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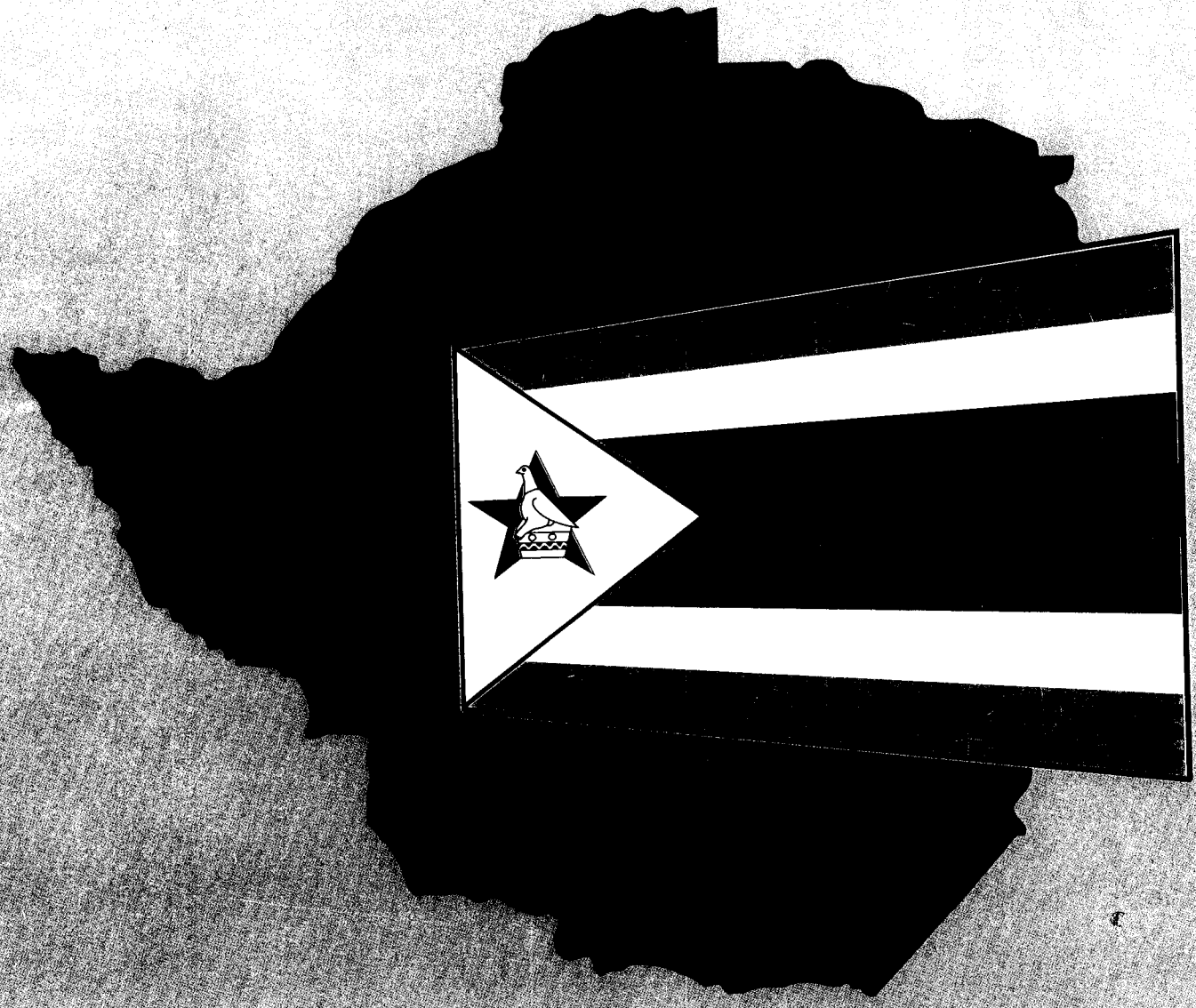

NATIONAL HIV/AIDS STRATEGIC FRAMEWORK

REPUBLIC OF ZIMBABWE

CAROLE.

WORKING DOCUMENT

FOR

NATIONAL AIDS COUNCIL

STRATEGIC FRAMEWORK

FOR

A NATIONAL RESPONSE TO HIV/AIDS

(2000–2004)

(NOVEMBER 1999)

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GLOSSARY OF TERMS

AIDS	—	Acquired Immuno-deficiency Syndrome
CBO	—	Community Based Organisation
CHBC	—	Community Home Based Care
HBC	—	Home Based Care
HIV	—	Human Immuno-deficiency Virus
IEC	—	Information, Education and Communication
MCH	—	Maternal and Child Health
MTCT	—	Mother to Child Transmission
NACP	—	National AIDS Co-ordination Programme
NGO	—	Non-Governmental Organisation
PHC	—	Primary Health Care
SDF	—	Social Dimensions Fund
STD	—	Sexually Transmitted Disease
STI	—	Sexually Transmitted Infection
UNDP	—	United Nations Development Programme
UNFPA	—	United Nations Population Fund
VCT	—	Voluntary Counselling and Testing

EXECUTIVE SUMMARY

It is becoming more and more apparent that HIV/AIDS is more than just a health issue. In fact, HIV/AIDS should be regarded as a development issue. As such, economic issues are inextricably linked to HIV/AIDS, both as determinants of vulnerability and as moderators of responses to the problem at the individual, household, community and national levels. This strategic framework for the national response to HIV/AIDS examines the economic issues pertinent to the HIV/AIDS pandemic and highlights, among others, the following:

ECONOMIC DRIVERS Of the HIV/AIDS Epidemic

Key determinants

- Unstable macro-economic environment
- Rising levels of poverty
- Declining public sector funding for education, health and social services
- Weak informal sector
- Lack of economic growth in the communal and resettlement areas.

Key obstacles to change

- Stagnation and declines in economic growth and employment opportunities
- Declines in incomes at household level, rising food insecurities and rising dependency ratios
- Inadequate provisions and access to health and social services and the demise of social safety nets
- Poor resourcing of the informal sector
- Poor infrastructure, lack of investment, rural to urban drift and crumbling extension services compromising economic growth in communal and resettlement areas

Key opportunities

- The proposed establishment of an Integrated Poverty Monitoring System
- The on-going Poverty Alleviation Action Plan
- The current capacity building programme for rural district councils
- Activities to promote the development of Small and Micro Enterprise (SMEs) by both Government, NGOs, the private sector and local authorities.

Key Strategies

- Mainstreaming HIV/AIDS into national economic planning and development programmes
- Sectoral plans to budget for HIV/AIDS prevention, care and support activities
- Decentralising the planning, programming and implementation of action plans supported by the deliberate devolution of capacities and responsibilities to district-level development committees
- Enhancing the capacity of extension services and development agents working in the area of poverty reduction
- Revamping and/or promoting traditional and grassroot support systems e.g. *Nhimbe* and *Zunde ramambo*.

Proposed areas for action

- Addressing the economic determinants
- Strengthening the national capacity to respond to the AIDS pandemic and its consequences
- Reducing rural to urban migration
- Maintaining and safe-guarding food security for vulnerable households
- Stimulating supporting economic growth in the informal sector and the communal and resettlement areas.

A holistic approach to confronting the HIV/AIDS pandemic demands that attention on the socio-cultural and social services contexts. The effectiveness of every element of the individual, family, community and even national response to the pandemic hinges on the creation of an enabling environment including:

- a willingness to confront norms and practices that fuel the spread of HIV
- openness and non-discrimination around HIV/AIDS
- enhancement of community and family support structures
- access to health and social services
- community development, etc.

The strategic framework addresses these and other issues in the social services and socio-cultural arena and highlights some of the following:

SOCIO-CULTURAL
Determinants of the HIV/AIDS epidemic

Key determinants

- Increasing urbanisation in the absence of adequate educational, health, housing and social services leading to declines in living, health and moral standards
- Dissolution of family (especially the extended) systems with the attendant loss of socialising and support agents
- Gender inequities in the provision of and access to education, health services, housing tenure, etc. for some segments of the population
- Cultural and religious traditions and sensitivities which disempower certain population groups and perpetrate their vulnerabilities by modulating access to information, interpersonal skills, services, etc.

Key obstacles to change

- Inadequate provision and/or access to health and social services
- Weakened traditional support systems and safety nets
- Poor targeting of meagre resources by community-based organisations
- Duplication of efforts and limited synergy among NGOs and CBOs
- Stigmatisation of HIV

Key opportunities

- A decentralised public health system
- Strong tradition of in-service training
- Majority of youths are in school up to 16 years of age
- Presence of committed advocacy groups and AIDS service organisations
- Concepts of CHBC taking root in most communities.

Proposed areas for action

- Addressing the social, cultural and interpersonal determinants
- Reducing inequities in the provision of and access to services
- Mobilising and resourcing for community participation
- Overcoming negative household coping responses
- Challenging and confronting retrogressive cultural norms

Key Strategies

- Lobbying for increased funding for public sector services as well as lobbying for greater political will and commitment to the fight
- Ensuring increased gender sensitivity in programme planning and implementation across all sectors
- Mainstreaming community development structures and traditional hierarchies into AIDS prevention and support efforts and fostering local "ownership" and accountability.
- Creating opportunities for enhancing incomes at household levels
- Co-opting and front-lining opinion leaders in moral rearmament and cultural activism

As with past Medium Term Plans, the most important and core objective of this strategic framework for the national response to HIV/AIDS continues to be prevention.

Prevention efforts will be aimed at reducing infectivity and reducing the rate of partner change. While these approaches apply across the populations at risk as a whole, scarcity of resources means that prevention efforts will have to be intensified where they will make the greatest difference.

Some of the key issues in prevention addressed by this strategic framework are as follows:

Issues in the prevention of HIV infection And transmission

Key Issues	***Key Strategic objectives***
• Preventing sexual transmission of HIV	• To delay onset of sexual activity among the youths • To promote abstinence outside marriage and mutual fidelity within marriage and other " steady" relationships • To make safe-sex normative in all sexual relationship that pose a risk for HIV transmission • To promote timeous and comprehensive treatment of STDs
• Preventing mother to child transmission of HIV	• To ensure access to VCTs, for families contemplating starting a family or having more children • To ensure access to antiretroviral treatments and confidential and comprehensive counselling for HIV positive pregnant women
• Preventing transmission through blood and blood products	• Reinforce the good work being done by the National Blood Transfusion Services • To make sure that health personnel are trained in the rational use of blood and blood products

Key Strategies

- Involving peers and role models in making the delay of onset of sexual activity normative and the "in thing" or "cool" thing among the as-yet uninitiated youths
- Improving access to appropriate and enabling information and interpersonal skills, backed by customer friendly services and provisions for protection such as condoms
- Involving influential segments of the community in community sensitisation and mobilisation, moral rearmament, cultural activism, peer education and support activities
- Improving, at the individual level, the capacity to recognise early, symptoms of STDs and the willingness to seek appropriate treatment coupled with, at the service provision level, improved access to well resourced and skilled treatment services
- Raising community awareness on the protocols for reducing mother to child transmission, increasing access to MTC transmission related VCTs, training a critical mass of health workers in MTC transmission counselling and management and availing at affordable costs, antiretroviral treatments to HIV positive pregnant women.

The increase in HIV/AIDS related morbidity and mortality demands greater focus on mitigation of impacts through care and psycho-social support. Key issues in this regard that are addressed in this strategic framework and which will need to be operationalised through concrete action plans include the following:

Management and mitigation of The impact of HIV/AIDS

Key Issues

- Comprehensive and holistic care for HIV/AIDS related morbidity
- Psycho-social support for those affected by HIV/AIDS

Key Strategic objectives

- To improve the capacity of the health care system to treat and care for people living with HIV/AIDS
- To improve the capacity of households and communities to take care of their sick and dying as well as those involved in care-giving
- To provide economic and social safety nets to individuals, households and families affected by HIV/AIDS related mortality

Key strategies

- Putting in place a comprehensive continuum of care from the health care facility to the individual household or family to the respective community
- Strengthening the primary health care system through adequate resourcing and training
- Mobilisation of community participation in care and support activities
- Initiating intersectoral development as well as mitigatory and relief programmes

The need for a multisectoral response that is well co-ordinated and managed at all levels is a running theme throughout this strategic framework. Focus is given to some of the following issues in this area:

Effective co-ordination of the National Response to HIV/AIDS

Key Issues

- Need for a formalised framework for co-ordinating the national response to HIV/AIDS
- Reducing fragmentation in the national response
- Maximise local input into the setting up of development agendas, management of HIV related programmes, monitoring of implementation and ultimate accountability

Key Strategies

- To reduce competition, overlapping, duplication and resultant gaps in the national response to HIV/AIDS
- To increase complementarity and synergy in HIV/AIDS activities, especially at community level

Key Strategies

- Operationalising the multisectoral National AIDS Council which was recently established by Act of Parliament and charged with an overall responsibility to provide leadership, policy direction, guidance and co-ordination to the national response and to ensure effective social and resource mobilisation to combat the epidemic
- Establish proper co-ordinating mechanisms at both national and local levels
- Integrating local government sector responses into the national response at the political, administrative, resourcing, and collaboration levels.

Effective interventions at community level depend on well resourced programmes. Some of the resource mobilisation and management issues addressed in this strategic framework include:

Improving resource provision and availability To the National response to HIV/AIDS

Key Issues

- Reducing donor dependency in resourcing HIV/AIDS activities
- Enhancement of political will and national commitment against HIV/AIDS

Key Strategies

- To maximise the deployment of resources to respond to the HIV/AIDS challenge
- To complement external resourcing with local contributions to the fight against HIV/AIDS
- To facilitate long-term perspectives to the national response through longer term funding cycles of programmes
- To engender a national disaster perspective to the AIDS pandemic that requires emergency responses befitting a state of emergency

Key Strategies

- Identifying and integrating the private sector's comparative advantages in resource mobilisation into the national response in order to maximise resources
- Developing and re-capitalising the public welfare assistance system to provide safety nets for those in greatest need at the household and community levels
- Integrating public health in general, and HIV/AIDS in particular, into national economic planning and development.
- Implementing sector budgeting for HIV/AIDS activities as part and parcel of sector-specific core business
- Galvanising all effective and national sentiment rousing political and social movement to commit to the HIV/AIDS national resources commensurate with the magnitude of the problem.

The strategic framework is not intended to remain a document to be fished out at the end of the plan period to remember what was promised at the beginning. It has to be operationalised into sector-specific and level-specific action plans through a highly consultative process that includes all relevant stakeholders. Some of the key issues in these areas are as follows:

Strengthening and supporting the Local/grassroots response to HIV/AIDS

Key Issues

- Local "ownership" of programmes and action plans
- Community participation
- Local level accountability
- Mutually agreed upon strategies and targets

Key Strategic objectives

- To ensure accountability at implementation levels
- To foster, at community level, the sentiment "Nothing about and/or for us without us"
- To ensure that programme objectives, indicators and targets are realistic and acceptable to implementors and other stakeholders

Key strategies

- Involving stakeholders across sectors in a consultative process of drawing up both process and outcome indicators for planned HIV/AIDS related activities
- Drawing up implementation-level master timetables for achieving milestones
- Putting in place, at implementation level, monitoring and evaluation mechanisms which are agreeable to all
- Developing sector-specific and level-specific operational strategies and plans based on the guidelines provided in this framework.

1. INTRODUCTION

The HIV/AIDS epidemic is a substantial and still increasing national problem that demands a wide response from all sectors. It has had public health impacts in terms of morbidity and mortality, social impacts in terms of the loss of parents and children, the break-up of family units, the increase in dependency and the stress and anxiety this brings as well as economic impacts due to lost productive labour and savings, increased costs of health care and a growth in insecurity and poverty. Yet none of these dimensions fully capture the penetrating impact of a disease that has swept through youth, partnerships, family and community, has withered vitality, and, while so fundamentally social in its determinants, has led to such social powerlessness in stopping it. In the late 1980s, there was disbelief that the epidemic existed. In the late 1990s the disbelief is that we seem to be unable to stop it.

If it is in the nature of our society to take time to recognise, understand and respond to problems, then the next five years must demonstrate the return on that investment of time. The strategies discussed in this strategic framework document deal with prevention, mitigation and care. Without doubt, however, the most important strategic goal for the next five years is to level the rate of new HIV infections, and to establish a momentum for progressively reducing HIV transmission to a level where the epidemic can no longer thrive. This next strategic plan phase must thus be the "turn-around phase".

The lack of aggregate visible impact of the efforts to do just this over the past 5 years may breed cynicism. The strategic framework must thus identify why past efforts did not work, which past efforts did work and what needs to be done to make the change. Beyond this, the framework should identify how to ensure that interventions that can make a difference do not remain plans on paper, but are instead translated into reality.

Confronting the epidemic, and all the issues and questions it provokes about our society, our lives and the way we manage disease, demands a thrust that emanates from personal to partnership, family, community and national levels. Many Zimbabweans now acknowledge that there is a critical need to confront the epidemic. Many call for the leadership and strategic vision that can bring the capacities that do exist within the country together, focus and direct them, to do the possible—to turn back the HIV tide on a sustainable basis.

Since the identification of the first HIV/AIDS case in 1985, the response to the disease has been very much driven by the health sector. This is because the problem initially presented itself as a medical problem. However, as time passed, it has become very evident that apart from the medical consequences of the disease, there are many more psycho-social problems that arise because the disease has a very long incubation period after infection as well as a very long period of illness before a person comes to die.

The proposed strategic framework for a national response to HIV/AIDS calls for greater mobilisation of commitment to the fight against HIV/AIDS from political, civic, economic and traditional leaders. It also advocates for the putting in place of a multisectoral participatory mechanism which involves relevant sectors, agencies and interest groups. In this way, it is hoped that the impression that AIDS is a health sector issue will be replaced with an appreciation that AIDS is a threat to Zimbabwe's development and thus demands an all encompassing and strategic national response.

2. METHODOLOGY

In 1997 the NACP commissioned 4 key studies:

- The socio-cultural context of the AIDS epidemic in Zimbabwe by Claude Mararike
- An assessment of the socio-economic and political context of the AIDS epidemic in Zimbabwe by Solomon Mombeshora
- Assessment of the Health Context of the AIDS Epidemic in Zimbabwe by G. Woelk.
- The Review of the Medium Term Plan II (MTPII) for the Prevention, Control and Care of HIV/AIDS/ STD.

These four studies provided a wealth of information and were circulated among key stakeholders for comment. The key stakeholder groups which were invited to make comments on these studies were:

- Zimbabwe AIDS Network (ZAN and the NGOs that are involved in ZAN)
- Private Sector (CZI, ZNCC, EMCOZ, ZCTU)
- Public Sector (All government ministries and parastatals)
- Farming Unions (ZFU, CFU, ICFU)
- Churches, Civic Society (e.g. WAG), donors
- People Living With AIDS (ZNPP+)
- Some individual health professionals and other opinion leaders.

Each stakeholder group was requested to make a detailed review of the studies and submit a written response to NACP. In addition they were invited to make a presentation at a feed-back workshop. Thus began the process towards the development of this strategic framework.

Once this initial consultative phase had been completed, a team of consultants was given the task of facilitating the development of a full strategic framework document based on the work (the 4 studies and the stakeholder reviews) that had been done since 1997. The work of developing the strategic plan (MTP3) therefore drew heavily on the work that had been undertaken by NACP before. In developing this strategic framework the following key tasks were undertaken:

- **Desk/document review**

  In addition to the 4 studies already mentioned above and the stakeholder comments which were made, an extensive review was made of other studies concerning the situation of HIV/AIDS in Zimbabwe, SADC and other countries. Government policy documents were also reviewed as part of this document review process. Appendix II to this report is a full Bibliography of the documents reviewed.

- **Consultations**

  Three types of consultations were held as follows:

  Interviews with key informants from NACP, government, the donor community, NGOs, the private sector, local government sector. Appendix III to this report is a full listing of the individuals who were interviewed as part of this consultative process.

  Discussions were held with various groups either as focused group discussions or special meetings. The consultants also attended a number of meetings at the invitation of the NACP.

- **Development of first draft and solicitation of comments**

  A first draft of the strategic plan document was developed based on all the information obtained during the first two tasks. This draft was circulated for comment by a limited number of stakeholders who are NACP, UNAIDS and experts in the areas of social, economic and institutional management and development.

- **Development of the second draft**

  Once comments had been obtained on the first draft, a full second draft was developed. This second draft will be distributed to a wide cross-section of stakeholders for their feedback before finalisation of the strategic framework document.

- **Way forward**

  The final strategic framework document will need to be operationalised into sector-specific and level-specific action plans. This will entail a highly consultative and inclusive process to ensure that the action plans, programmes, strategies, targets and indicators emanating from it are relevant and acceptable to all stakeholders.

3. SITUATION ANALYSIS

This section summarises the situation of HIV/AIDS in Zimbabwe and deals with the key determinants/drivers of the epidemic.

3.1 Epidemiology of HIV

HIV is primarily sexually transmitted in Zimbabwe and its epidemiology in terms of the transmission dynamics, persons affected, and places where infection occurs is exactly the same as that of classic sexually transmitted infections. A total of 828 652 new episodes of sexually transmitted infections presented at public health facilities including cities in 1998 according to National Health Information System which capture routine data on health facility utilisation. The following are evident characteristics of the epidemiology of Human Immuno-deficiency Virus in Zimbabwe:

- transmission is predominantly through sexual intercourse
- transmission may be vertical from mother to child or by contact with infected blood
- gender (what it means to be male or female in a certain society) shapes the opportunities one is offered in life, the roles one may play, and the kinds of relationships one may have — and thus influences the spread of HIV
- long incubation periods before symptoms become apparent during which transmission occurs
- risk factors for HIV infection are directly related to patterns of sexual behaviour. These include number of sex partners, a history of STDs, urban residence, being single and young
- Increasing urbanisation with disruption of traditional social structure, increased mobility for economic, social or political reasons, a large proportion (58.1%) of the population composed of teenagers and young adults (who have the highest incidence of STD) and high unemployment rates are all contributing to the high incidence of STD, and their complications and sequelae.

3.1.1 Reported AIDS Cases by Year

Although the first AIDS case in Zimbabwe was identified in 1985, routine reporting was only instituted in 1987. Since then there has been a rapid growth of the AIDS epidemic with a total cumulative number of reported cases of 74 782 as of end of June 1998. It has been established that the reporting system is incomplete due to a number of constraining factors which include the following:

- The national AIDS cases definition includes a positive HIV test which is inaccessible to many health facilities especially outside the urban centres.
- Some people with HIV/AIDS do not seek care from designated health facilities.
- Some people die before the diagnosis of AIDS is made. Even when the diagnosis is made some clinicians do not report to the relevant health authorities.

