household structures for social purposes it is important to have more disaggregation according to age.[5]
- Meaningful regional disaggregation of CSO data does not go beyond provinces. For purposes of designing social transfer schemes, data on district and sub-district level are required.

[5] This has been done in the meantime. Information is available on request at the MCDSS/GTZ Social Safety Net Project.

It is recommended to start data collection in those districts that qualify for pilot social transfer schemes. A number of interested stakeholders like the District Welfare Officers, the District Planning Officers (who require data for their District level PRSPs) the District level CSO Officers and NGOs should be integrated in the survey design, data collection and data analysis. This will facilitate ownership and subsequent use of the information generated. The information should also be made available to a wider public and should be used for awareness creation with regard to the need for social welfare interventions.

9.3 Conduct Pilot Social Transfer Activities

Mainstreaming Social Protection will most probably within a time horizon of approximately 5 years generate an increasing flow of national and international funds for social protection of extremely needy and incapacitated households. Once this money is available it can only be used effectively and efficiently, if well-designed, thoroughly tested, feasible and cost effective social transfer concepts are available. This can be best achieved by a three-year pilot scheme preferably covering at least one district.
A pilot scheme can test the feasibility and cost-effectiveness of different options for targeting social welfare interventions that aim at securing the survival and fostering the welfare of the most needy households. Through close monitoring of processes and impact, the costs and benefits of social transfers for OVCs and other vulnerable groups can be monitored. Impacts of transfers on social welfare indicators and impacts on local economies can also be assessed.
In summary the pilot activities will be the first step in establishing a social transfer scheme. It will at the same time generate the information required for a step-by-step gradual expansion of social protection until approximately in 2015 coverage of 80% of the most needy households will be achieved.

If a small District like Siavonga (approximately 10.000 households) is chosen and a social transfer of 6 US Dollar to 10% of the households is planned, an annual budget of 6 X 12 X 1000 = 72.000 US Dollar plus administrative costs of 8.000 Dollars is required. For a three years period this adds up to 240.000 US Dollars. This calculation does not include the costs for technical assistance for designing the pilot scheme, for capacity building, monitoring and guidance during the implementation, for analysis of the process and impacts and for making the results available for policy making. If a bigger district or two districts are chosen, the annual costs can be estimated by multiplying the number of beneficiary households that should be included (approximately 10% of all households of the respective Districts) by 80 US Dollar.

In fact – if funds were available – pilot projects in two districts using the Public Welfare Assistance Scheme as the implementing agency in one District and a NGO consortium like Csafe in another District, would be preferable to piloting in just one District.

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Annex 1 Terms of Reference

Terms of Reference for a Consultancy on the Social Impact of HIV/AIDS on vulnerability of poor households in Zambia

1. Background *(Describe context, relevance and expectations; type of consultancy, e.g. technical assistance for proposal writing, problem analysis, study, evaluation etc.); link to GFATM proposal or implementation process)*

According to the most recent Demographic and Health Survey (2000/2001), 15,6 % of adult Zambians (15 - 49 Years) are HIV positive. The infection rate is particularly high among the economically most active age groups (25-35). So HIV/Aids is the most important factor causing vulnerability and reducing the self-help capacity of poor households. Whereas there are numerous research activities carried out on sensitisation, awareness, prevention and treatment/care, the issue of social impact and of the coping strategies of HIV/AIDS affected families and households is not yet sufficiently addressed. The proposed Consultancy will support Zambian Government and Civil Society, including the task forces of the National Aids Council (NAC) and the GFTAM/CCM to address this issue more efficiently. In the framework of the planned elaboration of a Social Protection Strategy, backed by World Bank and German Technical Cooperation, the Consultancy will focus on HIV/AIDS related social problems and make contributions for a targeted approach in terms of Social Protection.