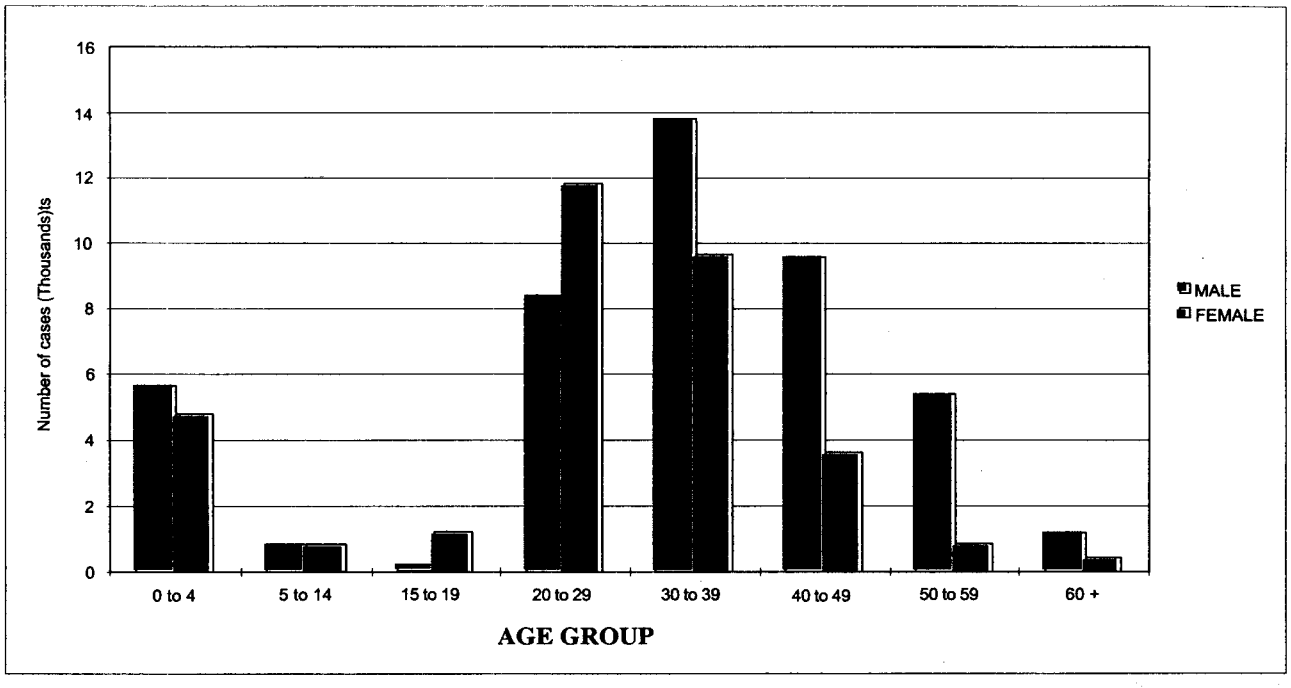
These and other factors result in a gross under reporting of AIDS so much so that the reported AIDS cases are only a small fraction of a big problem. Regrettably the reporting of AIDS has not improved over the years.

3.1.2. AIDS Cases by Transmission Category

The major route of HIV transmission in Zimbabwe is through unprotected heterosexual intercourse (92%) followed by vertical transmission (7%). Transmission through blood transfusion has been significantly reduced because transfused blood in the country is screened for HIV and other blood-transmissible infections.

Figure 3: Reported Cumulative AIDS Cases by age and gender

1987 TO SEPTEMBER 1998



Source: NACP/MOHCW

3.1.3. Reported AIDS Cases by Age and Gender

More than 70 percent of the reported AIDS cases have been consistently reported among adults aged 20– 49 years over the years. The age and gender distribution of cumulative reported AIDS cases for 1987–1998 is shown in Figure 3. With the exception of the age groups 15–19 years and 20–29 years, male cases dominate in all age groups.

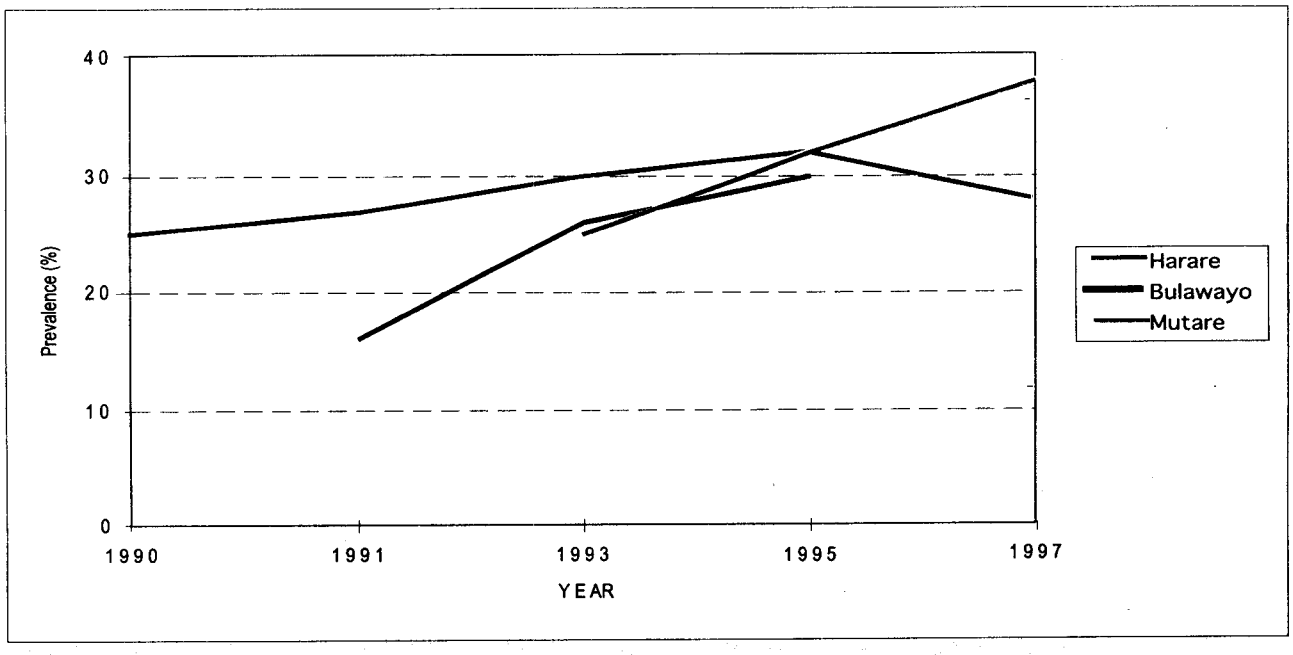
This indicates that females acquire HIV and develop AIDS at an earlier age than males. It is estimated that young women between the ages of 15–19 years are five times more likely to be infected than males of the same age. (AIDS 11(suppl. B): S5–S21, 1997). The peak ages for male and female reported cases are 20–39 years.

3.1.4 HIV Prevalence in Selected Populations

Zimbabwe has instituted an HIV sentinel surveillance system since 1989 to monitor the trends of HIV infection. The two main sentinel populations that have been used are pregnant women attending antenatal clinics and STD patients.

Information is available for both urban and rural sites. In the major urban centres, Harare and Bulawayo, HIV prevalence among pregnant women attending antenatal clinics tested increased from 10 percent in 1989 to 32 percent in 1995. A similar trend has been observed in Mutare. Only Harare has age specific data for 1995 where 28% of pregnant women aged 15–17 tested were positive for HIV.

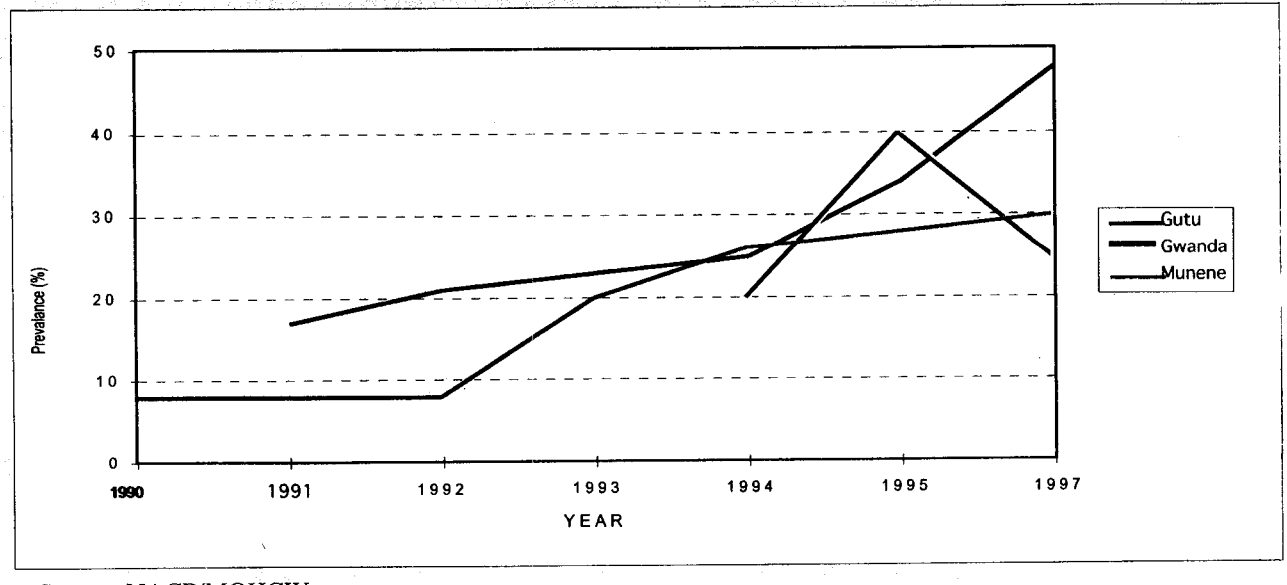
Figure 4: HIV Prevalence in Pregnant Women (15–49) in Selected Urban Sites



Source: NACP/MOHCW

Excluding the major urban sites, surveillance information is available since 1990 from 16 sites. HIV prevalence among pregnant women attending antenatal clinics tested increased from 8% in 1990 to 40% in 1995. In 1996, the median HIV prevalence from Masvingo, Chiredzi and Beitbridge had reached 47%. Information on age groups is available for Masvingo for 1995, where 42% of pregnant women attending antenatal clinics tested were HIV positive. The highest HIV prevalence of 49% was found in women 20 to 24 years of age.)

Figure 5: HIV Prevalence in Pregnant Women (15–49) in Selected Rural and Semi-rural sites



Source: NACP/MOHCW

Figure 5 above shows the HIV prevalence rates in selected rural and semi-rural sentinel sites.

There has been an increasing trend in HIV prevalence over the years.

3.1.5 Projections

HIV Infections—if the 1996 HIV adult prevalence of 20 percent rises modestly to near 22 percent by the year 2000 and remains nearly stable thereafter, the cumulative number of people infected with HIV (including children) would have increased from 1,56 million in 1997 to 1,8 million in 2000 and 2 million in 2005.

AIDS Cases—It takes on average 5 to 10 years for an HIV positive person to become sick of AIDS. The number of cumulative AIDS cases are estimated to rise from 54 cases in 1985 to 655 000 cases in 2000 and to over 1,3 million in the year 2005.

AIDS Deaths— the death toll would be staggering. By 1995, the cumulative number of AIDS deaths from the beginning of the epidemic was estimated at over 110 000. Over the ensuing 10 years, 1995–2005, an additional 1,1 million persons are likely to die from the disease, which would result in a cumulative total of about 1.2 million deaths by 2005.

3.2 DEMOGRAPHY OF HIV/AIDS

The AIDS mortality is having major demographic impacts on populations

+ crude death rates are higher (16% due to AIDS)
+ improvements in infant and child mortality rates have been reversed
+ Population growth has slowed
+ Life expectancies have fallen

These impacts are briefly described below:—

Crude death rate— Zimbabwe will have 4,4 million fewer people than there would be without the effect of AIDS. The crude death rate is over three times as high as it would have been without AIDS and it will be more than four times as high by the year 2010.

Crude mortality rate trends have fluctuated from (10.8/1 000 population) in 1982, (6.1) in 1987, (9.5) in 1992 to (12.2) in 1997. The HIV/AIDS epidemic is expected to induce an increase in CDR as the age specific death rate among 15–45 year olds and in the under-five group increases due to the disease.

Table 1: Child Mortality Rate 1982 –1992

Year	CMR per 1 000
1982	10.8
1987	6.1
1996	9.5
1997	12.2

AIDS also affects child survival. About 30 to 40 percent of infants born to infected mothers will also be infected with HIV. Most of these babies will develop AIDS and die within two years. Few will survive past the age of five.

Infant Mortality Rate— Infant mortality rate is now estimated to be 72% higher than it would have been without AIDS. By the year 2010, the infant mortality rate will be more than twice as high as it would be without AIDS. HIV- related deaths are among the top ten causes of deaths in this age group.

Child Mortality Rates—AIDS likely resulted in about 5 percent of the child deaths among children born over the 1986 – 1990 period. In projections by NACP, this proportion rises over time to more than 60 percent of child mortality between 2001–2005.

HIV/AIDS and related conditions— The emergence of HIV/AIDS as a major cause of ill health has had a major impact on the health status of Zimbabweans. The number of tuberculosis (TB) cases has been rising rapidly. The MOHCW reports a 550 percent increase in reported TB cases since 1985. In the absence of HIV, the number of new TB infections would be limited to about 0.2 percent of the population according to some estimates. This would result in 15 000 to 21 000 new TB cases each year.

With AIDS, the number of new cases will continue to increase rapidly. Assuming that 3.2 percent of people with both HIV and latent TB infections develop TB each year, then the additional number of TB cases due to HIV infection would be about 23 000 by 2005. Even this is likely to be an underestimate, since these new cases may transmit the diseases to others. The impact of HIV infection on tuberculosis is therefore an especially serious problem because TB is infectious through casual contact.

Population Growth Rate: The impact of the AIDS epidemic on population growth is an important question. Zimbabwe has had one of the most successful family planning programmes in sub-Saharan Africa. The fertility rate, which is the average number of children per woman, fell from well over 6 children per woman in the early 1980s to 4.3 according to the 1994 Zimbabwe Demographic and Health Survey. By 1994, about 42 percent of Zimbabwean women in their reproductive ages were using some form of modern contraception, one of the highest levels in the region. Consequently, the population growth rate dropped to about 2.3 percent per annum by 1994. It has been projected that with no AIDS, the population would grow to 13,1 million persons in 2000 and 14,9 million in 2005. With AIDS -related mortality the population will still grow from about 10,4 million at the time of the 1992 census to 12,4 million in 2000 and 13,3 million in 2005. AIDS will thus have a significant impact on population growth rate although not to the extent of approaching negative population growth over the projection period.

3.3. Economic Determinants and Drivers of the Epidemic

3.3.1 Rising levels of poverty

The incidence and depth of poverty has been rising rapidly during the 90s decade in Zimbabwe. High levels of unemployment and under-employment have worsened the income situation of most families. In Zimbabwe, most people are reliant on paid employment in the formal sector and the growth rate of this sector has been very slow (there have been periods of decline for the formal sector during the mid-1990s). Current economic projections are such that no appreciable improvement is forecast in the short to medium term because of a variety of reasons. The prospects for improved family incomes are therefore bleak during the period covered by this plan. Low family incomes have the following undesirable results.

1. Families do not have enough money to pay for their basic needs like food, housing, health and education. It has been recognised that without adequate food, proper housing and medication to deal with opportunistic infections, the quality of life for those afflicted by HIV/AIDS deteriorates to the extent that some of them die prematurely. Because of inadequate resources in the public realm for funding the care of those affected by the disease, the greatest burden for care is now falling on families. When these families do not have adequate resources, the problem becomes a very painful burden.

2. The neglect of education which is one of the prerequisites for enabling individuals and families to improve their income earning capacity means that a negative vicious cycle develops. Girls are the most severely affected because traditional and cultural beliefs assign girls to do most of the work around the home (and this includes care for the sick) which practices result in girls having less time to devote to their education. This, when coupled with the tendency of favouring the education for boys in situations where family incomes are low, will

perpetuate a situation where the rates of education for girls will lag behind. A Poverty Assessment Study which was undertaken by the Ministry of Public Service, Labour and Social Welfare indicated that on average, women were considered to be poorer than men. Prospects for women to improve their economic situation were constrained by the fact that they had less education and poor access to productive assets like land and capital which would enable them to engage in reasonable income generating activities.

3. When people are not able to access formal educational and health services, they lose out on opportunities for gaining information and knowledge about the HIV/AIDS problem. This is because most education, prevention and care work is being channelled through formal education and health facilities.

4. It is believed that poverty tends to lead people to engage in unsafe behaviour. This is because people in poverty may have fewer options and often are overwhelmed by a sense of hopelessness and have low levels of self-esteem.

3.3.2 Declining government/public sector funding for social services (education, health, social welfare)

Public funds allocated to social services by government and local authorities have been on the decline. The global economic trends which have seen a move towards privatisation and the attendant practice that individuals have to pay for services they consume has resulted in a situation where the majority of the population are at risk of failing to access the services they require at the time they most require those services. The Zimbabwean Press is full of stories of people being turned away (even from government institutions) because they do not have money to meet the necessary fees. Other stories tell of a number of people who have not received social welfare assistance when they require it for a variety of reasons. Current forecasts indicate that the funding situation is not likely to improve in the short to medium term. Accelerated privatisation and decentralisation of the responsibility for the provision of social services from central government to local authorities are trends which will continue to negatively impact on the capacity of both the public and private sectors to provide social services at prices and formats which can be accessed by the poor.

Below are some funding factors which have a negative impact on the control, prevention and mitigation of the HIV/AIDS pandemic:—

1. Low funding results in problems of human resources shortages, inadequate skills and inadequate human resources development programmes. This is a special problem for HIV/AIDS because it is a new disease which would require more people being assigned, more people receiving adequate training and personnel being adequately remunerated so that they can stay working in the area. Attraction and retention of adequately trained personnel is an imperative in the management and control of HIV/AIDS.

2. Low funding results in shortages of space, equipment and materials. HIV/AIDS is a long-term disease requiring high and long levels of care. The health institutions are overstretched and the situation is getting worse by the day. Many reports (from the Press and those commissioned by the institutions themselves) show that conditions at public health institutions are deteriorating without any major improvement being in sight in the short to medium term. Allocations for the health sector by both central government and local authorities have been in decline in real terms since the late 1980s. A number of strategies have been employed (decentralisation, cost recovery from users, retention of user fees, more stringent attention to the collection of debts, improved financial management, autonomy, fund raising etc.) in an effort to improve the availability of funds to public health institutions. These strategies have only been of limited success. Long-term institutional care for HIV/AIDS sufferers is therefore being cut back in favour of home based care. However, HBC remains poorly resourced and planned for so that those who are carrying the burden (families, CBOs, NGOs etc.) find themselves completely overwhelmed by the responsibility which is being thrust upon them.

3. Low funding has starved the relevant public institutions of the wherewithal to mount an effective response to the ever-rising demand for social welfare assistance. The SDF, which has been a major strategy by central government to meet the educational, health and welfare needs of the less fortunate has failed to cope. Funds allocation have been so minimal that the SDF has caused great cashflow/debt problems for schools and health institutions. Attempts to reverse the situation have not been very successful.

3.3.3 Inadequate insurance and pension provisions which would mitigate the plight of the affected while reducing the public burden for providing for the affected

Insurance and pension provisions present a traditional form of saving which enable people to pool resources in order to provide for those in need or those whose turn has arrived. In the past, it was possible to make such provision at reasonable cost to participants because the number of claims on the common pool of savings was limited. Fewer claims mean that adequate funds are left in the pool for investment in order to enhance the benefits stream without increasing contribution levels. This basis for insurance and pension provision is under strain (even threat) because of the high mortality of those affected by HIV/AIDS. This mortality is strongest in an age group that was expected to continue making contributions without claiming so as to maintain reasonable levels of surplus funds which could be invested.

HIV/AIDS is a new phenomenon that is not fully understood in the less than 2 decades the problem has come to the fore. Lack of information has led the insurance and pension industry to play it safe by discriminating against those who would place their portfolio at risk. Lack of information has also limited the extent to which the industry can become creative and innovative enough to offer cover at affordable cost and yet still yielding a good return for those who become participants of their schemes.

The challenge is therefore to provide adequate information and promoting dialogue and debate so that a balance can be struck—the insurance and pension industry has to reduce their profit margin in order to assist the nation to cope with the HIV/AIDS problem. At the very least, consideration should be given for the following:

- Contributing to prevention work—a decrease in infection rates means that the number of risky clients is reduced in the long term.

- Contributing to mitigation efforts improves resource availability for those offering services so that they are more efficient and effective with the possible result that the cost of assisting each individual declines when they get quality services on time. The current situation is that people are seeking and obtaining assistance when their condition has deteriorated and has become very costly to manage.

- Accepting and facing the problem improves openness so that the quality of available information improves and this in turn improves the quality of planning and forecasting by the insurance and pension industries.

  Participation rather than withdrawal presents more benefits in the medium to long term compared to being bogged down in cutting costs while maximising portfolio returns in the short term.

3.3.4 An unstable macro-economic environment which is characterised by stagnation [or even decline], high interest rates, low investment and high unemployment

The instability of the macro-economic environment and its negative impact on economic growth and well-being for the nation has been well documented by a number of authors, including the economic government ministries. In a nutshell, the focus on social development and wealth redistributive polices without placing similar emphasis on the need for new wealth creation has resulted in a situation where the economy is in decline in the face of very high levels of government debt. The human resources development, which was achieved at great cost through education, health and other social services, is proving to be a white elephant because of declining employment opportunities or other income earning opportunities. As already indicated in an earlier section, unemployment and a poor economic climate results in low family incomes with the attendant problems of failure to pay for basic human needs on the one hand, and on the other hand, a tendency to indulge in risky behaviour.

Without a marked improvement in the economic performance of the country, there is little hope of improving the living conditions of the population. There is also little hope for increased resources being channelled to the provision of essential services (health, education, shelter) which are an essential part of fighting the problem of HIV/AIDS.

3.3.5 Inadequate support for the informal sector which is a major safety net for those without jobs in the formal sector

As a result of pre-independence policies which were based on an economic development policy of promoting formal enterprise and maintaining an orderly physical environment, the informal sector continues to be regarded as a necessary evil which at best should be tolerated but at worst should be suppressed. The informal sector is regarded as a haven of crime and disease and therefore receives no official support in terms of resources (space, money, equipment, personnel, utilities like water, energy and communication facilities) which would enable the informal sector to operate in a more environmentally friendly manner.

The informal sector has traditionally provided income-earning opportunities for those who fail to secure employment in the formal sector. HIV/AIDS is a disease with long duration of ill health and for those individuals who have been lucky enough to be in formal employment, chances are that such people lose their formal jobs once absences from the job due to ill health become unbearable for the employer. The informal sector would therefore be the place where they could continue to make a living. Such an opportunity becomes very difficult if the operating environment remains difficult.

3.3.6 Lack of coherent policies to generate adequate economic growth for rural areas, especially the communal and resettlement areas

The colonial concept for native reserves (which have been renamed communal areas after independence) was to create a place of residence for a large labour reserve to provide workers for the farms and factories which were the bedrock of economic development in the then Southern Rhodesia. Economic infrastructure was therefore only developed to service the needs of urban areas, mining settlements and large-scale commercial farms. A minimal investment was made in the now communal areas. After independence, a lot of effort has gone into raising economic activity in communal areas. However, a variety of reasons have negated such efforts:

* overcrowding has lessened the amount of land which can be farmed and yield economic returns for the communal land farmer;
* not every resident in the communal areas has access to land on which they can farm;
* drought, lack of relevant technology and equipment, lack of up to date knowledge, lack of capital and poor rural infrastructure are some of the reasons why the rural economy continues to be below the level at which rural residents can derive adequate incomes.

Apart from the promotion of agriculture and infrastructure development as part of the economic development strategies of the early independence years little economic investment has taken place to stimulate the rural economy. This effort has however lost momentum because government has limited resources to fund assistance with tillage, extension work, animal husbandry facilities like dip tanks and veterinary services, improve access to marketing facilities [the privatisation of the agricultural marketing board has resulted in greater difficulty in accessing reliable and profitable markets]. Economic development policies have tended to favour areas other than communal areas, resettlement areas and small-scale commercial farming areas where the majority of Zimbabweans reside. Undesirable results from poor rural economic development policies are:—

- The migrant labour system remains a way of life—husbands (and of late, wives too) leave their families in the communal areas to go in search of paid formal employment and or income-earning opportunities in the urban formal and informal sectors. As already commented on in another section of this report, the migrant labour system encourages risky behaviour. The system also makes it difficult to manage family health when spouses are apart and or when children are left to fend for themselves in either the communal and or urban areas.
- The search for better educational facilities away from home (in urban areas and or in distant rural secondary schools) increases the vulnerability of young people to early onset of sexual activity and or risky behaviour (drug and alcohol abuse, prostitution, unprotected sex, sexual abuse by guardians or strangers etc.).
- Lack of formal provision for the aged and or adults who are not able to engage in gainful employment (there is no pension system for the aged or disabled). This creates a state of deprivation which may result in this group of persons indulging in risky behaviour in order to meet economic needs.
- Lack of formal provision for minor children who are without parents who either have to fend for themselves and or rely on elderly poverty-stricken relatives. The tendency is for such minor children to engage in commercial sexual activity on their own volition or at the instigation of adults in whose care they are in order to survive.
- Poor economic conditions are accelerating the rate at which the extended family system (a traditional haven of support) is disintegrating so that those who are vulnerable and in need can no longer rely on traditional support. In future, it shall not be surprising to find people dying on their own because there is no one to take care of them.

3.4 Socio-cultural Determinants of HIV/AIDS by Different Population Groups

The following are some of the socio-cultural determinants driving the HIV/AIDS pandemic in Zimbabwe:

3.4.1 General social determinants applicable to the entire population

- ***Dissolution of families*** for a variety of reasons e.g. economic problems which promote separation of families while bread-winners leave home to seek employment opportunities; lower moral standards which have resulted in permissiveness and a lower value being placed on lasting marriages;

- ***Increased urbanisation*** in the absence of adequate resources to provide essential social services like housing, education and health facilities. Since the pre-independence influx of rural refugees into urban centres, the trend has not been reversed. If anything, rural to urban migration has increased in the first two decades of independence.

- ***Overcrowding in urban areas*** promotes unhealthy living conditions where diseases like TB spread rapidly. In addition, overcrowding results in deteriorating moral standards (e.g. parents having to share cramped living space with children, relatives and in some cases, non-relations as is the case in the hostels in Mbare).

- ***Loss of parenting and socialising agencies at household level.*** Urbanisation, coupled with the breakdown of the extended family system has resulted in the absence of the "tete/sekuru" or even grandparents who would assist in the socialisation of children. These roles have not been replaced by a readiness/capability by parents to undertake all the social education of their children (e.g. sex education), have not been very successful to date. The demands of modern living where in most cases both parents work out of the home and or where single parenthood has become more the norm than the exception exacerbates the problem of socialising children. Children who are not socialised properly (and turn into under-socialised adults) are likely to adopt moral and behaviour standards which tend to be risky where HIV/AIDS is concerned e.g. alcohol/drug abuse, multiple sexual partners etc.

- ***Weakened traditional safety nets***—Care for the affected becomes a difficulty which in itself increases the vulnerability of children e.g. children being taken out of school to look after sick parents results in a long term problem of adults who are not able to earn enough income to meet their basic needs. Survival mechanisms that are adopted could be very risky e.g. commercial sex work. Weakened traditional safety nets are also increasing the vulnerability of orphaned children who often lack material provision, moral and social support to cope with their situation. The above situation is worsened by the inadequacy (even non-existence) of public safety nets and or a tax regime which encourages support/care for the extended family members.

- ***Inadequate health and social services***—Reduced funding to public health institutions has resulted in the continued deterioration of the quality and quantity of services available to the population. Although a number of private health institutions are being developed, these still fall far short of demand. In any case, such private institutions demand extremely high fees which are out of reach of most people. The section on economic determinants of the epidemic examines this issue in greater detail.

  Public social services (such as public assistance, education, including traditional sources of support like the extended family and the community) have also been negatively affected by the dwindling resources which are available to fund activities in these areas. For institutions, public grants from central and local governments have been in decline both in nominal and real terms since the mid-1980s. For communities and extended families, falling incomes and increasing levels of poverty limit the extent to which help can be extended to those in need.

- ***The problem of stigmatisation of HIV/AIDS*** — Stigmatisation stifles open discussion of the HIV/AIDS problem. Lack of discussion also leads to concealment of the problem so that those requiring assistance do not obtain such assistance on time.

3.4.2 General cultural determinants applicable to all population groups

- *Gender inequities which subordinate women to men.* This has a great influence on the decision-making process regarding sex and the extent to which those with information are able to act on it to protect themselves.

- *Cultural practices like widow inheritance and unsafe male circumcision if perpetuated in this day and age of high HIV prevalence will pose real risk to certain sections of the population.*

- *Cultural and religious sensitivities with regard to sexuality and sexual behaviour.* These tend to promote acquiescence to risky sexual practices and the avoidance of protective strategies like the use of condoms.

- *Problems in eliciting the tacit and/or active support of key influentials like churches* (on moral grounds), the chiefs, headmen and traditional healers (on cultural grounds). Where opinion leaders are not brought on board, the acceptability and sustainability of a programme becomes questionable.

3.5 Specific Vulnerabilities of Different Population Group

3.5.1 The vulnerability of women as a population group

Below are some statistics which tend to suggest that women are more vulnerable to infection than men:—

- In Africa south of the Sahara, there are 6 women with HIV for every 5 men.

- Between the ages 15–24 years, the risk of HIV infection between females and males is 2:1.
- The age distribution of AIDS in Zimbabwe indicates 5 times higher risk of infection in females than males in the age group 15–19 years.

- AIDS cases peak in younger age groups for females than for males.

- Rising rates of teenage pregnancy suggest a young age for the commencement of sexual activity. A number of reasons have been used to explain this trend (*cultural beliefs and practices which encourage older men to seek sexual activity with younger women; dangerous myths like the myth that HIV/AIDS can be cured by having sexual intercourse with a young woman; promotion of early marriages, economic hardship which results in girls accepting sexual activity and or early marriage, breakdown of families which is leading to less supervision of growing children, orphanhood etc.*).

Several factors have been cited as determinants and drivers of HIV infection in women including:—

- Women infected with some STDs like gonorrhoea are unaware of it because they are silent.
- Women have a higher biological vulnerability due to:
  * a larger mucosal surface than men,
  * higher concentrations of HIV in semen,
  * vaginal tearing and bleeding during sex.
- There is a dearth of female controlled barrier methods to prevent infection with HIV/AIDS. Knowledge of and distribution of materials and equipment is rather patchy.
- Competing social roles and demands limit the time available to women to seek health care for themselves.
- High and increasing cost of health and other services reduce access for women because in most cases, they have low incomes and or have no personal income which is independent from the control of a male head of household.
- The burden of care giving places a higher strain on women than on men because women are the traditional care givers.
- Women's low traditional/social status in society in general and in the marriage and or sexual relationship in particular makes it difficult for them to demand safe sex and or abstinence. Their low status and lack of independent means (and sometimes lack of knowledge and education) also results in women having difficulty in seeking early treatment in cases of STD infections. Finally, their low status sometimes forces women to accept the infidelities of their partners.
- Cultural socialisation patterns often do not give women the requisite skills for negotiating safe sex (and many other things that they may require).
- Death of a spouse can lead to undesirable states like being inherited (against their will), becoming poor because of being dispossessed or loss of a bread-winner, depression because of the taboos and social practices surrounding widowhood. This makes such women vulnerable to abuse in social, psychological and emotional terms so that they at times fall victim to situations which expose them to unsafe sex.

- The gaps between traditional customs and official laws tend to exert tremendous pressure on women to comply with the former and such compliance may include accepting situations which will put the woman at risk.
- Some cultural norms which encourage men to be macho and to be always in the lead (and therefore knowledgeable position) act as a barrier for men to admit any gaps in knowledge they may have regarding matters of sexuality and diseases. They may then continue to act as if everything is fine even when they may have niggling suspicions that something may not be quite right with them. By so acting, they may very well be putting their partners at risk.

Obstacles to change

There are a number of obstacles to changing the position of women in a way which would reduce their vulnerability. These are:

- There is a rise in the number of female-headed households in a mainly patriarchal society. Limited levels of education and limited access to productive assets mean that such female-headed households tend to be poorer than those households headed by men. Poverty is a major factor in rendering a population vulnerable to HIV/AIDS in terms of being infected and in terms of limited capacity of obtaining needed help.
- Utilisation of services is modulated by cultural beliefs, levels of knowledge and awareness as well as costs in terms of money and time—women have a limited capacity for many of these determinants.
- Women may lack information to enable them to recognise early symptoms of STIs as well as making informed decisions regarding pregnancy, nutrition etc.
- Women's low social status often makes it difficult for them to challenge negative cultural norms and or influence change in their favour at individual and at social levels.
- The negative perception of women's lobby groups as being dominated by Western ideology and less than ideal role models within the lobby groups (activists in this area tend to be divorced, widowed, single parents etc.) limit the effectiveness of such lobby groups.

3.5.2 The vulnerability of youths

Below is a summary of some of the determinants and drivers of the HIV/AIDS pandemic among young people:—

- A large proportion of new infection is in the 15–24 year age group. Youngsters account for up to 60% of all new infections. This suggests a high level of vulnerability which can be attributed to some of the following:

* Average age for first sexual intercourse is 16.6 years for boys and 17.6 years for girls. Sexual encounters are usually with older persons who are very likely to be infected;

* A recent study shows that about 53% of the youth surveyed did not use protection in the last sexual act. This may be a result of ignorance, negative beliefs/traditions (e.g. "a bull is known by it's scars" therefore it is manly to have had episodes of STI), poor access to protective measures like condoms due to poor distribution and or an unfriendly environment which makes it difficult for young people to seek help and the services they require;

* In the age group 15–19 years, females have a 5 times higher risk of HIV infection than males; female infection peaks at 14–23 years and male infection peaks at 24–33 years.
* Partner turnover is high during adolescence and its serial monogamous nature may give a false sense of security.

- The rate of mother to child transmission is currently at 30%.
- There is a high rate of increase in the population of orphans under the age of 15 years (risen from an estimated 15 000 in 1990 and projected to reach 1 000 000 by the year 2005). Orphans are vulnerable because of their heightened tendency to fall into poverty, likelihood to being a target for physical/emotional/psychological/sexual abuse by adults (who may be relatives or otherwise), and the absence of moral/spiritual support.
- Death peaks in the 0–4 years and 30–39 year age groups resulting in the loss of socialising agents.
- There is an increase in child-headed households.
- Pregnant teenagers are more likely to be HIV positive than other teenagers in the general population.
- Trends which show that population growth is being moderated by increase in infant and child mortality rather than a decrease in birth rate is indicative of the extent to which young people, especially those under 5 years, are vulnerable to HIV as a result of vertical transmission. A worrisome trend is the increased number of reported cases of sexual abuse of minors below the age of five years. Such a trend is being explained by the breakdown of families and the extended family system (which results in loss of reliable/trustworthy care for children), a declining moral climate and the absence of adequate protective services for children.
- There is an increasing burden of caring for sick family members, especially for the girl child.

- Breakdown of the traditional socialisation agency of aunts and uncles deprive young people of a reliable, safe and loving source/environment for learning about human sexuality and safe sexual behaviour. There is lack of clarity and commitment to a suitable replacement to the system so that a void remains. Both parents and the education authorities are not agreed on the extent to which this socialisation process should be a part of the normal educational curriculum.
- Parents feel unable to communicate openly and adequately about sexual issues with their children. This leaves the children vulnerable to influence from dubious sources of information. The parents' feelings of inadequacy may stem from the fact that they themselves are not fully informed on the subject and yet they are reluctant to support the creation and development of a non-family source of education on human sexuality like the public education and or health system.
- Exposure to other cultures through the mass media and other cultural events is undermining traditional norms.

Below are some of the obstacles to reducing the vulnerability of young people:—

- There is a large gap between what the youths want and need regarding HIV related information and services and what society/government is prepared to allow.
- Proscription against the provision of barrier methods to those under the age of 16 years without parental consent (especially for girls) continues to limit the level of access to protection for young people who are sexually active.
- Young people have a high sense of invulnerability due to their lack of information. This is exacerbated by the inherent tendency of wanting to experiment by young people.
- Lack of youth friendly services including counselling and provision of sensitive health services e.g. STI treatment.
- Peer pressure and emotional need to belong result in dangerous trade offs and priorities.
- Cultural and religious reservations about sex education.
- Sex education is deemed sensitive and controversial.
- Double standards for boys and girls in relation to responsibility, virginity etc.
- Gender imbalances in terms of equity in accessing educational opportunities.
- A significant percentage of youths are out of school and thus lack access to information on HIV/AIDS. High unemployment and the lack of suitable recreational facilities/programmes results in risky indulgences like abuse of alcohol and drugs under whose influence the capacity to practice safe sex diminishes.
- Youth poverty is on the increase and yet it is not regarded as a serious policy issue to warrant a serious attempt at improving youth capacity to secure gainful employment in the formal and informal sectors e.g. the provision of adequately equipped and staffed vocational training institutions.
- School curricula are seen as already too overcrowded to accommodate additional content like sexual education. Where HIV prevention and sexual health education exists in the curricula, it is heavily loaded with information at the expense of skills.
- Many of the teachers, trained through the cascade model, lack confidence to teach life skills. Some teachers are themselves not acceptable role models morally and behaviourally.

3.5.3 Vulnerability of workers

- ***Education, training and information dissemination*** — Great strides have been made in educating, training and disseminating information to employees in some parts of the formal sector. There are some who remain behind (e.g. the public service in general [including the local government sector]). The informal sector has however not been specifically targeted for education, training and information dissemination. This is because of the informality, transient and mobile nature of employment in the informal sector. And yet because of the informality and the general uncertainty of the conditions within which they work, informal sector workers are quite vulnerable to HIV infection.

  The informal sector is generally characterised by low levels of income and this negatively impacts the extent to which households which depend on this sector can raise the money required to pay for health services and or even purchase insurance cover (medical and life assurance).

  Because of informality, the informal sector also tends to be a hot bed environment for the flourishing of myths which promote unsafe sex practices. The dearth of correct and adequate information only serves to exacerbate the situation.

- ***Mobile occupations***— by their very nature, mobile occupations create conditions that increase the vulnerability of workers. Typical mobile occupations are in the uniformed services (army, air force, police, prison service, long

distance truck driving, travelling sales repping, infrastructure development crews, etc). Some of the conditions which increase vulnerability are:—

* Long periods away from family, especially spouse, generates loneliness which can lead to indulgence in alcohol and or drug abuse. Such indulgence may then diminish one's sense of responsibility and could very well result in one being involved in unsafe sex;
* Spouses who remain behind on their own can become lonely and or become overwhelmed by family responsibilities that they will find solace in extra-marital liaisons which can result in unprotected sex;
* There is a tendency by mobile populations of workers to establish relationships with local populations. Such populations may not be large enough to meet the needs of workers so that individuals can have multiple partners. When one part of the chain is infected, infection can rapidly spread to the rest of the chain;
* Because of their mobility, it is difficult to reach mobile workers with educational programmes whose design is based on the needs and characteristics of static populations.

- ***Management of time off/sick leave***—medium to large scale companies and the public sector tend to have well developed human resources management policies which make provision for various types of leave. Sick leave conditions can be quite generous although they fall short of the needs of those affected by HIV/AIDS, a disease with long periods of illness and many opportunistic infections. However, small companies and those operating in the informal sector do not have paid leave provisions. This leads to a sense of insecurity and a fear of losing one's job if one took time off. The rest, which is necessary for those who are affected, therefore becomes a problem.

  Those affected tend to avail themselves of services from traditional healers who are not recognised as persons who can authorise sick leave. Some employers have begun to tolerate situations where a person takes leave to be attended by a traditional healer. There is however no national standard which stipulates how attendance at a traditional healer should be treated in terms of sick leave provisions.

- ***Provision and financing of medical care (on site and off site, including at home)***—Except for a few employers (large private sector companies and the uniformed forces), the general trend is that employers do not provide on site medical care facilities. The only provisions in this direction are medical aid facilities to which most employers make a contribution. However, such an approach is rather inadequate given the quality and cost of care in both public and private institutions.

  HIV/AIDS is a long-term disease whose institutional costs discourage long term institutional care. The alternative is Home Based Care. Few employers, if any at all are giving material/financial/moral support for home based care programmes.

- The absence of adequate funding of institutional and home care by employers creates difficulties for the management and mitigation of HIV/AIDS among those who are lucky enough to be employed in a formal job.

- ***Discrimination***—Just like stigmatisation and ostracism occurs in the general population, there is not yet a full acceptance of the affected in the work place. However, little information is available on what is taking place and the magnitude of the problem. This is an issue which requires research so that interventions are based on objective information

- ***Confidentiality***—There are some employers who still demand disclosure of HIV status before employment or deployment on particular duties. Uniformed forces have been quoted as engaging in this practice. Once again, there is not enough research which has been undertaken to establish the extent to which employers demand to know a person's HIV status and use this as a basis for employment conditions and or progression for a particular individual.

- ***Protecting the interests of the employer***—loss of productivity (reduced capacity of a sick employee or outright absence), increased costs of providing for medical aid, pensions and loss of skills is of major concern to all employers. There are no coherent national policy guidelines to assist employers to mitigate these problems in a manner that would continue to protect the interests of both the employer and the employee. For example, there are no clear guidelines to assist employers to undertake manpower planning (succession, skills transfers, cross training, job overlapping) and human resources management and development strategies which enable employers to retain adequate skills, especially for the highly specialised areas. A good database on the manpower situation at national level would go a long way in improving the quality of human resources planning by employers.

3.6 Favourable Trends and Situations which Provide an Opportunity for a More Effective Response to the HIV/AIDS Pandemic

The discussion on the economic and socio-cultural determinants/drivers of the HIV/AIDS pandemic in Zimbabwe would suggest that there is only gloom. Indeed not, there are some trends which provide new opportunities which when exploited would result in a more effective response to the pandemic. These are summarised hereunder:

3.6.1 Opportunities in the economic sector

New opportunities have arisen from the work which is being carried out to reduce poverty in Zimbabwe. These opportunities are outlined below:

- A landmark survey on poverty in Zimbabwe completed in 1995 and the subsequent district poverty notional maps provide a detailed picture of the extent and characteristics of poverty in Zimbabwe. Plans to update this information and establish an Integrated Poverty Monitoring and Analysis System are very much advanced so that it will be possible to always have a clear picture of the poverty situation in any given locality. Such information goes a long way in the correct targeting and siting of programmes to assist poor communities to cope with the problem of HIV/AIDS. For instance, when considering resource allocation for Home Based Care and or community support structures, it is essential to set priorities given the poverty levels of a given locality.

- There has been a lot of work done to advocate and lobby key policy makers so that they can accept to integrate poverty reduction policies, strategies and programmes to their core mandates. This helps to increase the levels of resources available to fight poverty because a budget line is created once an issue as part of the core mandate is created. Through this work, it will be possible to obtain more local resources for dealing with the material needs of affected families.

- Currently, there is a Poverty Alleviation Action Plan and a Community Action Project (being funded by the UNDP and the World Bank respectively) whose aim is to empower communities to initiate and undertake community development to improve their quality of life. Already, a Home Based Care group in Matabeleland has been funded through this programme. The PAAP and the CAP offer an opportunity for more resources and the ultimate aim is to improve infrastructure and income-generating capacity at community level.

- The Ministry of Public Service, Labour and Social Welfare has approved a community based care policy for orphans and children in difficult circumstances. This policy lays out a framework for responding to the orphan problem and gives guidance and impetus to resource mobilisation for orphan care.

- There is a clear recognition and acceptance by government that rural infrastructure needs to be upgraded in order to stimulate the rural economy. This will result in better access to health and educational facilities while movement becomes easy. This work is being enhanced by the Rural Development Fund which was established in 1998.

- Work is currently being undertaken to improve the efficiency and resourcing of the public safety nets so that targeting and access are improved.

- The current capacity building programme for Rural District Councils will improve the capacity of RDCs to provide essential social services to the community—quality and accessibility are key issues for the RDC capacity building programme.

- While the RDCs (staff and elected officials) are in a learning mode because of the capacity building programme, an opportunity exists to influence them to take on board HIV/AIDS as not just a health problem, but also as a social and economic problem. The capacity building programme also provides an opportunity for influencing attitudes, behaviours and cultures of the RDC leadership and this will have a great impact at community level. For instance, during training sessions, matters relating to the socio-cultural and behavioural aspects to HIV/AIDS prevention and management can be discussed.

- Insurance companies have made a hesitant start to providing investment packages as opposed to insurance/assurance packages as a means of providing a channel for savings available to all regardless of HIV status. This is a trend which has to be exploited and further developed.

- There are many NGOs who are committed and are very much involved in poverty reduction activities. Such NGOs can be a source of support to community effort to assist the affected. In particular, work being done to promote Small and Micro Enterprise development provides an opportunity for income generation for affected individuals and their families.

3.6.2 Opportunities at the general social level

- ***Decentralised Public Health System.*** There are about 1 200 primary care centres country-wide so that most households are within an average of 8 km or less from a health facility. This provides a sound infrastructure which when properly staffed, equipped and stocked would enable people in need to access the help they require at the right time.

- ***High levels of commitment to fight the HIV/AIDS problem.*** There are over 60 international, national, governmental and non-governmental organisations which have committed themselves to the fight against HIV/AIDS. How

ever, as discussed in the section on management issues, these efforts have to be well co-ordinated in order to optimise resource deployment/utilisation while sending out consistent messages which remove possibilities of confusion on the part of the receivers of the message.

- ***Strong tradition of in-service training***. In all the organisations which are fighting the HIV/AIDS pandemic, there is a strong tradition of in-service training which has not only imparted information and skills, but has also proved to be a strong source for discussing and propagating new strategies and practices for fighting against the disease. Good examples are: *HIV/AIDS counselling, syndromic treatment for STD which has been widely adopted, National Guidelines for treating TB (DOTS) and other opportunistic infections.* The net effect has been greater facilitation of access to information, services and treatment by a wider cross-section of the affected population.

  In-service training is not confined to health personnel only nor has it been confined to those in traditional occupations. In-service training has been extended to all sorts of occupations (e.g. traditional healers, traditional midwives, commercial sex workers, long distance drivers, teachers in the education sectors, etc.) and this has helped to equip people with the basic information they require to spread information within their own population groups.

- ***Greater media attention of the HIV/AIDS pandemic***. This has improved the dispersion of information to the entire population.

- ***EDLIZ (Essential Drugs List of Zimbabwe)*** that provides a list of essential drugs to be used for particular conditions has promoted a culture of careful prescriptions. This is very important in an environment of high drug costs and shortages.

- ***Tradition and capacity for multi-sectoral collaboration***. This lays a good base for promoting a multi-sectoral approach to the fight against HIV/AIDS. The section that deals with management issues describes how this opportunity can be exploited to great advantage.

3.6.3 Opportunities for women

⇒ There is an increasing number of women who are now accessing tertiary education and these can use their new found capacity to make the right decisions while agitating for a better deal for those who have not been fortunate enough to receive such tertiary education. This can be complemented by the trend of more and more women occupying managerial/leadership positions which makes them influential.

⇒ The decentralised PHC system has great potential for integrating HIV/AIDS prevention and care services into existing services such as MCH and family planning.

⇒ Syndromic treatment protocols of STD exist which can be capitalised on through increased training, supply/provision and improved access to treatment.