2. Purpose of the Consultancy *(Why is this consultancy/study/appraisal necessary?)*

The purpose of the Consultancy is
+ to give a comprehensive overview on current status of knowledge with respect to the social Situation of HIV/Aids affected households and their coping strategies
+ To assess the Social Protection measures addressing this issue
+ To identify gaps in terms of knowledge
+ To elaborate hypothesis and proposals how to improve the efficiency and the targeting of Social Protection mechanisms

3. Specific Tasks *(Assess, review, identify, estimate, document, evaluate, prepare, moderate, etc.)*

3.1 Stocktaking of data and documents available concerning the social and economic impact of HIV/Aids on poor households, their coping strategies and the behaviour of communities they are living in. Particular attention should be payed to gender issues.

3.2 Evaluating the impact of selected Social Protection measures with respect to HIV/Aids concerned poor households with particular attention to informal social safety nets (extended families, communities). Semi-structured interviews with key stakeholders and resource persons and field visits in selected districts of Southern Province will be carried out. The field visits will particularly analyse the performance of NAC's district task forces and the Community Welfare Assistance Committees through interviews with Committee members and selected beneficiaries.

3.3 Examining the strength's and weaknesses of existing approaches with main actors and stakeholders of Social Safety nets and formulating of hypothesis how to improve the impact, among others with respect to networking between Government, local authorities and Civil Society Organisations. The issues to address are above all the targeting, the type of support with respect to priority problems of beneficiaries and the cooperation between agencies (governmental as well as non-governmental) dealing with the issue.

3.4 Identifying options to mobilise community support and to create awareness concerning child-misuse (orphans) , with particular respect to the potential role of the Public Welfare Assistance Scheme (PWAS) and other community-based structures.

3.5 Identifying the knowledge-gaps with respect to the above mentioned issues and designing a research strategy.

3.6 Organising a stakeholder-workshop presenting preliminary results of the mission and discussing next steps.

3.7 Writing a report on the results of the mission including the outcomes and recommendations of the above-mentioned workshop.

4. Methodology *(Orientation meetings, review of documentation and literature, interviews, etc.)*

Collection and analysis of existing documents, interviews with main actors and stakeholders on all levels (Government, NGOs, churches, CBOs and communities). Field visits and interviews with community based organisations will focus on Southern Province.

5. Outputs *(Advise on specific questions, conclusions, recommendations, format of report, dissemination)*

5.1 Report presenting the state of existing knowledge on HIV/Aids impact and social safety nets, including hypothesis on strength's an weaknesses of existing approaches.

5.2 Main features of a future research strategy taking into account the identified gaps.

5.3 Hypothesis adressing future Social Protection interventions targeting the HIV/Aids stroken poor households

5.3 Workshop with stakeholders, workshop report.

6. Time Frame & Schedule

Tasks	**No. of reimbursable days**	*Remarks*
Task/Activity 1: Stocktaking of existing documents and	5 days	Documentary study on households with limited

data		self-help capacity is available.
Task/Activity 2: **Evaluation of existing Social Protection approaches, including community response.**	15 days	Field visits will focus an selected districts in Southern Province.
Task/Activity 3: **Prepare and carry out stakeholder workshop**	2 days	
Report writing	3 days	
Preparation & facilitation of dissemination meeting	days	

The consultancy shall be completed by: 15 April

7. Profile of consultant - Qualifications

Social Policy expert with very good knowledges of Zambia and international approaches dealing with the impact of HIV/Aids.