⇒ The home based care concept provides an opportunity and channel for education/training, resource provision, attitude/behaviour change, positive influence on customs and traditions surrounding the care of the sick as well as the management of bereavement, etc.

⇒ The area of paedriatic HIV/AIDS is one area where solid evidence exists for efficacious interventions which have potential for affordability.

⇒ There is an increasing receptivity among certain traditional opinion leaders with respect to changing harmful cultural practices like widow inheritance, appeasement of *ngozi*, early marriages, polygamy etc.

⇒ Presence of women's lobby groups with potential for outreach work and the inclusion of "inside opinion leaders and peers".

⇒ Many families want to have a healthy baby and are therefore ready to pay for services which reduce mother to child transmission as well as being more receptive to information and counselling.

3.6.4 Opportunities for youths

- The majority of youth are in school up to the age of 16 to 18 years—educational programmes could be targeted at them.
- The peer education concept has high acceptability among youths and is supported by education authorities. Anti AIDS clubs have high acceptability and are beginning to take root.
- Children are highly valued in families, communities and society. Well designed programmes which deal with cultural sensitivities are likely to receive support.
- Advocacy groups lobbying for the upholding of children's rights have been important in influencing societal change e.g. in areas of upholding the rights of children, especially the girl child (e.g. the relegation of the practice of appeasing *ngozi* through the offering of young girls).
- Traditional leaders are increasing their support for orphans. Their capacity to mobilise communities (e.g. zunde ramambo) is a key resource to the formation of community resources for supporting orphans at material, social, emotional, psychological and spiritual levels.
- Potential role models exist in fields appealing to youths e.g. sports and entertainment.
- Ministry of Education, Sports and Culture (with support from UNICEF and other donors) has incorporated HIV/AIDS education in the curricula from Grade 4 upwards.
- Department of Social Welfare has a policy on orphaned children which should now be implemented with adequate supervision.
- More and more religious communities are running youth programmes.
- Youth oriented organisations like scouts, brigades, Jaycees etc. exist and provide another avenue for disseminating information and provide training in life skills.

3.6.5 Opportunities for workers

- The increased willingness by employers to be involved in the provision and funding of prevention activities (e.g. IEC at the work place [a most notable programme is that of the transport industry run through NECTOI, the programmes by the uniformed forces etc.], distribution of condoms, peer education programmes) and mitigation in terms of providing and funding medical services for the affected workers.
- The development and adoption of the statutory instrument on AIDS and employment.
- The ZCTU together with employers' organisations have undertaken research to assemble information on the HIV/AIDS problem in the work place.
- The harmonisation of all labour legislation under one Act to cover all workers from the public and private sectors.
- A group of employers have expressed a desire to work with NGOs who are able to offer care and support for the affected who are discharged from institutional care. These NGOs are therefore now being challenged to develop the right kind of capacity to be able to link up with the employer initiative: the NGOs would be the service providers while employers would reimburse the NGOs for their expenses. This opportunity could also make a significant contribution to the financial base for NGOs thus reduce dependence on external donations. If the programme works well, it can also provide a model in which even individuals would be able to access home care services at affordable cost.
- Establishment of private nursing homes is a trend which is providing an alternative care for those who have been discharged from hospitals. This has been a result of the relaxation of municipal by-laws that are now permitting the establishment of such facilities within the community. Deregulation is therefore creating an environment that is spawning creative solutions to the problem of care for the terminally ill who cannot be accommodated in hospitals.

4. RESPONSE ANALYSIS

This section characterises the national response to HIV/AIDS to date and lists some of the key institutions/actors who have been spearheading that response. The section also examines the following:

- The effectiveness of various responses
- Gaps in the response to HIV/AIDS to date
- Obstacles which have to be addressed
- Opportunities which have arisen which can improve the effectiveness of the national response to HIV/AIDS.

4.1 RESPONSE WITHIN THE VARIOUS SECTORS

4.1.1 Fragmentation

There are a number of actors who are responding to the problem of HIV/AIDS in the public and private sectors and these are listed hereunder:—

- Government ministries e.g. Health, Education, Agriculture, National Affairs, Department of State in the Office of the President on Gender
- Local authorities (urban and rural)
- Private health sector including mission run health institutions
- NGOs and CBOs
- Local communities and their traditional leaders
- Donor community
- Research community including special research programmes by universities.

Although all the above actors act in consultation and collaboration, there is no formalised framework for co-ordinating the national response to HIV/AIDS. This results in duplication, competition, overlapping and a less than optimum approach to the deployment of resources for fighting the HIV/AIDS problem.

All those who are responding to the HIV/AIDS pandemic have accumulated a lot of information which could be of greater impact if such information were pooled, analysed and used as an important ingredient in programme planning.

The fragmentation that exists at national level is translated through the provincial, district, ward and village levels. This fragmentation has resulted in situations where some communities are well covered by the different actors while some areas are neglected. The issue of fragmentation has therefore to be urgently addressed.

The National AIDS Co-ordination Programme (NACP) has over the years co-ordinated HIV/AIDS prevention and control efforts. With the AIDS epidemic having matured, such efforts are proving inadequate with the situation calling for a strong and sustainable multisectoral involvement. The NACP as constituted does not have the appropriate mandate, capacity and authority to effectively fulfil the role of stimulating and sustaining a strong multisectoral involvement in response to AIDS.

Preparations are however now advanced for putting in place a National AIDS Council/National AIDS Foundation with the responsibility of providing overall leadership, policy direction, guidance and co-ordination to the national response to HIV/AIDS and ensuring effective social and resource mobilisation to combat the epidemic. This is an opportunity which has to be exploited during the period of this proposed strategy.

4.1.2 Lack of a shared vision and approach in responding to the pandemic on a multi-sectoral level

The structural fragmentation which has been described above can be regarded as one of the reasons why to date, there has been little in terms of a shared vision on what the best strategy for responding to HIV/AIDS is. All programmes/projects are designed to deal with the problems based on the resources and capacity of a given set of actors. In addition, funding of most activities has been through foreign grants with a very small fraction of the total funding coming from local sources. Each grant making entity tends to influence programme design and implementation in ways which are meant to enable the grant making institution to accomplish its own goals. In the absence of a proper co-ordinating mechanism at national and local level, such goals of funders can be quite disparate. Another danger is that development agendas are set outside Zimbabwe based on information and knowledge which may not be fully in line with what is happening on the ground. Resultant programme content, design and strategy may achieve less than optimum effect/impact of the programme. In any case, a fragmented and unco-ordinated view of the HIV/AIDS problems tends to spawn a situation where some outdated strategies/practices continue to be implemented.

4.1.3 Over-reliance on voluntarism in providing services for the affected

As already indicated above, resourcing of the HIV/AIDS response has tended to overly rely on external sources. Added to this, most of the actors, especially those in the private sector, rely on volunteers more than full time paid personnel to deliver services to the affected. This is very much evident in the NGO, CBO and community sector where volunteers are the bedrock of the people who deliver services to the affected. For those in the public sector, there are many cases where staff concerned have to be prepared to put in extra time and other resources in order to cope with the demands that are placed on them. For instance, rural health personnel have to work long hours and travel long distances without compensation in order to be available to the communities which need their attention.

Reliance on voluntarism in the absence of clear and sustainable motivation and compensation strategies puts the HIV/AIDS response in a precarious position—burn out and fatigue are a threat which have to be faced every day and yet there is no coherent strategy or system to respond to such an eventuality. It is therefore important to have a sound national strategy and framework for promoting and managing voluntarism.

4.1.4 Community organisation

The community response to HIV/AIDS is proving to be a robust strategy for providing services and support to the affected and their families. However, this approach has not been well studied with a view to strengthening the response. Another problem is the scarcity of resources (money, materials, equipment, knowledge and techniques) which can empower communities to effectively respond to the problem of caring for the affected, including the orphans.

Rural areas appear to be better organised and more amenable to community support for affected persons and their families. In urban areas, community responses are being promoted in the high-density areas while in low density areas, little much appears to be happening. The population profile of low density residential areas is such that while the majority are property owners with reasonable economic means for coping with the cost of HIV/AIDS, there is a sizeable population of domestic workers who are also affected but have a poor economic base for dealing with the problem. In any case, the moral and psychological support which is being felt from the community groups in high density areas, would also be needed for both high and low income families in the low density areas. An opportunity therefore exists to promote a strategy which appears to be working, albeit needing improvement, for families in the high density and rural areas.

4.1.5 Invisible role of the local government sector

The local government sector has responded mainly through health institutions and schools. The health institutions provide clinical services for the affected. A number of local authorities have also embarked on the promotion of the Community Home Based Care strategy. However, the response of the local government sector is not well integrated into the national response at the political level. Since the community response to HIV/AIDS can only be strengthened if there is sound leadership, resourcing and collaboration by the political levels of the local government sector, it is important for this sector to be integrated into the national response. Failure to do so will result in an ineffective response.

4.1.6 Inadequate participation by the private sector

As already seen from the section dealing with employment and economic issues, the private sector has a role to play at the following levels:—

* Provision of employment opportunities which enable the affected families to earn a reasonable income.

* Provision of health and pension facilities which assist affected persons to meet the cost of basic needs for health, education, clothing and shelter.

* Provision of a working environment which provides physical, psychological and emotional security for the affected as well as those who are not affected.

* Contribution of resources (funds, expertise, equipment, space etc.) to the national effort.

* Complementing the health services and other services (e.g. counselling, home care, affordable institutional care etc.) which are already being provided by public and community based institutions.

* Influencing the pension and insurance industry to design and promote new products and services which meet the needs of the affected without jeopardising the interests of those not affected.

The private sector has been quite active in the above areas. However, the level of response falls far short of the demand which is in the communities they are serving and those which they could potentially serve. Any part of society which is not reached means that infection continues to occur at a high level with the plight of the affected not being mitigated. Greater involvement of the private sector should therefore be promoted and integrated into the national response in order to optimise resources and strategies.

4.1.7 Poor functioning of the public safety nets

As already described in an earlier part of this document, poverty is a pervasive problem in Zimbabwe which continues to be on the increase. In the past, government and local authorities have attempted to provide welfare assistance for those in need to pay for such needs as food, clothing, health, shelter and education. However, dwindling public finances have resulted in the reduction of the extent to which the public sector is able to provide welfare assistance to those in need. In fact, during 1999, the SDF (which had been the channel for a considerable amount of assistance with school and health fees) suspended its operations in this area due to a lack of funds. Even where funds have been available, the administration system has been complex, bureaucratic and inaccessible so that those in real need have found it difficult to get the help they require at the time and place they require it.

The poor functioning of the public safety nets is of great concern since HIV/AIDS is a long term problem for the sufferer, his/her family and those who survive (orphans and elderly grandparents who have to take on the burden of support). Without appearing to be favouring those who are affected, there is need for the public welfare assistance system to be revamped and to be re-capitalised in a manner which will assist those in greatest need while making a contribution to community efforts.

4.1.8 Programme administration

- Where programmes have been financed largely through donor funding, there remains uncertainty about the sustainability of such programmes. Such uncertainty promotes a short-term view in planning which is not necessarily strategic. In the long term, resource deployment becomes inefficient with the result that programme effectiveness is negatively affected.

- Current STI programmes for example, are arranged in a vertical mode with little activity to empower every level. This vertical arrangement reduces the extent to which long term sustainability can be developed in the health delivery system. For instance, there is no capacity at provincial and district levels to really characterise their situation vis-a-vis the epidemiology of STI and HIV infection.

- Facilities (time, space and systems for privacy, well endowed health care workers etc.) which are currently provided for STI management are not conducive to promoting more timely health seeking behaviour by those in need. Inadequate facilities and resources also militate against comprehensive STI treatment and counselling.

4.2 Response in Terms of Resource Provision/Availability

4.2.1 Dominance of donor funding

It has been observed that the national response to HIV/AIDS, especially in the areas of prevention and mitigation, is very much dependent on foreign donor funding which forms the larger proportion of the financing compared to local resources. For example, most of the activities spearheaded and co-ordinated by NACP and those of various NGOs and AIDS Service Organisations have relied heavily on multilateral and bilateral donor funding. As already mentioned, there are a number of risks associated with this state of affairs:—

* Priority setting, strategy formulation and programme implementation is very much influenced by the goals of the grant makers. In the most part, these goals are very much compatible with the national needs for responding to HIV/AIDS. However, some needs of the grant makers can be at variance with local needs so that programmes become less effective.

* Funding cycles of 2, 3 or 5 years have tended to promote a short-term view and yet HIV/AIDS is a long-term problem. Dealing with problems such as behaviour change, socio-cultural change, long-term solutions to the care and support for the affected including orphans, therefore becomes problematic.

* Grant making capacities are dependent on capacities and strategies of the host countries and are quite vulnerable to changes in political and economic situations. Obtaining assistance on a sustainable basis therefore becomes vulnerable to change at inopportune moments. The result can be quite negative in terms of delays and or even abandonment of some programmes and strategies.

Over-dependency on donor funding therefore poses a threat to the consistent and coherent planning and implementation of a co-ordinated national response. The result is ineffectiveness.

Having said this, however, it must be acknowledged that the government of Zimbabwe, through the MOHCW, has made increasing financial outlays to meet the rising costs associated with AIDS morbidity. The treatment of HIV/AIDS is expensive and requires a considerable amount of resources. CIMAS medical aid society estimated that the average direct cost of caring for a person with HIV/AIDS disease had increased to about Z$7 220,00 by 1996.

Assuming that the costs of care were to remain at about Z$7 220,00 per case (in constant Z$), and assuming that about 70 percent of AIDS patients received care, then expenditures would rise to Z$819 million in 2000 and Z$1 261 million in 2005. By contrast, the entire MOHCW budget for all health services equalled about Z$1 810 million in 1997, or about Z$165 per capita. If that per capita expenditure continued over time, the MOHCW health budget would be Z$2 005 million in 2000 and Z$2 105 million in 2005, so that about 60 percent of the entire budget would be required just to meet the needs of AIDS patients excluding antiretroviral therapy.

Health staff estimate that in 1999 as much as 50–70 percent of bed occupancy in some government hospitals was the result of HIV/AIDS. It is projected that this demand will be 2.3 times higher over the next ten years if the epidemic continues unabated and perhaps as many as two out of every three available beds would be occupied by AIDS patients.

Such a scenario calls for greater allocation of resources, both monetary and material, to meet the increasing costs and needs associated with HIV/AIDS. The government has therefore to increase budget allocations to those sectors playing a role in HIV prevention and control.

4.2.2 Differing value systems which drive the response to the pandemic

Without co-ordination and a unified vision and value system, it is very difficult to ensure that the manner of responding to the HIV/AIDS pandemic is consistent and complementary. For instance, churches, NGOs, political parties, donors, the private sector are all driven by different value systems. Too much diversity can result in contradictions which can give the wrong signals to society (e.g. issues surrounding sex education for young people, preventive strategies like use of condoms, cultural practices such as circumcision as part of rite of passage for males, etc.) and actually undermine the work that is being done by different sectors.

4.2.3 Unexplored local capacity for the provision of resources

There is a pervasive belief that local sources cannot be relied on to provide substantial resources to fund the national response to HIV/AIDS. As a result, little effort is being made to mobilise local resources. Apart from the failure to get at the potential resources which are available, such a perception promotes a sense of not being responsible/needed in the national response on the part of the various local sources which can be tapped into. There is also a possibility that failure to galvanise the local community to act could result in locals failing to own the problem and therefore taking action other than resource provision to curb the spread of HIV. Local resource mobilisation should therefore be pursued not only for the resources, but also as a means for promoting the full local ownership of the problem as a way of getting people to change their risky behaviour and taking any other action which is needed to curb the negative impact of HIV/AIDS.

4.2.4 Resource shortages (people, equipment, materials, transport, skills, information, funds)

The response to HIV/AIDS (whether by government, local authorities, NGOs or the private sector) is characterised by a shortage of resources. Practitioners have to do with the bare necessities and sometimes there is nothing. Inadequacy of resources results in the quality of service being compromised while the safety of workers is put at risk.

4.2.5 Inadequate government funding in the short to medium term

Government resources are channelled through public health institutions and social service providers like Ministries of Labour and Social Welfare, Education, Local Government and National Housing, National Affairs. It is widely accepted that these ministries are under-funded and are therefore hard-pressed to deliver services under the core mandates. HIV/AIDS is yet to become part of the core mandates of government ministries as employers and as service providers. However, during 1999, the government of Zimbabwe introduced an AIDS levy on all taxpayers. The money collected is being placed in an AIDS Trust Fund which shall be administered by the newly established National AIDS Council. These funds represent a significant move by the government of Zimbabwe to specifically set aside financial resources which will be dedicated to the fight of HIV/AIDS in the country. Although funds collected through the AIDS levy will be quite substantial, they fall short of the total requirement for money to fund the national response to HIV/AIDS. Other sources of funds will therefore remain important.

4.2.6 Challenge of resourcing community based responses

There has been a concerted move towards mobilising communities, especially in the rural areas and low-income urban residential areas, to respond to the HIV/AIDS pandemic by providing support (material, spiritual and moral) to affected persons and households. Communities have been forthcoming and formed structures to respond. The major gap and challenge now being faced is the lack of a clear resourcing strategy for the community response, especially CHBC, in order to put it on sustainable footing.

4.2.7 Self reliance for the families of the affected

Because of its long term duration, HIV/AIDS tends to impoverish the affected and their families. A lot of resources are needed to pay for treatment, food, clothing, shelter and education for the children. However, by the time a person comes to die, they are likely to have lost gainful employment and exhausted any savings they may have had so that there is little or no money to pay for the needs of the patient as well as those of the family. If one looks at the national poverty statistics, the majority of Zimbabweans are poor and are living below the poverty datum line. It therefore stands to reason that those who are affected by HIV/AIDS are likely to have been poor even without falling ill. It is therefore not surprising to see sick people living in squalor, without food, adequate clothing and bedding. Trends are showing that schoolchildren whose parents are afflicted experience difficulty in paying for the requirements of schooling.

The challenge is to provide opportunities for the affected and their families to enable them to maintain a reasonable income-generating capacity so that they can pay for their requirements. This is a challenge which the general population is having to grapple with. The challenge is much bigger when looking at the plight of those affected by HIV/AIDS because they have to start from an impoverished and debilitated condition.

4.2.8 The challenge for orphan care

Most orphans are finding themselves in the care of elderly relatives and or have to fend for themselves. This poses a great challenge in terms of providing money for the purchase of basic needs because of the huge numbers which are involved. In the absence of proper statistics, it is difficult to quantify the problem and thus provide a sound base for planning effective strategies.

Failure to assist orphans renders them vulnerable to HIV/AIDS because they may have to engage in commercial sex work in order to obtain money. Because of their age and vulnerable social position, orphans are also not able to fend off the physical, mental and sexual abuse from predators who may even be part of their own kith and kin.

4.3 The Response in the Health Sector

Work in this area has been geared towards prevention and mitigation of HIV. A number of actors have been involved and resources have been provided from different sources. Both the public and private sectors as well as the civil society have engaged in work aimed at reducing the incidence of the disease while offering support and care for the affected. Government, local authorities and donors have come together to provide resources for this work. Below are specific programmes and activities which have been undertaken:

- A lot of work has been done to improve STI management through the upgrading of personnel. One successful programme has been the World Bank/DfID funded programme which provided resources for training 1 000 nurses (out of a target of 2 000) and 60 doctors at GU centres. In addition, 12 doctors have received specialist training in the UK.
- STD management protocols and flow charts have been produced, are being used and are being updated every 2–3 years. These protocols and flow charts are available throughout the country. In addition, collection of statistics on STIs is being undertaken at all health institutions, including rural health centres. This has gone a long way in improving the quality of information available for planning and evaluation of the effectiveness of various interventions which are being undertaken.
- Currently, there is a major programme to train the rest of the health workers in the Syndromic Management of STIs. It has been proven that early treatment of STIs has a significant impact in the reduction of vulnerability to infection by HIV.
- Improved promotion, distribution and education on condoms has increased condom uptake significantly.
- Activities by the National Blood Transfusion Service (e.g. pledge 25, donor self deferral counselling, targeted recruitment of donors) have gone a long way in achieving the objective of providing safe blood for transfusion.
- HIV/AIDS campaigns have sustained awareness at very high levels. Channels for IEC are very well established and are also acting as sources of information for other matters like orphans and the situation of the affected. These activities are being well supported by various parts of the community.
- UNFPA has provided support for the integration of HIV/AIDS activities in reproductive health and MCH projects and in particular, has strengthened the training of health workers in counselling techniques.
- New policies have been developed to give guidance to activities e.g. the National AIDS Policy, a school health policy, guidelines on infant feeding as it relates to HIV.

There are some gaps in the health sector response to date which need to be addressed including the following:

- Traditional healers are providing health care for those who are not able to afford and or access formal health facilities. In addition, there are some who prefer to be attended to by traditional healers because of their cultural beliefs. However, there is no clear strategy for integrating traditional healers in programmes which have been mentioned above. Contact with traditional healers has tended to be relegated to IEC activity and yet traditional healers could be classified as health workers whose skills and knowledge have to be upgraded and updated periodically. ZINATHA provides a channel which could be used for collaboration on this matter.
- Some districts in collaboration with the Department of Psychiatry—initiated "Traditional Healers Project" have successfully undertaken activities to train traditional healers in infection control, counselling and the challenging of retrogressive cultural norms. This presents an opportunity of a practice which could be replicated at all levels throughout the country.
- There are some successes in palliative care (e.g. dietary/nutritional strategies). However, little has gone on to document and further research such successes as a means of fully integrating such practices in the care and management of patients. For example, FACT has published dietary guidelines which have been effective but these are not available throughout the country.
- HIV/AIDS is not mainstreamed into the activities of those public sector organisations (government departments, local authorities etc.) whose core activity is not health.

The absence of a clear strategy for dealing with problems like burnout of staff. HIV/AIDS management is very demanding and drains people physically, emotionally and psychologically. The human misery experienced during periods of illness, the hopelessness of some of the bereaved and the poverty of the affected can test the constitution of even those with high stamina. Service providers have to be looked after not only in terms of protection from infection, but also from the psychological demands of the work they have to undertake.

4.4. The Response in Socio-Cultural Terms

The work that has been undertaken in this area has aimed to aid prevention through improved levels of awareness on the one hand. On the other hand, activities have been geared towards providing care and support to those who are discharged from institutional care. Some specific activities have been:

- The mainstreaming of gender issues has resulted in government ministries establishing gender focal points and some ministries have engaged consultants to initiate action in this area. This sets a precedence which could be followed for strengthening the HIV/AIDS focal points which have been established which have not done as well as the gender focal points due to lack of commitment and resources.

- Many communities have embarked on initiatives to mitigate the impact of HIV/AIDS e.g. Home Based Care groups, orphan support groups and projects, *Zunde Ramambo* etc. NGOs have been very much at the forefront of mobilising communities in this direction. NGOs and donors remain quite committed. However, resources remain inadequate and such shortages sometimes tend to dampen the enthusiasm which is generated when communities are mobilised.

  Involvement in care and support by communities and NGOs has been a logical evolutionary step from IEC. This is demonstrative of the flexibility and sensitivity of communities and NGOs to the changing demands resulting from new impacts of the HIV/AIDS pandemic.

  Community and NGO effort and commitment have also acted as a key channel for influencing social behaviour and attitudes so that key influential persons are being recruited e.g. one community in Manicaland has recruited a local chief into a Home Based Care group and this move went a long way in attracting other men to become involved in patient care. This is quite a breakthrough in cultural terms because traditionally, men would be looked down upon if they physically got involved in patient care in the home, a task which has been exclusively left to women.

- Peer education initiatives are under way in various sectors (workplaces, schools and communities) and these have proved to be an effective channel for disseminating information and materials like condoms, gloves for the care of patients etc. Peer educators are also a useful source of information in gauging trends and or discovering new trends which provide a basis for reviewing strategies and or developing new interventions.

- Affected households are increasingly adopting short-term strategies to cope without having to use cash e.g. with-drawing children from school, intra-household re-allocation of labour, diversification of crop production. The first two coping mechanisms do however have negative effects in the long term in that children are left in a vulnerable situation when they become orphans—without education it is difficult to find gainful employment and poverty deepens. In any case, children who drop out of school are vulnerable to early sexual activity and early marriage, a situation which may expose the children to HIV infection. This response is therefore not regarded as being effective.

- Provincial and district levels intersectoral AIDS committees have been formed and collaboration is beginning to take place. These initiatives need to be strengthened and resourced accordingly.

- Networking among NGOs is highly developed and an umbrella organisation, ZAN, exists. This has proved to be an effective way of disseminating information and sharing resources.

Key challenges which remain are:

- Effective strategies to promote behaviour change. There is wide agreement that national awareness of HIV/AIDS is almost universal although there are some indications that some of the information and perception held by people are not correct.

. . . In the economic arena

- A good number of employers have committed themselves to IEC activities in the workplace while those who can afford it provide on site medical facilities. There are some employers who through the CZI and ZNCC have expressed an interest in providing and or financing home-based care activities if NGOs can be credible and reliable service providers. Such offers need to be exploited.

- The recently gazetted Labour Relations HIV/AIDS regulations under Statutory Instrument 202 of 1998 need to be enforced and monitored in order to promote a supportive environment in the workplace for a rational response to HIV/AIDS that is free of discrimination and stigmatisation.

. . . ***With women in mind***

- An office responsible for prevention of mother to child transmission has been created within NACP.
- A UNAIDS sponsored pilot programme has been initiated:

* A number of clinics have been designated for preventing MTCT
* Health workers at clinics have been trained in and are offering VCT, nutritional counselling and psycho-social support
* Mothers who have volunteered for testing and are HIV positive are being given antiretroviral treatments
* There is a vision to replicate the programme nationally in an integrated manner. This can only be speeded up if cheaper intervention become available for the initiative to be sustainable.

- A lot of work is being done to empower communities and individuals to make informed decisions about starting a family and or having babies through IEC and VCT.
- UNESCO and other donors have sponsored workshops on AIDS education for grassroot women's NGOs.

4.5 The Political and Legal Responses

The political and legal responses are important determinants of the effectiveness of the other responses to HIV/AIDS. With regard to the political response, it is a great influence on the extent of the resources which are provided to fight HIV/AIDS on the one hand. On the other hand, political attitudes strongly influence the socio-cultural response. This is because political pronouncements tend to have a very potent effect on the manner in which society will react to a threatening situation. With regard to the legal framework, the presence or absence of particular provisions has a great impact on the status accorded to the institutions and persons providing resources and services to the affected. In addition, the safeguards that protect the interest of both the affected and the non-affected are based on the laws and legal provisions which are in place at any given time. Aspects of the political and legal response which are of concern are as follows:—

4.5.1 Inadequate political commitment to accept/acknowledge the problem and to avail required resources for fighting the problem

During 1998/1999, there has been a noticeable improvement in the level of political commitment to acknowledging the HIV/AIDS pandemic as a burgeoning socio-economic problem with serious implications for the development and well-being of the nation. A number of high ranking political leaders have lent their support to various initiatives. The greatest signal of stronger political commitment has been the passing of legislation to establish the National AIDS Council and the introduction of an AIDS levy.

However, there remains a big need for a clear and resounding social and political commitment to admit that HIV/AIDS is decimating the population and that the nation has to take the matter seriously. Leaders from every walk of life should therefore increase their support for the various national initiatives aimed at effectively responding to the problem of HIV/AIDS. Such a commitment would have the effect of increasing the amount of resources which are deployed to fight the problem, help to generate a consensus and or models which promote the right behaviours e.g. if there is a clear condemnation of certain practices like spouse inheritance, society will move that much faster to eradicate the practice. Political figures have a tremendous impact on the behaviour, attitudes and perceptions of the general population. When they are expressing support and acceptance of the HIV/AIDS problem, society in general will receive the right signals and problems like stigmatisation will begin to wane.

4.5.2 Promotion of human rights

HIV/AIDS has become a human rights issue in that those affected want their interests to be safeguarded, in other words, they do not want to suffer needless discrimination and or ostracism. On the other hand, those who are not affected are also concerned about the dilution of their rights and interests should full account be taken of those affected by the disease. Areas of insurance, pensions, occupation etc. continue to remain unclear in terms of

policies and services for the affected because they profess intentions of protecting the interests of the unaffected. There are clandestine demands for the disclosure of HIV status for the living and the dead in order to make informed decisions about permitting enjoyment of certain services and or benefits. Such demands compromise the right to confidentiality of those who are affected.

Service providers have a legitimate right to correct information in order to be in a position to develop sound policies, plans and strategies. The current environment appears to offer inadequate information. A middle ground has to be struck so that information requirements are satisfied without revealing the personal details which would result in discrimination and or victimisation.

4.5.3 Possible criminalisation of infecting others with HIV

In the absence of a lasting cure for the HIV/AIDS, people are scared of the consequences of being infected by those who know their status but for vengeful and or careless reasons, decide to continue to behave in a reckless manner which endangers others. The fear of being put at risk unnecessarily has resulted in some people calling for criminal prosecution for those who knowingly infect others. It is quite difficult to establish the extent to which blame can be pinned to a particular individual and evidence can be obtained that someone knowingly infected others. Indeed, there have been a few cases of individuals who are quoted as having vowed to pass on the disease in order to avenge the misfortune which has befallen them. It is however debatable whether an entire piece of legislation should be put in place to deal with such a small minority.

What is needed is frank dialogue on the subject so that the rights of all are upheld.

4.6 The Response of the Research Community

A lot of HIV/AIDS related research has been undertaken in Zimbabwe mainly in the areas of prevention, diagnosis and management with relatively little research on the impact of AIDS at household and community levels. This research over the past decade or so has taught us a great deal about the epidemiology of HIV/AIDS, especially the extent of the problem in different population groups as well as the contextual and behavioural risk factors that continue to drive the epidemic. It has however been commented on that while there has been a surfeit of non-intervention linked KABP studies in Zimbabwe, there still remains a need for qualitative research focusing on the gap between knowledge and practice. In addition, behavioural surveillance surveys to monitor trends in high-risk behaviours, research into the aetiology, diagnosis, treatment and prevention of opportunistic infections, as well as research to evaluate the effectiveness of the clinical guidelines for management of various HIV related conditions need to be given greater priority in the national research agenda. The challenge now as perceived by many in the field, is to mount effective interventions that are well informed by social and biological sciences and that are underpinned by timeous policy research and formulation. In essence this calls for more participatory action linked research. Below are some areas that have been highlighted in a review of research to date as needing further research:

- Epidemiological information which gives a more complete picture about the prevalence of new infections according to population groups and geographical sites; death rates according to different populations; incidence of opportunistic infections.
- In the clinical area, studies in peripheral health facilities that document patterns of progression of infection as well as the usefulness and cost effectiveness of various models of treatment and clinical guidelines.
- How to improve sustainability, quality and coverage of home care programmes in relation to felt needs.
- Statistics on orphans, their living conditions, their material needs.
- The articulation of the burden on women as primary care givers and how this is made worse by the underlying social, cultural, economic, political and legal inequalities.
- Comprehensive reports on the resources which are available and how they are being deployed; indication of sources of resources (local and foreign) which are being tapped now and that could be tapped in the future.
- An analysis of the various social, cultural, economic and political structural barriers to behaviour change.
- How to improve self-efficacy particularly among vulnerable and or marginalised groups.
- How to help those in authority (parents, teachers, etc.) to provide better support to the youths regarding sexual health.

- An exploration of policy, cost and programme development issues related to the linking of contraceptive needs and infection control through the use of barrier methods.
- Documentation of best practices at all levels (medical, social, psychological, emotional, economic etc.). For instance, there is a lot that can be learnt if the performance and achievements of the Home Based Care concept and community care were to be fully documented.
- Documentation of that which is not working or that which continues to pose risks to given populations e.g. there is a lot said about some traditional practices as being harmful and yet there has been no objective research undertaken to verify some of the assertions which are being made.
- How to increase the link between research and actual programme and policy development and between researchers, programme implementors and target beneficiaries.

There is need for co-ordination of research effort in given areas and efficient dissemination of information to those who require it. This also calls for the training of users on how to best use information which is available to them. For instance, a lot of NGOs are collecting information as a matter of course and yet such information is not being fully analysed because the NGO staff do not have the requisite skills.

There is also need to establish the research needs in the area of HIV/AIDS as both a medical and a socio-economic problem as a means of assisting to set an agenda for focused research. Such a focus is needed in order to optimise the limited resources which are available for research.

5. KEY LESSONS FROM THE NATIONAL RESPONSE TO DATE

The situation analysis and the response analysis clearly indicate that:

- HIV/AIDS is not a problem for the health sector alone; it is a condition, which has many non-medical consequences and impacts. The response should therefore be multi-sectoral in approach while recognising that there is no homogeneity in the manner in which different populations respond and are affected by the disease. A response to the disease will only be successful if everyone acts in unison and with full commitment.
- Co-ordination should be down to grassroots level and facilitate the full participation and contribution of every stakeholder. Experiences from provincial and district level inter-sectoral HIV/AIDS committees (e.g. Mashonaland Central inter-sectoral HIV/AIDS cascading plan and the Shurugwi Development Association initiative) show that a good co-ordination and a multi-sectoral approach is a successful strategy for mobilising communities to participate.
- Peer led prevention efforts supported by resourced outreach work by CBOs, when backed by role models and opinion leaders in the community, provide an effective challenge for risk related norms.
- Innovation in IEC (e.g. drama groups) are proving to be popular and effective in disseminating information and changing behaviour. Great care in theatre productions is however needed to ensure that the correct information is passed on. There is therefore need for close collaboration between playwrights and medical personnel.
- Community home based care (CHBC) initiatives that rely on volunteers are proving to be cost effective and a less expensive option. However, a suitable incentive and management structure has to be put in place to give the volunteers a reasonable compensation for their effort. Good management also ensures that only suitable persons remain on the programme while issues like burnout are dealt with in good time.
- Communities have moved from an initial position of denial to one in which they accept and are trying to cope with the existence of HIV/AIDS. However, poverty and inadequate information/support tends to trigger a sense of apathy and fatalism
- HIV/AIDS is impacting on all sectors in various ways and this calls for a wider response which is national in character. A balance has to be struck between contributions and costs on households, communities, private and public sector and donors.
- Political commitment to publicly acknowledge the problem and taking steps to respond positively has been patchy and sporadic. There is an absence of a sustained commitment and action to address the problem as a national emergency. Action has to be in the form of providing material and financial resources, giving moral support to those affected and those who are providing services. To date, there is little public and political acknowledgement of the work that is being done to prevent and mitigate the impact of HIV/AIDS.
- HIV/AIDS is a huge problem which sadly continues to have a low priority status in the nation's consciousness.

- Fighting HIV/AIDS requires a huge amount of resources. Donations and grants from external donors will always be welcome, however, these should not remain the major sources of funding for the national response to HIV/AIDS. Local resources have to be mobilised because it is in the process of committing resources that all concerned will make the necessary decisions to change the fundamental behaviours, attitudes and practices which exacerbate the pandemic.

The lessons summarised above provide a basis for the vision which will guide the strategy formulation process for the national response to HIV/AIDS during the next five years. This vision is characterised by the following:

1. An appreciation of the need to raise awareness and debate, leadership and change in those social, political and cultural practices which have made it difficult to implement health promoting and risk reducing behaviours.
2. A commitment to support actions by households, communities and organisations with well targeted public, private and NGO interventions.
3. An undertaking to promote the provision of cost effective care without over-burdening families and individuals.
4. A desire to mitigate the medical, social and economic impacts of the problem as well as stepping up prevention through behaviour change—youths will be a special area of focus.
5. A recognition that government shall be the facilitator and resource mobiliser more than being the sole and or major actor. Facilitation shall include vote allocations specifically earmarked for HIV/AIDS activities.
6. An acknowledgement that all stakeholders have a contribution to make. The aim is to optimise multisectoral participation and resource deployment and to avoid duplication and dysfunctional competition, as well as avoiding the marginalisation of any sector or group.

6. KEY STRATEGIES FOR THE FRAMEWORK

The proposed strategies which are presented in this section are aimed at addressing the following:

- Strengthening of those responses which have had the greatest impact in the past
- Discarding those responses which are no longer relevant
- Addressing the gaps which have not been dealt with in the past and yet they present an opportunity to make a greater impact
- Emphasising prevention of those persons not yet affected through IEC and reduction of vulnerability and susceptibility. This calls for a national mind-set which is characterised by the following:—
  - * *highly visible leadership and commitment by all in the political, civil and business communities;*
  - * *a willingness to confront norms and practices that promote the spread of HIV;*
  - * *a willingness to be open and non-discriminatory around persons and issues concerning HIV/AIDS;*
  - * *a willingness to change power relations and to promote the empowerment of those most vulnerable due to their weak positions (e.g. women and youth);*
  - * *a desire to enhance the stability, strength and support of all forms of family structures;*
  - * *a desire to promote greater partner and sexual responsibility;*
  - * *a willingness to enhance availability of housing and security of housing tenure, improved food security and improved income-generating capacity at household and community levels;*
  - * *a commitment to a macro-economic environment which promotes economic growth and stability;*
  - * *enhanced household and community planning for social development and needs.*
- As far as possible, mitigating the impact of HIV/AIDS through provision of cost effective care and support for the affected and their families.
- Ensuring that all strategies are in compliance with the guiding principles of the National Policy on HIV/AIDS as outlined in Appendix 1. The list of guiding principles is open to review as new situations arise.
- Promoting research as the basis for policy and programme design and development.

- Making advocacy and lobbying the primary tool for influencing policy change in all sectors. This calls for information dissemination (this has to be timeous, every available channel and strategy has to be used, HIV/AIDS should become a normal agenda item for all human interaction, the mass media is a potent ally which has to be educated and supported with correct information), promotion of dialogue and debate through various fora, showcasing best practices and achievements, documentation of processes and information and as an advocacy tool etc.
- Ensuring that long term sustainability is an integral part of the design of any project or programme.

6.1 Strategies to Promote Prevention

Strategies to promote prevention shall be underpinned by a multi-sectoral approach which aims to mobilise all sectors to act according to their ability but within an agreed strategic framework and vision. Specifically, the following objectives will be addressed in order to accomplish the overall goal of reducing vulnerability to HIV infection in susceptible individuals, groups and sectors of the population:—

- To make health a key ingredient to development and growth—without a healthy population to work and contribute, quality development plans will at best only achieve mediocre results.
- To reduce inequity in the provision and access to health. Recent moves to introduce cost recovery measures as a means for increasing the funds available to the health sector has reversed the gains made during the first decade of independence when past inequities in access to health had been the major focus of development in the health sector.
- To reduce the burden of premature and excessive death and disability on the poor.
- To harness and maximise on the comparative advantage of other sectors and other ministries for a well resourced, integrated and complementary HIV/AIDS programme. There has to be a clear identification of what the comparative advantage of each sector is (public sector and private sector as both service providers, resource providers and influencers; NGOs and CBOs, as service providers; donors as resource mobilisers and resource providers; etc).
- To encourage the active participation of as broad and representative a group of community members as possible. This has to be accompanied by a sound mobilisation and skills/knowledge development process accompanied by an attitude change process so that communities and individuals accept their new roles and execute the responsibilities that the new roles call for. A sound management and administration structure has to underpin this process in order to achieve standardisation and institutionalisation of the new roles and role performance.

Suggested strategies for accomplishing the above strategic objectives are:—

⇒ Ensuring that essential drugs and other supplies are readily available at all levels of the health delivery system; This should be completed by the decentralisation of budgets/funds to the lowest possible level in order to shorten reaction time. However, all levels which are allocated resources should be adequately trained and have the systems for accountable management of resources;

⇒ Developing a sound community mobilisation, management and resourcing programme which ensures that all communities which are involved in CHBC are well managed and have adequate resources (knowledge, skills, protective materials, blankets, food, medicines and any other materials required for care for the sick); In this regard, it is important to ensure that community based organisations are flexible, integrative and complementary. Specifically, the community mobilisation and management strategy should be characterised by the following:

* Giving support to local initiatives through the provision of grants and or any other materials or support which they may require;
* Working within existing community structures and organisations which are already involved in HIV/AIDS work or those with potential to deliver services at community level;
* Promoting the creation of linkages between and among community initiatives with other external sources of support and collaboration;

⇒ Advocating and lobbying other sectors (in the private sector, government and local authorities) which are not directly involved in health provision so that they can include HIV/AIDS issues as part of their core business in terms of human resources management and social development and or community outreach. In addition, there is need to develop a sound monitoring and evaluation system which provides feedback and performance to all stakeholders. Action plans should have clear indicators and targets which guide the performance and management within each sector;

⇒ Involving other sectors should be accompanied by a strategy of increasing the mobilisation of local resources which are provided for the fight against HIV/AIDS;

⇒ Promoting participation by all stakeholders in the strategic and operational planning process at every level— from national to community levels;

⇒ Promoting participatory action research in order to understand the tenets of effective community involvement in the area of HIV/AIDS care and support.

- To maintain and safeguard food security for vulnerable households.
- To overcome negative household coping responses such as reduced consumption and substituting of cheaper foods on the one hand. On the other hand, to promote positive coping responses.
- To reduce rural to urban migration by stimulating economic growth in the rural areas.

Suggested strategies for accomplishing the above strategic objectives are:—

⇒ Promoting collaboration and linkages between extension and development agents working in the area of reducing poverty and improving access to services by marginalised members within communities. To this end, to have a clear programme of identifying, recruiting and maintaining continuing contact process and forum for this area of endeavour. Consideration could be given to setting up a periodic forum, distribution of a newsletter etc. This can also be aided by lobbying these development agents to place HIV/AIDS as part of their core agenda;

⇒ Actively contributing to the debate and strategy formulation process for addressing the whole questions of rural and community development. Key targets for advocacy can be MPs, Permanent Secretaries, Association of Rural District Councils, Association of Urban Local Authorities and any other who are engaged in economic development as a means of curbing the rural to urban drift;

⇒ Revamping and promoting traditional/grassroots support systems such as labour and draught power clubs (nhimbe) and community based co-operative day care centres and nutritional gardens. Under this strategy, the *Zunde Ramambo* strategy should be promoted and resourced so that optimum productivity is achieved.

For example, the current land reform programme should make provision of land for communal food production and income generation for community based organisations. Other community development projects like CAMPFIRE, mining development etc. could be harnessed for providing support at community level for those involved in supporting and caring for the affected. The government provided tillage units could offer tillage services to community groups which are engaged in communal food production to support the affected;

⇒ Promoting linkages between communities and organisations which promote micro enterprise development and savings clubs. These organisations are an important source of training, loan funds and trade facilitation services which resources are crucial to successful micro enterprise development, especially in the rural areas and poor sectors of the urban areas;

⇒ Promoting a culture of working with and improving traditional systems and structures so that they are more amenable to engage in community effort to respond to, support and care for those affected by HIV/AIDS.

- To challenge and confront negative social and cultural norms with a view to promoting positive socio-cultural norms which reduce the vulnerability and susceptibility of different population groups. This calls for the promotion of good role models and targeting influential leaders at community and national levels e.g. traditional leaders (chiefs, spirit mediums, traditional healers etc.), political leaders at grassroots and at national levels, business leaders, leaders in other spheres e.g. sports, theatre and entertainment.

Suggested strategies for accomplishing the above strategic objectives are:—

⇒ Setting up a programme aimed at advocating with and lobbying influential members of society to support changes to traditional and social practices which promote vulnerability to infection by HIV/AIDS. This will entail identifying different types of influentials and designing an advocacy/information programme which is appropriate to their needs and characteristics.

- To put into practice the national code of practice on HIV/AIDS and employment at each and every work place in order to reduce work-related factors that make workers vulnerable to HIV infection. Special strategies have to be employed in the informal sector and in mobile populations.

Suggested strategies for accomplishing the above strategic objectives are:—

⇒ Instituting a programme that promotes the acceptance and implementation of the National Code of Practice on HIV/AIDS

⇒ Advocating for and lobbying those responsible for housing provision in the urban areas to facilitate access to housing by the poor, especially women and youth and influencing these authorities to safeguard the rights of women and children to a family home at the death of a father and or a breadwinner

⇒ Lobbying and advocating policies and practices which enable married couples to live in the same locality e.g. teachers, uniformed forces and personnel, contract workers (road maintenance, infrastructure development etc.).

- To promote the prevention of sexual transmission of HIV through targeted and innovative IEC strategies.This can be achieved when target groups are reached in a manner that is acceptable to them and the information which is provided is appropriate to meet their specific needs and circumstances. Raising the visibility of HIV/AIDS in the national consciousness is a key ingredient to the success of this strategy.

- To prevent vertical transmission of HIV and to promote options for pregnant women. This calls for ensuring that those at risk access health services regularly and to exploit the fact that "everybody wants a healthy baby".

- To prevent and treat STDs through timeous health seeking behaviours.

- To prevent transmission among workers. This calls for both the employer and employee to become partners in the fight against HIV/AIDS. For their part, employers have to be encouraged to develop, finance and implement prevention strategies which are acceptable and appropriate to the characteristics of their employee body. For their part, employee organisations have to support employer initiatives while encouraging workers to be committed and involved in any work-based programme. For this to be a success, access to the right information and other resources has to be easy and timeous.

Suggested strategies for accomplishing the above strategic objectives are:—

⇒ Building a culture of prevention and risk reduction that promotes abstinence outside marriage and fidelity within marriage and discouraging the norm of multiple, serial/concurrent sexual partners. In addition, encouraging condom use in all risky sexual encounters

⇒ Ensuring that STD prevention, control and care are widely available, accessible, acceptable and at affordable cost

⇒ Ensuring that there is competency in the detection and treatment of STD throughout the health system (including traditional healers and birth attendants)

⇒ Promoting the de-stigmatisation of treatment

⇒ Undertaking ethnographic action research (involving the particularly vulnerable and hard to reach) on identifying and removing barriers to STD treatment and to condom uptake.

- To change the underlying socio-cultural structures that perpetuate the vulnerability of women to HIV infection and transmission
- To increase employment and income generating opportunities for women so that they can gain greater control over their personal, social and economic lives
- To bridge the gender gap
- To promote equity of access to education, productive assets such as land, equipment and technology as well as equity before the law and customary practices
- To improve access to anti-retroviral treatments, especially for pregnant women
- To promote the provision of safe obstetric obstretic and gynaecological services, including antenatal care services.

Suggested strategies for accomplishing the above strategic objectives are:—

⇒ Advocacy and lobbying for more equitable access to education and other productive assets such as land and technology which enhance the capacity of individuals and families to generate income for themselves. Special attention shall be given to the education of girls and orphans

⇒ Establishment of scholarship funds to aid those in need, especially orphans

⇒ Intensifying IEC efforts

⇒ Promoting client friendly environments which encourage service seeking behaviour by those in need

⇒ Improving availability and access to drugs and treatment.

- To make youth oriented programmes acceptable to all stakeholders (parents, teachers, churches, traditional leaders, political leaders etc.). This calls for dialogue and stakeholder participation in the design and implementation of youth programmes.