Annex 2: Schedule and Persons Consulted

Sunday, 16th March 2003

- Dr. Jörg Goldberg, GTZ Advisor Social Safety Net Project
- Dr. Uwe Wendl-Richter, GTZ Advisor Reproductive Health Project
- Dr. Eberhard Krain, GTZ Advisor, District Development Project Southern Province

Monday, 17th March 2003

- Ms. Ara Musonda, Director General, National AIDS Council
- Mr. Kristof, German Ambassador
- Ms. Konrad, German Deputy Ambassador
- Ms. Martina Bergschneider, GTZ Director Zambia

Tuesday, 18th March 2003

- Mr. Edward Mwale, ZAMSIF Operations Controller
- Ms. Patricia Malasha, ZAMSIF Expert on Vulnerable Groups
- Ms. Sam Gibson, DFID, Social Development Advisor
- Dr. Musumali, Zambia Integrated Health Project
- Ms. Florence S. Phiri, Zambia Integrated Health Project

Wednesday, 19th March 2003

- Ms. Linyando, MCDSS Head of Planning Unit
- Mr. Chipoma, EU Coordinator for Assistance to Public Welfare Assistance Scheme
- Dr. Karen Shelley, USAID Senior Technical Advisor for HIV Programmes and Child Survival
- Dr. Mphuka, Church Health Association of Zambia (CHAZ), Executive Director
- Ms. Karen Seshenha, Church Health Association of Zambia
- Dr. Karen Sissolak, DED attached to CHAZ

Thursday, 20th March, 2003

- Mr. Modesto Banda, Central Statistical Office, Deputy Director
- Mr. Situmbeko Musokotwane, Ministry of Finance, PRSP Advisor
- Ms. Brenda Cupper, CARE Zambia Country Director
- Ms. Kathryn Tovey, DFID attached to CARE Zambia

- Mr. Dong Quingsong, FAO Representative in Zambia

Friday, 21st March, 2003

- Mr. Gabriel Fernandez, UNICEF Project Officer, Child Protection

Saturday, 22nd March, 2003

- Travel to Choma
- Mr. Alexander von Braunmühl, GTZ Food Aid Consultant

Sunday, 23rd March, 2003

- Mr. Mbulwe Mwiimba, GTZ Advisor to HIV/AIDS Task Force Choma
- Ms. Brenda Siamusuku, Municipal Council Choma, Assistant Director of Planning

Monday, 24th March, 2003

- Sister Phillipa Olsullivan, Director Kara Counselling, Choma
- Mr. C. Sikwibele, District Public Welfare Officer, Choma
- Ms. Jean Hamoonga, Assistant Public Welfare Officer, Choma
- Mr. Kennedy Chilimboyi, Relief Food Coordinator, Choma
- Ms. Veronica M. Kayombokwa, World Vision Manager, Choma
- Mr. L. Zulu, Town Clerk, Choma
- Mr. T.K. Habemba, District Administrator, Choma

Tuesday, 25th March, 2003

- Rapid Social Appraisal with key informants and interviews in 10 destitute households of villages Chuulu and Hajuunza, Choma District

Wednesday, 26th March, 2003

- Mr. Simon Mwanza, CARE International Manager, Kalomo
- Ms. Cynthia Mulenga, District Planning Officer, Kalomo
- Mr. Hangwemu, Former Town Clerk, Choma
- Mr. Dierk Hesselbarth, GTZ Advisor, Agricultural Support Project Southern Province

Thursday, 27th march, 2003

- Rapid Social Appraisal with key informants and interviews of 10 destitute households in Manyepa and Jalila Villages, Choma District

Friday, 28th March, 2003

- Rapid Social Appraisal with key informants and interviews of 12 destitute households in Haluumba and Hamachila villages, Choma District

Saturday, 29th March, 2003

- Return to Lusaka
- Data analysis

Monday, 31st March, 2003

- Ms. Charlotte Harland, EU Advisor to Public Welfare Assistance Scheme
- Mr. Rossetti, EU Social Sector Advisor

Tuesday, 1stand Wednesday, 2nd April, 2003

- Writing preliminary report

Thursday, 3rd April, 2003

- Workshop on preliminary results of the consultancy in GTZ Office, Lusaka

Friday, 4th April, 2003

- Drafting request to Social Fund for AIDS, Tuberculosis and Malaria (GFATM) for funding pilot project