- To empower those who work with and or affect the lives of young people with the right skills and knowledge. Some of the resistance to change by adults is because they do not have the right skills and knowledge for dealing with young people. Sometimes they lack confidence and view equity in dialogue with youth as a threat to their authority. This can only be dealt with successfully if such adults are fully equipped to be comfortable in their dealings with young people.

- To promote youth oriented outreach work in which the youth themselves are encouraged to act.

- To ensure that training programmes and materials are appropriate for the needs and circumstances of different categories of youth (e.g. in school, out of school, girls, boys etc.). This should be complemented by easy access to information about human sexuality beyond biological consideration to include moral and life skills in dealing with threatening situations.

- To promote and support norms which delay the onset of sexual activity and promote abstinence outside marriage and promote behaviours and perceptions which result in youth experimentation in risky behaviours e.g. alcohol and drug abuse. This should be accompanied by strategies which help youths to remain occupied in healthy activity (e.g. gainful employment, sport, clean entertainment etc.). Youth problems like loneliness, low self esteem, lack of life skills etc. should also be addressed.

- To facilitate access to services in an environment which is supportive rather than judgmental for young people e.g. access to health services and prevention materials like condoms.

Suggested strategies for accomplishing the above strategic objectives are:—

⇒ Improved provision and access to youth friendly services

⇒ Design and implementation of programmes to equip adults with skills and knowledge required for educating young people on human sexuality and other life skills

⇒ Promotion of dialogue between parents, churches, schools and other relevant parties in the design and implementation of an education curricula whose content includes issues of sexuality and other life skills for young people

⇒ Strengthening of current pilot efforts by the Ministry of Education

⇒ Promotion and recognition of youth organisations and ensuring that these organisations have correct and adequate information to enable them to undertake IEC on HIV/AIDS. Such organisations as Scouts, Girl Guides, Jaycees, YMCA, YWCA, Church, Youth Groups etc. should be promoted and become an integral part of the fight against HIV/AIDS.

6.2 Strategies to Promote Mitigation by Caring and Supporting the Affected

The aim of these strategies is to promote the role of households as the primary sources of mitigation. This calls for supporting the households materially and psychologically so that the burden does not become too onerous for them. Key objectives shall be:—

- To reduce the stigma associated with HIV/AIDS
- To provide psycho-social support for the infected and the affected
- To promote an accessible, responsive and well resourced health delivery system and to ensure acceptable standards of health care are being adhered to
- To promote policies and legislation which safeguard the rights of those infected and affected by HIV. A key area is the assurance of equity in service programming, delivery and utilisation
- To ensure gender sensitivity in policies and plans and programmes
- To promote sustained care and support for the infected and affected within communities
- To have clear orphan care and support strategies

Suggested strategies for accomplishing the above strategic objectives are:—

⇒ Researching and documenting the experiences of CHBC initiatives with a view to strengthening this type of response to HIV/AIDS. CHBC should never be considered to be a substitute to institutional care for the affected. However, it provides a vital complementary service. For it to be effective, there is need for subsidising community effort.

⇒ Researching and documenting the conditions under which carers work with a view to designing suitable solutions to some of the problems they experience. For instance, designing and implementing national guidelines on the prevention and management of burnout.

⇒ Developing the capacity for providing counselling at every level of response. This calls for research and documentation of what is currently available and what and where the gaps are. The aim is to enable every community to have access to skilled counsellors who are readily accessible to those in need.

⇒ Promoting and supporting the formation of support groups in all communities. To this end to research and document the experiences of the current initiatives with a view to developing national guidelines. Low and medium density residential areas in cities and towns should be an area of special concern as they appear to be marginalised at present. Care should be taken to employ neutral channels like churches in order to go past the normal reserve of the high-income groups.

⇒ Lobbying and advocating for the provision of adequate personnel in the public sector (health and social welfare).

⇒ Developing and implementing a nationally agreed upon and appropriate orphan care policy which is backed by public resources to those who undertake community care for orphans. To this end, to develop and implement a scholarship and health care policy for orphans.

⇒ Promoting and encouraging gender balance in care giving activities at community and at household levels.

⇒ Encouraging employers, local authorities and communities to provide relief services for family members who give care to the affected and or to care for those affected who are on their own.

⇒ To lobby and advocate for economic policies which promote and strengthen families, including the extended family system e.g. designing a tax regime which encourages people to look after the extended family.

⇒ Intensifying initiatives which lead to the reduction of the stigma which continues to be attached to the problem of HIV/AIDS.

6.3 Strategies to Reduce Negative Economic Impact in General

There is a lot of work that is being done to address issues of poverty at national level. This work is being cascaded down to community level. The aim is to ensure that HIV/AIDS prevention, management and mitigation becomes an integral part of the content of the policies, plans and programmes which are being implemented in the area of poverty reduction. More specifically, the following areas have to be attended to:

- To provide resources to communities which have support programmes for the affected and orphans;
- To promote income generating activities and opportunities for communities and households. To this end, NGOs which are involved in the promotion of micro enterprise development (through the provision of loans, training and facilitation of access to markets) have to be interested in working with those who are giving care and support to those infected and affected by HIV/AIDS at household and at community level. This shall be possible if those at the forefront of promoting community and household level activity are fully aware of who the micro enterprise development agencies are. For their part, micro enterprise development agencies have to be informed on HIV/AIDS issues and the strategic framework.
- To develop and implement a sound management structure of the community effort which promotes transparency, accountability and quality service delivery. National standardisation and training will go a long way in making this a reality. Government and local authorities should be at the forefront of making this a reality.

Suggested strategies for accomplishing the above strategic objectives are:—

⇒ Designing and implementing a standardised community mobilisation, training and resourcing programme for use by various actors (including donors, NGOs and CBOs)

⇒ Designing and implementing a monitoring and evaluation system aimed at keeping the national levels informed of what is happening at grassroots levels. To this end, commission research from whose findings a sound system can be developed

⇒ Lobbying and advocating for a vote allocation to district level departments of health and social welfare dedicated to fund the material requirements for service provision by community volunteers

⇒ Supporting the work of grassroots initiatives which are aimed at improving the resource mobilisation and resource management capacity of community groups involved in the mitigation of HIV/AIDS impacts

⇒ Developing and nurturing mutually beneficial linkages between and among development oriented NGOs and CBOs, especially those involved in fighting poverty and HIV/AIDS

⇒ Developing a national framework for channelling and managing support and care for orphans. This calls for a multi-sectoral approach involving the NACP, Ministry of Labour and Social Welfare, Ministries of Education, Ministry of National affairs, local authorities, traditional leaders and others

⇒ Developing and implementing guidelines for orphan care and support

⇒ Mobilising resources for assisting aged relatives who have to take care of orphans. Working through organisations like HelpAge and churches would provide a ready made structure which can be easily developed to ensure transparency and accountability

6.4 Strategies to Improve the Management of the National Response

- To mobilise and maximise the private sector's commitment to and participation in the fight against HIV/AIDS. This calls for a national structure for co-ordinating and integrating activities of bodies such as CZI, ZNCC, ZFU, CFU, ZCTU, EMCOZ, National Employment Councils, Chamber of Mines, etc. into the national strategy and activities. It is therefore important to fully catalogue these activities and integrate them into the national response. In turn, the planning processes of the private sector have to be informed by the national strategic framework.
- To mobilise and maximise the public sector's (other than the health sector) commitment and involvement in the fight against HIV/AIDS. This calls for the strengthening of focal points and the mainstreaming of HIV/AIDS so that every entity has a budgetary component for the fight against HIV/AIDS.

Suggested strategies for accomplishing the above strategic objectives are:—

⇒ Setting up a tripartite forum for discussing and acting on HIV/AIDS issues drawing representatives from employers, employees and government

⇒ Creating sound linkages between private sector companies and community initiatives with a view to sharing information, sharing resources and providing services to one another

⇒ Strengthening the focal points in all sector ministries and public institutions with a view to providing adequate support and resources to the responsible focal persons

⇒ Lobbying and advocating with both government ministries and Parliament with a view to a budget line for HIV/AIDS for every government ministry

⇒ Developing and disseminating suitable publicity materials to all constituents

⇒ Promoting research and documentation of the co-ordination process and structures with a view to continuously upgrade current structures, processes and systems.

- To develop a clear structure for co-ordinating and promoting collaboration among all actors from national, through provincial and district to local community levels. The role of local authorities is very important since they have closer contact with communities — everyone (including institutions) reside in a local government area and can be mobilised to act if local authorities are fully empowered to promote the right action by all citizens in a given local government area. Areas affected are the institution of HIV/AIDS programmes in the work places which could be the subject of inspection by the health department of any local authority.

Suggested strategies for accomplishing the above strategic objectives are:—

⇒ Undertaking a consultative process in order to obtain required information for developing a co-ordinating structure from national to grassroots levels. This structure should be derived from the proposed structure of the National AIDS Council

⇒ Designing and implementing an advocacy and lobbying programme for local authorities to include HIV/AIDS as part and parcel of their core business

⇒ Conducting research to identify areas of action by other actors (e.g. employers' provision of health services at the work place) which lend themselves to promotion and supervision by local authorities

⇒ Creating a discussion forum for local authorities and different sectors of the community in co-ordinating local responses to HIV/AIDS

⇒ Undertaking appropriate IEC activities targeted at the non-health sectors of the local government community, staff and elected officials included. For instance, there could be a programme for IEC with all local government councillors in Zimbabwe, another for chief executives etc.

6.5 Strategies for Resource Mobilisation

In order to mobilise the resources which are required for the implementation of the programmes which will be derived from this strategic framework, the following tasks have to be completed:—

- ***Quantification after sector specific strategies and plans have been worked out*** — it is important for all actors from all sectors to indicate what their resource requirements are so that these can be drawn up into a composite budget at national level. A composite budget provides a good basis for the following:—

* resource mobilisation,

* planning for future capacity e.g. human resources development strategies and programmes,

* giving a clear signal to all current and potential sources (local and foreign) on the magnitude of the resources required and the nature of such resources including the sequence in which the resources are required (funds, personnel, information, equipment, technology, space etc.). A composite budget in conjunction with the strategic framework will assist current and potential resource providers to align their resource provision priorities and objectives to those of the nation.

- ***Identification of local resources already available*** —apart from government and local authorities, there are a number of private sector actors who are providing their own resources to serve the needs of their target populations. Communities are also making a considerable contribution to the work that they undertake at local level. It is important to identify who is doing what, the level of their current contributions and the indication of their potential. This information is an important input to the resource mobilisation strategy. This information will also indicate which sources have not yet been tapped which could become targets for resource mobilisation activities.

- ***Identification of potential local resources*** — this is a logical step from the identification of current local resources. There is a perception that local resources are scarce and yet from the composite budget, it is very possible to identify new potential local sources that can be tapped.

- ***Identification of current donors and capacity*** — donors have funding programmes and priorities which change with time. It is important to establish these trends at the beginning of the five-year period so that all those who are going to approach them have a clear picture of what these programmes and priorities are. Such information (which should also indicate the eligibility criteria and application procedures) should be compiled and disseminated as a means of empowering various grant seekers. Such a strategy helps to save time and resources which are deployed for requesting donor funds.

- ***Indentification of potential new donors***—although there are traditional donors to the HIV/AIDS fight in Zimbabwe, some of them are changing focus and pulling out. However, there are others who are looking at HIV/AIDS as a possible area of action. When these potential donors are known, they can be on the list of recipients of various kinds of information which can aid them in their planning. In addition, the resource mobilisation process can specifically target and or help to direct these potential donors to areas of priority need.

- ***Development of resource mobilisation strategy specific to each source*** —to date, independent effort by different actors has managed to garner a lot of support and resources for their activity. However, there has been a lot of fragmentation, duplication and or overlap. This has resulted in a less than optimum deployment and or utilisation of the available limited resources. A national resource mobilisation strategy is therefore important, as it will provide guidelines and new ideas to various actors in order to improve efficiency and effectiveness.

- ***Development of resource deployment and distribution guidelines***—the aim should be to enable all actors and service providers to retain autonomy but promote transparency, accountability, collaboration and resource sharing rather than competition, duplication and overlapping while other areas are being neglected.

Resource mobilisation at national level right down to district/community level is an important task which merits the institution of a clear programme that has objectives, indicators, targets and a monitoring and evaluation component. The national resource mobilisation strategy should therefore be worked out as part of the operationalisation of this strategic framework.

6.6 Operationalising the Strategic Framework

The ultimate aim is to ensure total ownership by all stakeholders so that they commit themselves to act and make the investment which is required to make the MTP3 a success. As such the strategy for operationalising this framework should include:—

- Wide distribution of document with a high profile launch
- Development of sector specific and level specific operational strategies and plans based on the guidelines provided in this framework (the affected, public sector and its levels [central government, local authorities—urban and rural], private sector, NGOs, CBOs, donors)
- Establishment of requisite structures
- Development of a monitoring and evaluation mechanism which is agreed to by all stakeholders because they are going to be responsible for implementing the system.

6.7 Strategies for Monitoring and Evaluation

There is need for highly consultative process that will clarify objectives, indicators and targets so that they are realistic and acceptable to implementors and stakeholders alike. The strategy for monitoring and evaluation should entail the following:

- Establishing a master time table of achieving milestones
- Clarifying roles of all stakeholders and set out areas of responsibility
- Agreeing on frequency of monitoring and evaluation activity
- Agreeing on evaluation criteria
- Agreeing on monitoring mechanism (levels, detail, information collection strategies, information analysis methods and tools, storage and management of information, dissemination of information).

APPENDIX 1

GUIDING PRINCIPLES OF THE NATIONAL POLICY ON HIV/AIDS

Guiding Principle 1: HIV/AIDS should be addressed through a multisectoral approach that will be co-ordinated by the National AIDS Council (NAC). All sectors, organisations and communities should participate actively in the fight against HIV/AIDS utilising their comparative advantages.

Guiding principle 2: The human rights and dignity of people living with HIV/AIDS should be promoted and protected. Discrimination and stigmatisation should be avoided as far as is consistent with the rights of society and those who are uninfected.

Guiding principle 3: Confidentiality regarding a person's HIV status should be respected. Legal provisions should be made to enable health professionals to disclose a client's/patient's HIV status to those who have critical reasons to know.

Guiding principle 4: Reducing HIV transmission should be central to combating the HIV/AIDS epidemic.

Guiding principle 5: The promotion of marital integrity and sustainability should be a primary objective of society.

Guiding principle 6: Quality STI care services should be made available and accessible at all levels of the health care delivery system and in the community.

Guiding principle 7: Safety of all blood and blood products should be ensured before any transfusion.

Guiding principle 8: Transfusion of blood and blood products should be carried out only when absolutely necessary.

Guiding principle 9: To limit HIV transmission through sexual intercourse, condoms should be made available, accessible and affordable to all sexually active individuals.

Guiding principle 10: Individuals and couples considering marriage or bearing children should have access to accurate information about HIV infection and pregnancy and Voluntary Counselling and Testing.

Guiding principle 11: Breast-feeding should continue to be encouraged unless there are viable options to ensure appropriate infant and child feeding for women who know they are HIV positive.

Guiding principle 12: Comprehensive, cost-effective and affordable care should be made accessible to people living with HIV/AIDS.

Guiding principle 13: People with HIV/AIDS have the right to choose the type of care they want and should have access to accurate information regarding orthodox and traditional medicine. Public awareness about the known benefits and limitations of the different sources of care should be made widely available to enable people to make informed choices.

Guiding principle 14: Nursing care, provided by health professionals in collaboration with care providers from the community, churches, NGOs, traditional medical practitioners etc., should be holistic and of acceptable quality.

Guiding principle 15: Community Home Based Care should be fully developed and supported as an essential component of the continuum of care for PLWHA and their families.

Guiding principle 16: Counselling services should be made accessible to all people affected by HIV/AIDS.

Guiding principle 17: Voluntary HIV counselling and testing services should be made available and accessible to all members of the public.

Guiding principle 18: Access to information and counselling necessary for informed consent to HIV testing should be ensured as a fundamental human right.

Guiding principle 19: An effective referral and discharge plan should be an integral part of the continuum of care.

Guiding principle 20: Burn-out experienced by health care and other HIV/AIDS care providers needs to be recognised and addressed as a serious and fundamental problem.

Guiding principle 21: Legalising mandatory testing is not recommended in any situation other than in the case of a person charged with any sexual offence that could involve risk of HIV transmission. In this case, prompt testing of the perpetrator is required. The assaulted person should be offered voluntary counselling and testing, and where appropriate, treatment at the expense of the State.

Guiding principle 22: All asymptomatic people with HIV infection should be treated as any other healthy individual with respect to education, training, employment, housing, travel, health care and other social amenities and citizenship rights. People with AIDS should be treated as others who may have chronic or life-threatening conditions.

Guiding principle 23: Partner notification of HIV status is an important issue for both men and women and should be encouraged and supported.

Guiding principle 24: Where either HIV or AIDS is deemed to be a public health concern, it shall be notified separately and confidentially by the practitioner in terms of the Public Health Act.

Guiding principle 25: The rights of children and young people with, or affected by HIV/AIDS must be protected and respected.

Guiding principle 26: Children orphaned as a result of HIV/AIDS shall not be discriminated against in any way and require such support as is necessary to grow up with respect and dignity.

Guiding principle 27: Children and young people have the right to information and to advice on means to protect themselves from early sex, unwanted pregnancy and HIV/STI. Girls, in particular, should have equal access to education, training and employment. Abstinence and the deferment of sexual debut should be a major component of reproductive health advice to the children and the youths.

Guiding principle 28: Children and young people should be protected from any form of abuse that is likely to expose them to HIV infection.

Guiding principle 29: Children and young people below the age of 16 years who have concerns about and/or have an STI have the right to appropriate counselling and care services and advice on means to prevent HIV/STI. The counselling and professional advice given should depend on each young person's circumstances and potential risk of HIV/STI.

Guiding principle 30: Wilful transmission of HIV in any setting should be considered a crime in the same sense as inflicting other life-threatening injuries to another.

Guiding principle 31: Apply the most effective policies and strategies to deal with commercial sex work in order to reduce the transmission of HIV and STIs and deal appropriately with legislative provisions and revise those which do not comply with current community concerns.

Guiding principle 32: Information, education, counselling, male and female condoms and STI care services must be made accessible and affordable to all sex workers and their clients.

Guiding principle 33: Prisoners have basic rights that must be respected and protected including the right to HIV/AIDS/STI information, counselling and care.

Guiding principle 34: Routine segregation of HIV infected prisoners is neither desirable nor practical.

Guiding principle 35: Men and women should be accorded equal status with equal opportunity for education and advancement in all spheres of life.

Guiding principle 36: Men and women need to understand and respect their own and each other's sexuality.

Guiding principle 37: All HIV/AIDS/STI programmes should be gender sensitive and include gender-related issues.

Guiding principle 38: Gender violence in any form and setting is unacceptable and should be prescribed by law.

Guiding principle 39: All persons have the absolute right to clear and accurate information, education and communication on HIV/AIDS/STIs.

Guiding principle 40: Information, education and communication on HIV/AIDS/STI should address the relationships and promote positive family and cultural values through a language and approach which must be appropriate for the respective target groups, communities, and individuals.

Guiding principle 41: The development of IEC material should be based on participatory methods involving the intended target audience/population.

Guiding principle 42: Mass media should be utilised in a manner positive towards cultural values in order to create and promote awareness about HIV/AIDS/STI and promote positive and supportive attitudes in response to the epidemic.

Guiding principle 43: HIV/AIDS/STI research should focus on priority needs in Zimbabwe and should be undertaken through a co-ordinated and multidisciplinary collaborative strategy with active participation of the potential beneficiaries as well as the investigated community throughout the research process where possible.

APPENDIX 2

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APPENDIX 3

LIST OF PEOPLE INTERVIEWED

NAME	ORGANISATION	NAME	ORGANISATION
P. Harding	Vita-Foam Byo	Dr. O. Mugurungi	NACP-MOHCW
M. Gotha	MAC	Zibanayi	PSI
R. Muirimi	COMARTON	Dr. R. Labode	PMD — Mat North
R. Kerkhoven	SAfAIDS	Dr. G. Bango	PMD — Mat South
Mr. Katsumbe	CIMAS	Dr. Pazvakavambwa	Blair Research
J. Makamure	ZNCC	Dr. R. A. Dhlodhlo	Bulawayo City Health
M. Ncube	NSSA	B. Mpofu	Consumer Council of Zimbabwe

M. Mukwewa	MOPSLW
Dr. S. Laver	U. Z.
Dr. S. Perry/Kerry Kay	CFU
E. Zhou	ZFU
C. Dehwe	ZCTU
L. Murazvu	ZIMASCO
Gwata	NEC Catering
P. Moses	NACP-MOHCW
E. Serima	FHI
V. Muzezewa	ZAPP
E. Dendere	Chirumanzu Home Based Care
T. Tigere	St. Albert's Hospital
M. Taremba	
Fr. T. Rogers	Jesuits AIDS Project
M. Khumalo	ZBC-AIDS Section
F. Read	Bankers' Association of Zimbabwe
The Director	Rotary and Lyons
Mr. Mukodzani	NECTOI
Dr. M. Kadenge	ZIMASCO
The Director	Chamber of Mines
Dr. M. Bassett	ZAPP
Dr. G. Woelk	U. Z.
Dr. F. Zawaira	WHO
Dr. A. Latif	University of Zimbabwe
Dr. D. Wilson	University of Zimbabwe
Dr. Ncube	ZNFPC
Dr. O. L. Mbengeranwa	Harare City Health
Dr. M. Wellington	Harare City Health
Dr. Jaravaza	ZIMA
Dr. Nyathi	Health Review Comm.
Dr. Bruno Piotti	Epidemiology
Dr. A. Geldermalsen	PMD—Mash Central
Prof. G. Chavunduka	ZINATHA
Isabel Laher	ZNNP+
T. Mahlangu	ZAN
Mr. Masimira	MASO
Prof. Nyazema	U. Z.
Dr. S. Chandiwana	Blair Research
L. Mudekunye	SCF (UK)
Mrs. Mumbengegwi	WAG
C. Nondo	ZINA
P. Misihairabwi	WASN
F. Mutsvene	Air Force of Zimbabwe
E. Muzenda	CONNECT
F. Hatendi	UNICEF
Rev Pashapa	Baptist Church
Dr. M. Mhloyi	University of Zimbabwe
S. Gudyanga	UNICEF
Mr. Sibanda	ZINATHA
Sr. Noleen	Mashambanzou
Dr. P. Maclean	Mutare City Health
Mr. Vhoko	PMD Office — Masvingo
Ms Gumbie	NACP — MOHCW
Mr. Simbi	Health Education
Mrs. Ndimande	NACP-MOHCW
Dr. S. Laver	University of Zimbabwe
Mrs. Muteiwa	Gender/HIV Co-ordinator — NACP
Mrs. Pembere	Gender Consultant—MOHCW
Dr. I. Chitsike	MTCT—Project Officer — NACP
M. Ruzvidzo	Informal Traders Association—Marondera
J. Swift	CFU
Dr. P. Osewe	USAID
Dr. Kambarami	
Dr. G. Foster	FACT
K. Kostermans	World Bank

APPENDIX 4

DETAILED SUMMARY OF SITUATION ANALYSIS AND RESPONSE ANALYSIS

SITUATION ANALYSIS: What is the situation—General population

National guiding principles	*Population issues*	*Health issues*	*Socio-cultural issues*	*Social services issues*	*Economic issues*
Main Determinants of HIV spread.	• In 1997, over 70% of AIDS cases came from among adults in the 20–49 year age band. • In Harare, HIV/AIDS diseases accounted for more than 25% of deaths in the 25–50 age group. • Orphanhood on the increase. • In cities like Harare, land for burial is reportedly fast running out. • Paediatric AIDS now the leading cause of death among infants and the under 5s. • There are between 50–60 thousand infected children born in a year. • Increased morbidity. • Increased mortality. • Decreased life expectancy from 61 to 46,9 years in 1998. • A high proportion of adult population still getting infected with STDs.	• Sexual history, especially of STD infection. • In the city of Harare, 60% of those who visited health centres have STDs. • Limited sexual health knowledge and life skills of certain sectors of the population. • While AIDS increases mortality and morbidity it at the same time reduces resources available to deal with other health problems. • There is an upsurge in HIV related opportunistic infections such as TB, Meningitis etc. • Dual epidemic of HIV and TB stretching the health system. • Opportunistic infections accounting for around 50% of admissions into health institutions and projected to account for 60% of bed occupancy by 2005. • 92% of HIV infection due to heterosexual transmission. • 7% of HIV infection due to mother to child transmission. • HIV/AIDS consuming a $^{1}/_{3}$ of the national health budget through the treatment of opportunistic infections.	• Gender inequities. • Stigma attached to HIV. • Traditional leaders like chiefs, headman, *svikiros* who are custodians of culture and traditions in their communities feel marginalised and disempowered. • Perceived moral and social responsibility vacuum due to break-down of extended family systems in most communities. • Gatekeepers and opinion leaders (political, traditional, religious) influencing information coming into a community and decisions made therein. • A tendency towards externalising the HIV/AIDS problem at both the individual and collective level.	• Inadequacy of health and social services. • In accessibility of health and social services due to bureaucracy, distance and cost. • More and more terminal AIDS patients moving to rurals areas to spend their last days with families. • Insecure housing tenure plus seasonal employment in the agricultural sector.	• Limited resource-backed commitment from non-health sectors. • In 1993, the poorest 40% of the population were getting only 10,1% of the country's revenue. • The 1995 Poverty Assessment study put 62% of population as living in households with income per person insufficient for basic needs. • Gender gap in disposable income and asset ownership due to gender inequality in access to income earning opportunities. • AIDS care cost as a % MOHCW budget rising from under 1% in 1990 to 11% in 1996/7 and projected to be 42% in 2000 and 58% in 2005. • Poverty and insecurities in such areas as housing, food and health provision have relegated HIV prevention needs to the background as people struggle to meet basic needs. • Substantial income reduction at household level due to loss of bread winner and diversion of labour, income, savings and assets.

	• Dissolution of families. • Overcrowded housing, migrant labour, plus separation of spouses increasing the likelihood of risky sexual behaviours. • Rural to urban migration weakening extended family networks. • Declining population growth rate from 3,5% in 1969 to 2,8% in 1997. • Prevalence of HIV infection higher in urban than rural areas especially along major highways and in border towns. • Competing political/ national priorities and agendas.	• There has been a noted increase in condom uptake although not so among married couples. • Condom use still remains inconsistent especially in relationship to steady partners. • Inadequacy of infection control supplies at household level for home based care. • Reversal of gains made in MCH soon after independence with very high HIV related infant morbidity and mortality. • Mortality related loss and grief compromising psychological well-being and adjustment especially among vulnerable groups like orphaned children and the aged who are left with care responsibilities without the requisite support of breadwinners. • Morbidity and caregiving related stress and burn out among care givers both within the health sector and at household level.	• Loss of parenting and socialising agencies at household level. • Weakened traditional community safety nets and threats to social cohesion at community level. • Intra household reallocation of labour burdening women and children (especially the girl child).	• Reduction in social security and support networks. • Public assistance demands increasing in a situation where available assistance coverage is less than 20% of target population.	• Cost containment approaches such as capping of costs borne by the public sector are adding a cost burden to households already stressed by labour and income losses due to AIDS morbidity. • Death of breadwinner leading to food insecurity and loss of income at household level. • High dependency ratio of the aged and the youth on the economically productive but AIDS battered adult population. • Loss of household revenue due to reallocation of labour and reduced remittance due to death of wage earners and shifts from cash to subsistence farming.
Obstacles to change	• Housing to be made a human rights issue.	• Problems in eliciting the tacit and/or active support of key influentials like the churches (on moral grounds) the chiefs, headman and traditional healers (on cultural grounds) and extension services officers like the EHT, SCN and CHW (due to low morale induced by low wages and overwork). • Constraints in access and availability of such material resources as	• Cultural and religious sensitivities with respect of sexuality and sexual behaviour. • Incomplete representation of communities or certain segments of the community by leaders acting on their own agendas.	• Poor management skills within most community based organisation. • Inadequate funding of and poor targeting of support by CBOs. • The economic structural adjustment programme plus the health sector reforms impacting on the availability and	• Rising unemployment. • Decline in incomes. • Lack of an obvious relationship between priorities and resource allocation. • For affected households, there is spiral from acute/seasonal poverty, to chronic poverty and food insecurity.

		drugs, condoms, gloves and IEC materials. • The introduction of cost sharing in the health sector is hitting the poorest hardest. • Decline in public expenditure on health from $16,50 per person per year 1990/91 to $10,92 in 1993/4.	• Incomplete participation by certain segments of the community who may be the most affected. • Common misconceptions about decreased sexuality among the elderly. • Strong superstitious beliefs among elderly e.g. *runyoka*.	accessibility of health and social services. • Inflexible planning in community programmes to accommodate such issues as seasonal imperatives (planting) or unplanned for events like the ever increasing funerals.	• Reported 15% of agricultural extension workers having died in one province (Mutangadura 1998). • Projected four fold increase in mortality related loss of employees in the next five years and around 15 years average lost in working life.
Obstacles to change		• The uncertainty surrounding the continuity of the donor funded STI programme. • The quasi-vertical nature of the STI programme raises issues of sustainability. • Constraints in terms of time, facilities for privacy and lack of confidence on the part of health workers militate against comprehensive STD treatment and counselling. • Lack of capacity at provincial and district levels to really characterise their situation vis-a-vis the epidemiology of STI and HIV infection.	• Negative perception of and stigma associated with HIV/AIDS leading to stigmatisation as well as discrimination and isolation of the infected. • Cultural and or gender barriers to condom use. • Lack of traditional and cultural legitimacy of many CBOs that sideline traditional leadership structure.	• Line ministries have not made HIV/AIDS part of their core business and fully incorporated HIV/AIDS in their action plans and budgets. • Many sectors, have in the main, been doing their own thing guided by their own vision and objectives of their donors. • Limited synergy amongst the various organisations involved in HIV/AIDS work resulting in a lot of duplication as well as gaps.	• Minework and migrancy are linked to health problems such as overcrowded housing, alcoholism, purchase of sex, STDs and chronic occupational lung disease and TB which in themselves are associated with increased risk for HIV.
Opportunities	• A multisectoral approach can highlight to different national sectors how their own personnel are differen-	• Decentralised PHC system. — 1 200 primary care centres countrywide putting most households within 8 km of a health facility.	• Cultural officers can engage opinion leaders in dialogue. • Traditional healers have a decentralised struc	• Line ministries have at least identified and designated AIDS focal persons who form part and parcel of inter-	• Organised labour unions. • Sympathetic and proactive employers organisation. • A fairly literate workforce.

tially affected as well as how they are best positioned to react at little extra cost.

- i.e. their stake in HIV prevention, support and mitigation.
- High adult literacy rate of 84,7% according to the 1998 UNDP Human Development Report.
- Free family planning services and fairly high levels of contraceptives use at 48% (1994).
- High levels of commitment in the fight against HIV/AIDS.
  - — over 60 international, national, governmental and non-governmental organisations involved.
- Tradition of in-service training e.g. in:
  - — HIV/AIDS counselling
  - — Syndromic treatment of STD now adopted standard
  - — National guidelines for treatment of TB, and other opportunistic infection in place.
- Tradition of and capacity for multisectoral collaboration in other programmes.

ture, are receptive to participatory intervention and are still key infuential in their communities.

- Some chiefs are willing to take up the gauntlet in the fight against HIV/AIDS.

sectoral AIDS, committees at central, provincial and district levels.

- Ministry of education and culture can:
  - —reach in school-children through their curriculum
  - —Reach out of school youths through the sports for all progamme.
- The recently unveiled draft national policy on housing that is supported by the national housing trust and the national housing finance bank.
- Ministry of Agriculture — can train extension workers in HIV/AIDS prevention and impact mitigation measures such as teaching communities zero tillage and intercropping.
- Farm health workers can work with the seasonal labour force that is temporarily displaced.
- The transport sector has an outreach prevention programme along major transport routes.

RESPONSE ANALYSIS: What is being done — General population

Health arena

- The world Bank and the British governmentfunded STI programme has trained around 50% of the targeted 2 000 nurses and 100% of the targeted 60 doctors at GU centres. In addition 12 doctors have received specialist training in the UK.
- STD management protocols and flow charts have been produced, are being updated every two to three years and are available throughout the health system.
- In-service training of the rest of the health workers in Syndromic Management of STIs is under way.
- Condom promotion and distribution has resulted in between 13–48% improvement in condom uptake.
- Health workers continue to shoulder the main burden of HIV/AIDS related IEC and counselling.
- NBTS activities (e.g. pledge 25, donor self deferral counselling, targeted recruitment of donors etc) are in line with the objective of providing safe blood for transmission.
- HIV/AIDS IEC campaigns have sustained awareness at very high levels.

Socio-cultural arena

- The Ministry of National Affairs has trained and facilitated the putting in place of gender focal persons in such ministries as health, lands and education.
- The Ministry of Health has engaged a gender consultant and has come up with a "Gender-in-health strategy"
  - each department, province, and central hospital has identified and trained a gender focal person.
  - A gender training manual, informed by a baseline survey of stakeholders opinions has been written and will be used to train health workers along the cascade model.
- Ministry of Education has also engaged a gender consultant.
- Many communities have embarked on initiatives to mitigate the impacts of HIV/AIDS e.g., Orphan Support projects, *Zunde ramambo* etc.
- Peer education initiatives are under way in various sectors such as the workplace, schools and within communities.
- Many community-based organisations have evolved their functions in accordance with the stage of the epidemic-progressing from a focus on IEC to increasingly providing care and support.
- Affected households increasingly adopting short-term coping strategies which do not require cash, such as withdrawal of children from school, intra-household reallocation of labour and diversification of crop production.
- Traditional healers' training programmes in infection control, conselling and in the challenging of retrogressive cultural norms and practices is taking root in a number of districts.

Economic arena

- A national code of practice on AIDS and employment now in place.
  - most workplaces have in place IEC programmes, condom distribution outlets and some care and support programmes.
- At household level there is increased spending of savings, borrowing and reduced consumption.
- Savings clubs, credit schems, self-help groups are being initiated in some communities.
- HIV prevention programmes at the workplace in commercial, industrial, mining and agricultural sectors.

RESPONSE ANALYSIS: Lessons learned — General population

To reduce vulnerability

Provincial and district level inter-sectoral HIV/AIDS committees such as the Mashonaland Central inter-sectoral HIV/AIDS cascading plan and the Shurugwi Development Association are succeeding in energising community participation.

To strengthen prevention efforts

- Peer-led prevention efforts, supported by resourced outreach work by CBOs with the blessing and backing of role-models and opinion leaders in the communities, are proving effective and challenging risk related norms.
- Innovative IEC dissemination strategies such as drama groups are proving popular.

To mitigate impacts

- Community based home care programmes that involve local volunteers seem more cost effective and sustainable. However the volunteers motivation needs to be sustained through appropriate incentives. After all they have competing demands on their time and energy. In addition CHBC needs to be supported by a greater availability of drugs and other material requirements.
- Hospital outreach for home based care is very costly as 75% of hospital staff time is spent travelling to patients' homes.
- As things stand, expenditure by donors, NGOs and CBOs has been heavily weighted in favour of overheads, salaries and transport at the expense of prevention and care activities.

STRATEGY FORMULATION: What needs to be done—General population

Priority area	*The identified Needs*	*Specific objectives*	*Suggested strategies*
Reduce vulnerability to HIV infection in susceptible individuals, groups and sectors of the population.	A strategic mix of relief and investment oriented strategies.	∇ To make health a key ingredient to development and growth. ∇ To reduce inequity in health. ∇ To reduce the burden of premature and excessive death and disability on the poor.	• Essential drugs and other supplies should be readily available at all levels. • Expand community services to resource careers at PHC level, at community level and within households through health sector reform and financing plus community mobilisation and involvement. • Mainstreaming AIDS into development programmes (from the planning stage through the resourcing stage to the implementaion and monitoring stages) by each and every sector. • Involve stakeholders in developing strategic plans to ensure that there is a common and shared vision at operational level. — Involve key stakeholders in developing realistic targets based on up to date participatory community action research findings.
	A multi-sectoral approach to HIV/AIDS prevention, control, care and mitigation.	❖ To harness and maximise on the comparative advantage of other sectors and ministries for a well resourced, integrated and complementary HIV/AIDS programme.	• Participatory action research and analysis of sectoral factors that influence HIV infection risk and vulnerability. • Sectoral accountability. • Decentralised funding of plus joint brainstorming and resource contribution by different government ministries, business, NGOs and the community. • Maximise use of local resources (business, governmental, community, NGO, family support and mutual obligation traditions).
		■ To encourage active participation by as broad and representative a group of community members as possible.	• Community based organisation to be more flexible, integrative and complementary e.g.: — to support small-scale local initiatives i.e. many small grants. — work with existing community structures such as churches, women's groups, clubs, schools etc. — embrace the concept of community organising so as to engender trust, encourage direct community inputs to emerging needs and to increase ownership by and self determination of communities. — work on short-term achievable goals that involve as many people as possible i.e. small-scale but visible achievements.

		— create linkages with outside supportive services to offset the community's limitations. — increase households access to resources including extended family and community supports so that they do not progressively resort to use of savings, sale of assets, borrowing, wage labour and resignation.
Maintaining and safe-guarding food security for vulnerable households. Overcoming negative household coping responses such as reduced consumption and substituting in cheaper foods and reinforce positive household coping responses.	■ Empowerment of affected groups. ■ Increase access of household to the limited resources. ■ Increase income and food security at household level.	• Revamp traditional/grassroots social support systems such as labour and draught power clubs (Nhimbe) and community based co-operative day care centres and nutritional gardens. • Community based organisations to implement vocational training schemes where vulnerable groups like out of school youths and the unemployed can be trained in marketable skills such as handcraft, bee-keeping, sewing and farming. • Jump start savings clubs and credit schemes.
	• Promote the concept of *Zunde ramambo*.	• Allocate to chiefs land designated for producing food to help out vulnerable households. — support this with draft power and/or tillage assistance as well as agricultural inputs like seeds and fertiliser.
• Reducing rural to urban migration.	• Build capacity at local level and ensure sustainability.	• Increase rural employment opportunities. • Expand and strengthen extension services for technical support. • Promote appropriate technologies. • Rehabilitate and/or expand essential services such as health care, land resettlement, irrigation, education. • Agricultural extension services to teach communities such innovations as zero tillage and inter-cropping to offset increasing food insecurity due to decreases in cultivated areas for affected households. • Social safety nets to provide decentralised social assistance based on direct poverty indicators.

	• To involve communities in the process of indentifying needy households and targeting social assistance to them.	• Development agencies and policy makers to work through existing indigenous traditional community mechanisms instead of sidelining or displacing them e.g.: — Chiefs and headmen to compile a register of child-headed families or other households in need and target community responses to responding to their needs through for example, the *Zunde ramambo* scheme, *Nhimbe* (for draught power and labour) etc.
	• To make relevant information and skills accessible and available to all.	• Legislative and policy measures to enhance access of vulnerable groups to education (including tertiary), employment, skills training, credit, etc. • A combination of outreach and peer-led strategies to reach marginalised and other hard to reach groups. • Combine traditional with innovative means, channels and forms of communication strategies and messages in languages appropriate to target audiences. • Integrate life-skills and HIV/AIDS issues in all educational and training curricula relevant to development stage, life/sexual experience and history as well as context.
• Challenging negative social and cultural premises and norms.	• To tap on positive and credible role models within communities.	• Involve key opinion leaders in key areas like traditional cultural (chiefs, *svikiros*, headmen, *n'angas*) moral religious (churches, *tetes*) civic educationists and political in questioning retrogressive assumptions and setting norms at community level, that reduce vulnerability, susceptibility, to and the impact of HIV/AIDS on community members.
	• To reduce work-related factors that make workers vulnerable to HIV infection.	• Deliberate attempts at corporate and management leads to reduction in the number of days mobile workers spend away from their spouses and families. • Provision of adequate housing for families and/or couples to live together. • Deliberate policies within the civil service to ensure that married employees are placed in the same area as their spouses so that they can live together and not be separated.

Prevent sexual transmission of HIV.	• Targeted and innovative IEC strategies.	• To reach target groups, in a manner acceptable to them, with information appropriate to their needs and circumstances. • To give HIV/AIDS the requisite visibility.	• Take a multimedia approach that combines the usual/standard channels of communication (radio, TV, Newspaper) with innovation. • For specific target audiences, design information packages taking into account socio-cultural, gender and spiritual imperatives. • In designing IEC materials and deciding on appropriate strategies, involve opinion leaders (political, cultural, spiritual), as well as members of the target groups. • Mobilise communities to question attitutes and norms that have stigmatising effects on certain groups or individuals in communities.
	• Building up a culture of prevention and risk reduction.	• To make abstinence outside marriage and fidelity within marriage normative. • To discourage the norm of multiple serial/ concurrent sexual partners. • To increase condom use in all risky sexual encounters.	• Strengthen the perception that others also abstain, delay onset of sex and practice safe sex. • Complement individual change approaches with community and structural level programmes. • Make intervention strategies skills-based for the enhancement of individual self efficacy. • Engage target groups in risk assessment dialogue, in making risk reduction normative and the formulation of risk reduction plans utilising health personnel, peers and significant opinion leaders. • Co-opt opinion leaders and role models in challenging the macho image of "bhuru rinoonekwa nemavanga aro" and in empowering women to also take the initiative of ensuring safe sex e.g. advocating for availability, accessibility and affordability of female controlled protection. • Improve the accessibility, in an equitable manner, of protection methods: varied distribution outlets, with the accent on the innovative and non-stigmatised, subsidised pricing, free distribution in certain cases and social marketing. • Sustained IEC and condom promotion and distribution: innovative strategies to address access issues for such vulnerable groups as the youths, women, mobile workers and CSW. • Social marketing of condoms using commercial marketing techniques like advertising attractive packaging (to increase social accessibility) coupled with enhanced multi-sites availability (tuckshops, bars, supermarkets, hotels, clinics, clubs).

Prevent vertical transmission of HIV.	• Options for pregnant women.	• To ensure that those at risk access health services regularly. • To capitalise on the fact that "everybody wants a healthy baby".	• Make available antiretrovirals to as many needy women as possible in an equitable manner. • Intensify information and counselling strategies to inform women on options and services available. • Expand VCT services related to prevention of mother to child transmission.
Prevent and treat STDs.	• Timeous STD related health seeking behaviours.	• To make STD prevention, control and care widely available, accessible, acceptable and as affordable to many as possible. • To ensure competency in the detection and treatment of STD throughout the health system. • To destigmatise STD treatment.	• Targeted IEC, that enables early self detection of symptoms. • Integrating STD control in PHC and ANC services to make it accessible. • Augmenting integrated STD control services with specific services that are acceptable and affordable to high risk, vulnerable groups. • Training of health workers in early detection and comprehensive treatment e.g. the syndromic approach particularly at district level. • Sensitisation of health workers on the need for appropriate attitudes of respect and being non-judgmental to destigmatise STD treatment.
Prevent HIV transmission among the workers.	• Private sector involvement in HIV prevention, control, care and mitigation.	• To promote workplace based HIV/AIDS prevention strategies within the various sectors. • To encourage and persuade companies to invest in HIV/AIDS prevention activities at their workplaces.	• Comprehensive HIV related health and safety education and intervention programme in each place of employment including STD treatment. • Peer educators trained and in place in each place of employment. • Corporate support of peer education efforts that includes policy, management and material inputs. • Employer and labour organisations to support prevention efforts at the workplace through policy, training, and material support. • Targeted IEC strategies for mobile workers that is supported by: — peer-led normative culture against "steady girlfriends" spread across several work stations and against unprotected sexual intercourse with these and other more casual partners. • Provision of condoms by the employer (free of charge) in recognition of the occupational hazard inherent in the mobile nature of the work.

Mitigate the impact of HIV/AIDS.	• Reduced of the stigma associated with HIV/AIDS. • Psycho-social support for the inffected and affected. • An accessible, reponsive and well resourced health delivery system.	• To augment services for dealing with the psychological ramifications of HIV infection and/or AIDS. • To counter the social rejection and isolation experience by PWAs. • To ensure equity in health access. • To ensure acceptable standards in health care.	• Increase the availability of counselling services through conveniently located centres that are accessible and non-stigmatised and manned by well trained staff. • Extend and integrate peer counselling services for target groups in health and non-health settings as well as in formal (schools and workplace) and non-formal progammes (clubs). • Training, including in-service training of staff. • STD diagnosis and treatment. • Improve availability and accessibility of drugs for treating opportunistic infections and for palliative care. • Support for staff and caregivers at household level to minimise stress and burn-out.
	• Policies and legislation to safeguard the rights of those infected and affected by HIV/AIDS. • Gender sensitivity in policies, action plans and programmes.	• To ensure equity in service programming, delivery and utilisation.	• Mainstream gender issues in all HIV/AIDS programmes and activities. • Such programmes to be informed by qualitative research so that they meet the different needs of both men and women. • Undertake training programmes for policy makers, programme managers and implementers in gender sensitivity. • Have in place at central, provincial and district levels trained gender focal persons at levels high enough to influence policy and programming in all relevant ministries and sectors. • All policies, programmes and action plans to be reviewed routinely by the focal persons. • Where AIDS focal persons and gender focal persons are in place but are not one and the same person, rationalise their inputs for synergy.
	• Mobilisation and maximisation on private sector commitment to and participation in the fight against AIDS.	• To put in place a national structure for co-ordinating private sector involvement in collaboration with such bodies as CZI, ZNCC, IBDC, ZFU, CFU, ZCTU etc. • To strengthen social and economic safety-nets.	• Garner other sectors commitment to ensuring the integration and mainstreaming of HIV/AIDS activities in their plans and budgets. • Engage planning officers in line ministries and other sectors in the process of identifying: — their own stake in HIV/AIDS prevention, control, care and mitigation. — the target population best placed to reach and service.

		— the most cost effective responses at their disposal which entail little additional costs. — their best opportunities for resource mobilisation to carry the additional load consequent upon HIV/AIDS activities.
Sustained care and support for the infected and affected within communities.	• To ensure continuum of care from health facilities to communities right into the households.	• Make these projects demand driven rather than supply driven. • Create opportunities at community level for income generating projects. • Impart skills (vocational and entrepreneurial). • Provide access to finance e.g. credit schemes.
	• To make home based care and orphan support projects self sustaining.	• Look after people who contribute their time and energy to prevention and care projects in the community through such strategies as time-outs, social activities and regular brainstorming, feedback and gripe sessions. • Provide psychosocial support to caregivers e.g. time out, tokens of appreciation, counselling etc.
	• To go beyond awareness.	• Innovative IEC strategies that resonate with personal, cultural, and social realities of target audience, influence their values and norms, and that can relate to behavioural patterns and so influence behavioural change.
	• To implement informed targeting and prioritisation in allocating resources.	• Commission community level baseline participatory research and monitoring. • Encourage consensual development of programme indicators.