Saturday, 5th April, 2003

- Travel to Livingstone

Sunday, 6th April, 2003

- Report writing

Monday, 7th April, 2003

- Mr. E.C.M. Walumba, Provincial Social Welfare Officer, Southern Province
- Ms. Gwendolyne Sampa, District Social Welfare Officer, Livingstone

Tuesday, 8th April, 2003

- Mr. Jimmy Katolo, Social Welfare Officer, Kazungula

Wednesday, 9th April, 200

- Mr. Edgar H. Mainza, District Social Welfare Officer, Monze
- Ms. Febby Chalwe, Assistant District Social Welfare Officer, Monze

Thursday, 10th April, 2003

- Mr. Lewis Bangwe, Assistant FAO Representative
- Ms. D. Mutunwa, Assistant Director of Planning, Ministry of Community Development and Social Services

Friday, 11th April, 2003

- Mr. Coillard Hamusimbi, Research Officer, Farming Systems Association of Zambia
- Debriefing at GTZ Office

Annex 3: Request for funding by the Global Fund for AIDS, Tuberculosis and Malaria of a Pilot Scheme for Social Transfers to AIDS Affected Households in Zambia

Pilot Scheme for Social Welfare Interventions to Ensure the Survival of AIDS Affected Households with Special Emphasis on OVCs

Preliminary results of a consultancy on "Effective Social Welfare Interventions for AIDS Affected Households in Zambia" (report attached) indicate, that as an effect of AIDS approximatly 10% of the rural households are in a state of severe destitution. Many have lost all their breadwinners, some have chronically sick household members and most have to care for a large number of orphans and vulnerable children.

Work constrained destitute households cannot respond to traditional development programmes or to opportunities offered by Cash for Work or Food for Work programmes. In order to ensure their survival, well targeted social welfare interventions are required.

The Ministry for Community Development and Social Services (MCDSS) therefor requests funds from the GFATM for conducting a pilot Social Transfer Scheme in one District. The objective of the pilot scheme is to test the feasibility and to identify the costs and benefits of social transfers to households that are extremely incapacitated due to AIDS. Executing agency will be the recently reorganised Public Welfare Assistance Scheme (PWAS) of the MCDSS. Based on the results of the pilot activities decisions with regard to a national strategy for social protection of AIDS affected households and OVCs will be facilitated.

The workplan for the pilot scheme contains the following activities and cost estimates:

2003
- Selection of a pilot District
- Vulnerability assesment of Aids affected households and OVCs
- Designing the scheme
- Training of staff
- Setting up of auditing and monitoring systems

Budget required for 2003: USD 100,000.-

2004 Delivering well targeted transfers to AIDS affected and incapacitated households. Assuming an average sized District (50,000 households) of which 10% urgently require social welfare interventions of at least USD 6 per month, the annual transfers per household amount to USD 72. Allowing for administrative expenses of USD 8 the unit costs are USD 80. The annual costs are therefor estimated at USD 400,000.- plus USD 100,000.- for monitoring the process and impact closely and for taking corrective action where required

Budget required for 2004: USD 500,000.-

2005 The costs of social transfers to 5,000 incapacitated households will again amount to USD 400,000.-. Costs for continued monitoring and for analysing and publishing the results of the scheme are estimated at USD 100,000.-.

Budget required for 2005: USD 500,000.-

The benefits expected from the scheme are:

1. Approximatly 15,000 vulnerable adults (elderly, chronically sick or otherwise unfit for work) and approximatly 15,000 OVCs living in the 5,000 target households will benefit. They will be able to meet some of their most urgent needs in terms of food, medical expenses and/or school expenses. Some will invest part of the transfers in seeds, fertilizer or small livestock in order to improve their livelyhood. This in turn will significantly impact on child mortality, malnutrition, schooling rates and other welfare indicators in the respective District.

2. Reliable and well tested information on the feasibility and on the costs and benefits of a social transfer scheme to AIDS affected households will be generated.