WOMEN: SITUATION ANALYSIS

	Population issues	*Health issues*	*Socio-cultural issues*	*Social services issues*	*Economic issues*
Main determinants of spread of HIV	• In Africa south of the Sahara, there are 6 women with HIV for every 5 men. • Between the ages 15 – 24 years, the risk of HIV infection between females and males is 2:1. • The age distribution of AIDS in Zimbabwe indicates 5 times higher risk of infection in female than males in the age group 15 – 19 years. • AIDS cases peak in younger age groups (20 – 29) for females than for males (30 – 39). • Rising rates of teenage pregnancy.	• Women infected with some STDs like gonorrhoea are unaware of it because they are silent. • Biological vulnerability due to bigger mucosal surface, higher concentration of HIV in semen, vaginal tearing and bleeding. • Vertical transmission a double blow to women as they are then often blamed for infecting children. • Unavailability of female controlled barrier methods to prevent infection with HIV. • Problematic access to care services due to competing household chores (no time) and cost of services where women have no independent funds • Burden of care falling on women, especially the psychosocial aspect of it.	• Many married women have been infected by their one partner—their husband. • Double standards in relation to the number of sexual partners—extra marital affairs favouring men. • The socially disadvantaged position of many women give them little control over abstinence, or comdom use within marriage. It also makes it difficult for them to seek early treatment in case of infections with STIs. • Cultural socialisation denying women requisite skills to negotiate safe sex. • Death of spouse which may lead to loss of property ownership, widow ineheritance. • Low social status. • Gaps between traditional customs and official laws with tremendous pressure to comply with tradition. • Divorce practices.	• In equities in access to education resulting in higher levels of ignorance about sexual health and services. • Separation from spouses due to inadequacy in housing for employees as well as mobile nature of some occupations of husbands. • Weakened traditional community safety-nets like the extended family following spouse's death.	• Dependency • Poverty leading to for example sex as an economic currency. • Drop in food security and disposable income when woman is ill and husband is ill/dead. • Women represent the backbone of the small holder agricultural and informal traders sectors. • Property inheritance practices. • Lack of income opportunities.

Obstacles to change.	• The rise in female-headed households in a mainly patriarchal society.	• Utilisation of services modulated by cultural beliefs, levels of knowledge and awareness, as well as costs in terms of money, time and competing demands. • Lack of access to such resources as condoms and STD treatment due to cost, time and opportunity. • Lack of up to date information to enable women to recognise early signs and symptoms of STI infections as well as to make informed decisions vis-a-vis pregnancy, nutrition, etc.	• Low self-efficacy to challenge cultural norms. • Negative perception of women's lobby groups as dominated by Western ideology and less than ideal role models who are themselves divorced or single parents. • Cultural submissiveness. • Institutionalisation (within families) of traditional norms.	• Limited access to social services for relief from poverty and burden of care.	• Lack of enterpreneurial skills. • Limited marketability for many in a shrinking job market. • Cost of antiretroviral drugs may still be out of reach for the majority. • Female headed households form the majority of households living in poverty.
Opportunities	• A sgnificant proportion of women accessing tertiary education. • A discernible trend of more and more women in top management positions at work.	• A decentralised PHC system with potential for integrating HIV/AIDS prevention and care services into existing services such as MCH and Family Planning. • Syndromic treatment protocols of STD exist which can be capitalised on through increased training, supply of provisions and improved accessibility. • Concept of community based home care that is supported by volunteers within same communities. • The area of paediatric AIDS is one area where solid evidence exists for efficacious interventions which have potential for affordability.	• Receptivity among certain traditional opinion leaders with respect to changing harmful cultural practices like widow inheritance and appeasement of *ngozi*. • Presence of women's lobby groups with potential for outreach work and incorporation of "inside" opinion leaders and peers. • Most families want to have a healthy baby, hence may be willing to pay for services that reduce mother-to-child transmission as well as be receptive to information and counselling.	• The existence of the Social Dimension Fund (which if augmented) can provide relief for e.g. female headed households in need. • Gender focal persons have been engaged in a number of ministries and a deliberate policy on gender sensitivity training adopted.	• Ministries with extension services that can be mobilised to support income generating projects through skills training. • Donor funded CBO which can provide seed funds. • Minister of State responsible for Gender issues in the President's Office. • Ministry of National Affairs co-ordinating functions of gender focal persons who are now employed in most ministries. • Cheaper intervention for reducing mother-to-child transmission are past the trials stage.

RESPONSE ANALYSIS: What is being done

Population services	*Health services*	*Socio-cultural services*	*Social services*	*Economic services*
	• An office responsible for prevention of mother to child transmission has been created within NACP. • A UNAIDS sponsored pilot programme has been initiated: — a number of clinics designated for the purpose of preventing MTCT. — health workers at the clinics trained in and offering VCT nutritional counselling and psychosocial support. — mothers who have volunteered for testing and are HIV positive are being given antiretroviral treatments. • The current vision being for the programme to go nation-wide in an integrated manner, with cheaper intervention coming on board for sustainability, accessibility and affordability reasons.	• Empowerment of community to make informed decisions about starting a family and or having babies through IEC and VCT. • UNESCO sponsored work-shop on AIDS education for grassroot women's NGOs.		• Trials carried out on cheaper intervention protocols for reducing MTCT.

Priority areas	*The identified needs*	*Special objectives*	*Subjected strategies*
Reduce vulnerability to HIV infection.	• Changing underlying cultural and social structures that perpetuate the vulnerability of women to HIV transmission. • Employment of women so as to have greater control over their personal, social and economic lives. • Bridging the gender gap. • Equity in access to education. • Equity in property ownership rights. • Equity in employment opportunities. • Equity before the law and customary practices.	• To work towards greater economic independence for more women. Fair income distribution. • To combat ignorance. • To identify and change gender-related norms that act as barriers to HIV prevention. • To encourage community adoption of norms that eliminate the risk of HIV transmission among women. • To increase equity in decision making at household level. • To ensure 100% awareness among women including those hard to reach due to lack of education, lack of access to visual services and marginalisation.	• Increase access to formal education for women by ensuring that the girl-child's years in school are comparable to those of the boy-child. • Provide more women-friendly services. • Provide sexual health education with a strong life-skills component. • Accessible STD treatment services, VCTs, and condoms and other protections that are woman-controlled. • Foster greater discussion within families, communities and educational curricula of gender roles, sexuality and relationships. • Women's advocacy structures (e.g. the gender desk in the president's office, ministry of women's affairs, women's lobby groups etc.) to sensitise community gatekeepers and opinion leaders, co-opt them, and then through outreach work, support their efforts to challenge unsafe norms and build safer ones within their communities • Increase vocational training opportunities. • Encourage and support the establishment of credit saving schemes for women. • Increase access to information, sexual health services, and prevention methods that are female controlled. • Use channels and venues other than health services for information dissemination (e.g. church groups, clubs and associations as well as hairdressers).
• Prevent mother to child transmission of HIV.	• Antiretroviral treatments for HIV positive pregnant mothers. • Safe obstetric services. • Good antenatal care services.	• To strengthen primary prevention of infection in women of child-bearing age. • To prevent secondary transmission of HIV from mother to child during pregnancy, at birth, and through breast-feeding. • To provide psychosocial support for mothers where mother-to-child transmission has occurred.	• Increase access to information services and resources for preventing HIV transmission from mother to child. • Strengthen MCH and family planning services within the PHC framework. • Incorporate information on HIV within reproductive health education.

			• Comprehensive HIV counselling, including access to VCT services, should be made readily available and accessible to women contemplating pregnancy and those already pregnant. • Ensure equity in accessing drugs that reduce the risk of mother-to-child transmission for HIV positive pregnant mothers. • Comprehensive counselling services in areas like nutrition, hygiene, and psychosocial support. • Facilitate access to supportive counselling, including appropriate referrals for follow-up care, support and networking. • Empowering health workers, including those in private practice, with correct and consistent information on available strategies for reducing MTCT and nutritional options. • Intensify IEC blitz on VCTs, strategies for preventing MTCT and nutritional options at community level to enable families to access the relevant services. • Encourage formation of community support groups for infected mothers and children.
Prevent sexual transmission	• Targeted and innovative IEC strategies. • Building up a culture of prevention and risk reduction.	• To reach women in a manner acceptable and empowering them with information on HIV/AIDS prevention.	• Peer led educational strategies focusing on risk assessment and realistic harm reduction opportunities and options. • Complementary outreach work by health, social and spiritual workers to jump-start and/or support peer-led programmes. • Increase access to condoms (both male and female) through non-stigmatised, conveniently located and diversified distribution outlets.
	• Timeous treatment of STDs.	• To make STD prevention, control and care as widely available, accessible, acceptable and affordable to as many women as possible.	• Peer led IEC programmes that incorporate information on how to detect symptoms early (especially of the so-called silent STDs), and where to go for friendly service. • Improve access to health services capable of offering syndromic treatment as well as confidential counselling.
	• Reducing HIV transmission in commercial/instrumental sexual encounters.	• To increase survival options to offset the need to engage in commercial/instrumental sex.	• Enabling strategies—such as economic development programmes that offer skills-training as well as opportunities for alternative sources of income.

- Promote networking among sex workers in a locality for exchange of information through peer education as well as for mutual support in risk reduction efforts (e.g. all insisting on "no condom no sex").
- Gender sensitive harm reduction strategies that target both parties involved in instrumental sex.

YOUTH: SITUATION ANALYSIS

	Population issues	*Health issues*	*Socio-cultural issues*	*Social services issues*	*Economic issues*
National Guiding Principles	• Rights defined in the UN convention on the Rights of the Child. • The African charter on the Rights and Welfare of the Child. • The Child Protection and Adoption Act. • The Education Act. • The Guardianship and Adoption Act.	• Health for all by year 2000. • Rights for information on HIV/AIDS/STDs as well as sexual health services including barrier methods and early treatment.	• Legal age of majority—18 years. Traditional customs, norms that have authority vested in elders with limited rights for youths and expectations for them to conform.	• Access to education and other social services.	
Determinants of HIV Spread.	• A large proportion of new infection are in the 15–24 year age group. • Average age for first sexual intercourse 16.6 years for boys and 17.6 years for girls. • 53% of youth did not use protection in last sexual act. • In the age group 15–19 years, females have 5 times higher HIV risk than males. • Female infection peaks at ages 14–23 and male infection at 24–33. • In 1996 34% of total population was aged between 10–24 years.	• Reversal of gains in infant and child mortality as well as life expectancy. • Early onset of sexual activity including between adolescent females and older man. • Lack of or limited access to youth friendly services offering sexual health information, STD treatment, and barrier protection. • Poor access to condoms among sexually active youths. • Partner turnover is high during adolescence and its serial monogamous nature may give a false sense of security. • Burden of caring for sick family members especially for the girls.	• A fundamental question lingers whether sexual health education should be offered to the youths (especially in schools) at all. • Breakdown of traditional socialisation agents like *tetes* and *sekurus* leaving a void. • Perceived usurping of parental control through such legislation as the legal age of majority. • Parents feel unable to communicate openly and adequately about sex with their children.	• Department of Social Welfare's draft policy on orphaned children and those in difficult circumstances has not been translated into adequate safety nets. • Loss of income due to death of parents has compromised access to education of some children, especially girls. • Extended families may be unable/unwilling to care for orphans due to lack of resources. • Sex education though incorporated in the school curriculum is not	• Increased dependency due to lack of employment opportunites. • Increased tendency towards child labour to supplement household incomes. • Reduced consumption at household levels where there is AIDS related mortality and morbidity. • Poverty may expose the youth to risk for HIV infection e.g. sugar daddy or mummy syndrome.

	Population issues	*Health issues*	*Socio-cultural issues*	*Social services issues*	*Economic issues*
National Guiding Principles	• The rate of mother to child transmission is currently 30%. • Population of orphans under 15 years has risen from 15 000 in 1990 to 150 000 by 1996/7 and projected to reach 1 000 000 by 2005. • Death peaks in the 0–4 years and 30–39 years age groups resulting in loss of care-givers and socialising agents as well in more child headed households. • Youngsters account for 60% of all new infections. • Increasing teenage pregnancy.	• Pregnant teenagers more likely to be HIV positive than their counterparts in the general population. • Population growth being moderated by increase in infant and child mortality rather than decrease in birth rate.	• Traditional cultural values and norms are being undermined by exposure to other cultures through the media. • Norms that discourages access to information and services for safe sex especially for girls.	complemented out of school. • Weakened traditional Community safety nets. • The reversal of the free education policy may be exarcebating dropping out of school due to inability to pay school levies and fees.	
	Population issues	*Health issues*	*Socio-cultural issues*	*Social services*	*Economic services*
Obstacles of change	• Large gap between what the youths want and need regarding HIV related information and services and what society and government are prepared to allow.	• Proscription against providing barrier methods to those under 16 years without parental consent especially for girls. • Sense of invulnerability due to lack of/or inadequate information as well as need to experiment. • Limited access to youth friendly health and counselling services for family planning and STD treatment. • The trade offs between various priorities (e.g. health risk vs belonging).	• Cultural and religious reservations about sex education. • Sex education in school is deemed sensitive and controversial. • Double standards for boys and girls in relation to responsibility, virginity, etc. • Gender imbalances in terms of equity in accessing educational opportunities.	• A significant percentage of youths are out of school and thus lack of access to information on HIV/AIDS. • Limited availability of youth centres offering recreational and information facilities. • Youths easily bored with formal occasions. • School curricula is often seen as already too overcrowded to accommodate additional input.	• Unemployment. • Limited vocational skills training opportunities.

	Population issues	*Health issues*	*Socio-cultural issues*	*Social services*	*Economic services*
Obstacles of change			• Peer pressure. • Pressure for early marriage especially for girls. • Existence of some traditional practices that put girls at risk. • Religious resistance to family planning contraception and condoms.	• Where HIV prevention and sexual health education exists in the curricula, it is heavily loaded with information at the expense of behavioural skills. • Many of the few teachers, trained through the cascade model lack confidence to teach life skills. • Some of the teachers are not themselves acceptable role models morally and behaviourally.	
	Population issues	*Health issues*	*Socio-cultural issues*	*Social services*	*Economic issues*
Opportunities	• Majority of youths attending school.	• ZNFPC has embarked on a decentralised youth responsibility programme. • The concept of peer education on sexual health and HIV/AIDS matters has shown high level of acceptability among youths both in and out of school.	• Children very highly valued in families, communities and society. • Existence of groups advocating for rights of children especially the girl-child as well as agitating against cultural practices like "kuripa ngozi" that put girls at risk. • Traditional leadership such as chiefs and headmen who can mobilise community resources to support	• Ministry of Education with support from UNICEF has incorporated HIV/AIDS education in the curricula from Grade 4 upwards. • Ministry of Youths Sports and Culture can take up the challenge. • Department of Social Welfare can implement its policy on orphaned children and those in difficult circumstances.	

	Population issues	*Health issues*	*Socio-cultural issues*	*Social services*	*Economic issues*
Opportunities			orphans e.g. Zunde ramambo concept. • Potential role models exist in fields appealing to youths such as sports and entertainment.	• The concept of Anti-AIDS clubs has taken roots in some communities. • Most religious denominations have youth programmes. • Other youth oriented organisations like boy and girl scouts exist.	

RESPONSE ANALYSIS: What is being done

Population issues

- Wide spread IEC programmes have been undertaken at various levels resulting in high levels of awareness even among the youth.

Health issues

- Collaboration between ZNFPA, Ministry of Health and other stakeholders in some districts like Shurugwi has resulted in Youths Responsibility Programme for 10–24-year olds especially those out of school.

  Main activities include peer and drama group education on sexual health, growing up life skills and material production.

  — 3 local health centres identified and designated as youth friendly health centres.

  — Health workers here sensitised and trained and complemented by a youth friendly corner manned by trained peer (youth).

- Research in progress and protocols for reducing vertical transmission in trial phase.
- Training of Community Based caregivers in infection control.
- Agitation for youth friendly health services.
- UNFPA supporting the promotion of youth responsibility programmes and the development of a model health service for youths through the strengthening of the youth reproductive health programme.

Socio-cultural issues

- Sensitisation of the local civic, political, traditional and church leadership.
- Formation of youth/teen support groups and clubs in which delaying onset of sexual activity and engaging in safe sex are normative behaviours.

Social services

- Sports football teams formed in some districts.
- A library with HIV/AIDS information at Tongogara centre.
- "Youth for real" programme airing 2 days a week on radio 3 (which is the station of choice for youth).
- A magazine for youth called "Straight Talk" and a booklet "Young people speak out" are widely disseminated through support from UNESCO and UNICEF.
- Community home based care and orphan support projects are taking root in most communities and providing essential services.
- The Baptist Church has started a "Youth in Touch Programme" that provides youths with group friendship to assist them in dealing with peer pressure.
- A number of schools have anti-AIDS clubs in place.
- CADEC has running, a programme for youths, looking at sexual responsibility, reproductive health and responsible moral behaviour.
- Masvingo district has in place a functioning child welfare forum.
- UNICEF supported life-skills programmes targeting school-going youths, orphan care programmes, as well as youth advocacy programmes for out of school youths and youth friendly health services.

Economic issues

- Poultry and dairy income generating projects.
- Some district development associations have been sold on the idea of fund raising for activity to reduce vulnerability e.g. Shurugwi holding a district AIDS convention.

STRATEGY FORMULATION: What needs to be done—Youths

Priority area	*The identified needs*	*Specific objectives*	*Suggested strategies*
Reduce the vulnerability of the youths to HIV infection.	• Advocacy and consensus building among the various stakeholders to get community behind prevention efforts.	• To make youth oriented programmes acceptable to all key stakeholders.	• Garner the support of the wider community (politic, cultural, traditional, spiritual opinion makers) leadership in initiating programmes tailored for the youths. • Utilise opinion leaders within communities (educational, religious, traditional, peers) to: — disseminate HIV prevention information. — encourage and support prevention norms, attitudes and skills. — Embed HIV/AIDS prevention in an overall message of sexual health since pregnancy and STDs may be of more immediate concern to youths. • Review national policies to reduce the vulnerability of young people to HIV and to ensure respect and protection of their rights.
	• Youth oriented outreach work.	• To engage youths in proactive HIV activities.	• Listen more to what young people think and believe to ensure acceptable and appropriate programmes. • Pay special focus on the disadvantaged youths (such as those out of school, street kids, orphans) with a view to improving their access to resources and/or create more recreational centres with information desks and IEC activities for the out of school youths. • Creating more income generating opportunities supported by vocational training. • Capitalise on the comparative advantages of relevant ministries, sectors, organisations and available structures to reach with relevant information and empower with requisite support, the youths e.g. schools for the in-schools, sports-for-all for the out of school).
	• Appropriate and adequate training.	• To tailor training programmes to suit and respond to the prevailing conditions and needs of the youths.	• Match the right training with the target population to reflect prevailing conditions e.g. — Type of education (whether academic or vocational) to depend on ability, resources and opportunity. — Type of vocational skills training (whether carpentry, agricultural, garment making) to depend on potential resources and the job market in the community.

Priority area	*The identified needs*	*Specific objectives*	*Suggested strategies*
Prevent sexual transmission of HIV.	• Enabling norms for preventing HIV transmission.	• To delay the onset of sexual activity among youths.	• Studies of the social and or media influence on sexual behaviour in order to be able to strengthen group norms about delaying sex and against unprotected sex. • Employ participatory and entertaining strategies for the dissemination of information (music, drama) using a variety of setting and occasions (soccer matches, favourite programmes on radio and TV) featuring stars and role models. • Intensify sexual education among the youth that have never had sex before—(this has been found to delay onset of sexual intercourse). Shift focus from information about modes of transmission to information and discussion on which behaviours put the youths at risk and how and why and when. • Intensity formation of peer groups in schools and community that advocate a culture of abstinence and delaying onset of sexual activity—such groups to be supported by adults who accept youths on their own terms.
	• Complete coverage and reaching of all youths.	• To ensure that the youths have access to youth friendly services.	• Multi-channel and multi-site/venue approach to include radio spots on popular stations such as radio 3, television spots on popular programmes such teen scene, social and cultural centres and clubs for youths that can double as youth friendly clinic by day and social/entertainment centres by night, and sports and recreational clubs. • Establish youth-friendly drop-in centres where sexual health information, STD treatment, condom distribution, prevention and supportive counselling are available. • Establish youth clinics in all districts manned by sensitised and trained health workers complemented by youth corners manned by trained peers.
	• Multi-dimensional approach to behaviour change.	• To enhance the youths' sense of self-efficiency.	• Behaviour skills enhancement strategies that include risk education and sensitisation, sexual communication skills training and condom use and safe-sex skills training. • Imparting context-specific information and skills that: — increase youths' ability to communicate effectively about sex. — Icrease condom use skills — Personalise risk and make risk avoidance normative — Support and reinforce sustained risk reduction. • Targeted risk-reduction skills through instruction, feedback modelling and practice to address the cognitive and psychosocial dissonance to behaviour change.

Priority area	*The identified needs*	*Specific objectives*	*Suggested strategies*
	• Improving sex education beyond the biology and mechanics of sex.	• To increase the confidence and competence of teachers and school health masters.	• Teacher training to include the emotional, attitudinal and interpersonal aspects of sexuality and sexual behaviour. • Incorporate HIV/AIDS and life skills into teacher training curriculum and support this with an enabling teaching environment and class curriculum.
	• Effective continuum of prevention programmes from school to home to community.	• To increase the proportion of youths who learn how to reduce risk of HIV infection.	• Classroom sessions to impart accurate information about risks including outcomes of unprotected sex and how to avoid them commencing before sexual activity starts. • School-wide-peer-led activities (relevant to age and sexual experience) to address social influence. • Ensuring the best criteria for selection of peer educators who should: — be acceptable to other members of the group — respected opinion leaders within the group — willing to undergo the necessary training — Commitment to program goals. • Increasing the interaction between the school (teachers and PTAs) the home (family) and the community (opinion leaders, gatekeepers and health and social services providers). • Use social networks: — to disseminate information — as a source of emotional and instrumental support — as reference for social norms. • Changes at the community level by co-opting key opinion leaders and getting them to adopt and endorse behaviour changes. In addition role models to spearhead change in community norms, especially for the youth who are vulnerable to the effects of peers. Such a focus should address the socio-cultural factors surrounding the individual that may impinge on behaviour change.

Priority area	*The identified needs*	*Specific objectives*	*Suggested strategies*
	Creation of a partnership between policy makers, religious and community leaders, parents and teachers.	To create norm changing programmes involving school authorities, opinion leaders and role models.	• Open dialogue inclusive of all stakeholders, find out or establish areas of consensus. build on established or existing consensus and cement this in national policy. • Strive for continuity and co-ordination between different levels such as local schools, district and provincial offices and the national level. • Enhance complementarity among the different sectors with a stake in the welfare of youths such as health, education, religious and NGOs. • Complement good in-school curriculum with responsive extra curricula programmes.
Prevent mother to child transmission of HIV	• Reduction of paediatric AIDS cases	• To cut down the proportion of babies infected with HIV.	• Strengthen MCH and family planning services within the PHC framework. • Incorporate information of HIV within reproductive health education. • Comprehensive HIV counselling, including access to VCT services, should be made readily available and accessible to women contemplating pregnancy and those already pregnant. • Ensure equity in accessing drugs that reduce the risk of mother-to-child transmission for HIV positive pregnant mothers.