HIV and AIDS Conference

Zimbabwe

Taking Stock, Looking to the Future

15-18 June 2004

Report prepared by:

Organizing Committee
National HIV and AIDS Conference

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Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retroviral (drug)
ART	Anti-retroviral Therapy
ARV	Anti-retroviral (drug)
ASOs	AIDS Service Organisations
Byo	Bulawayo
CBO	Community Based Organisation
CDC	Centers for Disease Control
CD-ROM	Compact Disk – Read Only Memory
Cotco	Cotton Company of Zimbabwe
CPCPZ	College of Primary Care Physicians
DAAC	District AIDS Action Committee
DART	Development of Anti-retrovial Therapy
DNA	Deoxy-ribonucleic Acid
EC	European Commission
EU	European Union
GF-CCM	Global Fund – Country Coordinating Mechanism
HBC	Community Home-Based Care
GIPA	Greater Involvement of People living with AIDS
HIV	Human Immuno-deficiency Virus
IEC	Information, Education and Communication
MoHCW	Ministry of Health and Child Welfare
MSF	Medecin Sans Frontiers
NAC	National AIDS Council
NACP	National AIDS Control Programme
NATF	National AIDS Trust Fund
NBTF	National Blood Transfusion Service
NGOs	Non-Governmental Organisations
NPA	National Plan of Action
NTP	National TB Programme
HOSPAZ	Hospice Association of Zimbabwe
HQ	Headquarters
ILO	International Labour Organisation
NANGO	National Association of Non-government Organisations
NATF	National AIDS Trust Funds
NGO	Non-government Organisation
OC	Organising Committee
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PAAC	Provincial AIDS Action Committee
PCR	Polymerase Chain Reaction
PI	Principal Investigator

PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother To Child Transmission
PSZ	Pharmaceutical Society of Zimbabwe
PTCT	Parent to Child Transmission
PWAs	People With AIDS
SADC	Southern African Development Community
SAPES	Southern African Political and Economic Series
STI	Sexually Transmitted Infection
STI	Structured Treatment Interruption
TB	Tuberculosis
PMD	Provincial Medical Director
RDC	Rural District Council
SA	South Africa
SADC	Southern Africa Development Community
SHAZ	Shaping the Health of Adolescents in Zimbabwe
TMPAZ	Traditional Medical Practitioners Association of Zimbabwe
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
UZ	University of Zimbabwe
VCT	Voluntary Counselling and Testing
WBC	White Blood Cells count
WHO	World Health Organisation
ZBCA	Zimbabwe Business Council on AIDS
UNAIDS	United Nations AIDS (Organisation)
UNGASS	United Nations General Assembly Special Session
VAAC	Village AIDS Action Committee
WASN	Women and AIDS Support Network
ZACH	Zimbabwe Association of Church Hospitals
ZAN	Zimbabwe AIDS Network
ZCPHP	Zimbabwe College of Public Health Physicians
ZIMA	Zimbabwe Medical Association
ZINATHA	Zimbabwe National Traditional Healers Association
ZITHA	Zimbabwe Traditional Healers Association
ZW	Zimbabwe
ZWRCN	Zimbabwe Women's Resource Centre and Network

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Finally, we would like to thank all the participants who came to the conference, without whose support this event would not have taken place. We would also like to thank their organizations who sponsored them to attend the conference.

Foreword by the Minister of Health and Child Welfare
Dr D Parirenyatwa

Zimbabwe continues to have one of the highest HIV infection rates in the world. By the end of 2003, it was estimated that 24.6% of the adult population was infected with the virus. Since the first case of HIV in Zimbabwe was identified almost 20 years ago, several response initiatives have been put in place at various levels through out the country yet the problem remains. It is with this background that the Ministry of Health and Child Welfare together with its partners decided to hold a national HIV and AIDS conference to take stock of all HIV response initiatives, and to use lessons learnt from these initiatives to improve the nation's HIV response. This national conference had representatives from all sectors of Zimbabwean Society, including government departments, private sector organizations, religious organizations, NGOs, bilateral partners and UN agencies.

This conference report outlines the many HIV response initiatives that the ministry, together with its partners from various sectors have introduced. The report also gives us a better insight into the epidemic and our response to it than before, thus enabling us to better plan and effectively implement future interventions.

It is pleasing to note that the three thematic areas of Prevention, Care and Mitigation were given similar importance during the conference and in this report. Recommendations for each thematic area are clearly articulated at the end of each thematic chapter. A separate chapter has been dedicated to the conference recommendations. This chapter includes the overall conference recommendations as well as the recommendations for the three thematic areas. It is hoped that this lay out will enable one to easily identify recommendations on the thematic areas of interest in order to act on them immediately.

One of the main recommendations of the conference was to improve coordination in all activities and at all levels. The issue of coordination was highlighted through out the conference. The President, Cde. R. G. Mugabe, in his opening speech set the tone by encouraging those involved in HIV and AIDS programmes to work in a coordinated manner in order to strengthen the agreed framework of the three ones which were outlined as:

- One national strategic plan for the fight against HIV and AIDS
- One coordinating authority and
- One monitoring and evaluation system.

Other key conference recommendations included the need to intensify prevention, improve access to ART, improve access of services to women and children as well as the need to improve human resource capacity through training and innovative retention schemes.

This truly national conference gave us an opportune time to look anew at the status and course of the HIV and AIDS epidemic and our national response and to map a way forward. Best practices, achievements and challenges have been clearly outlined in this report. What is left is for all of us to take note and to start implementing the conference recommendations without fail.

Dr. David Parirenyatwa
Minister of Health and Child Welfare

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OPENING ADDRESS BY HIS EXCELLENCY THE PRESIDENT OF THE REPUBLIC OF ZIMBABWE, CDE. PRESIDENT ROBERT GABRIEL MUGABE

His Excellency, President R G Mugabe

The Honourable Vice President of Zimbabwe, Comrade Joseph Msika,
The Minister of Health and Child Welfare, Dr David Parirenyatwa, Ministers of Health from the SADC Region, Other Ministers present, The Resident Minister of the Harare Metropolitan Province, Comrade Witness Mangwende, Members of the Diplomatic Corps and Heads of International Organisations, The National Aids Council Board, Invited Guests and Delegates, Comrades and Friends.

It is almost twenty years since the first case of AIDS was identified in Zimbabwe. Subsequently, Zimbabwe became one of the very first countries in Africa to introduce testing for HIV, initially, to screen blood for the HIV virus once it was known that it could be transmitted through blood and related products. I want to proudly note that, since then, blood donation has always remained safe in Zimbabwe.

However, because of the unrelenting onslaught of HIV and AIDS, we gather here, today, for the first ever National Conference on HIV and AIDS under the theme, "Taking Stock: Looking to the future".

Estimates released last year by the Ministry of Health and Child Welfare show that HIV

prevalence among sexually active adults between the ages of 15 and 49 years stood at 24,6 per cent with an estimated 1,82 million persons living with HIV and AIDS. An estimated 40,000 new HIV infections occurred while about 135 000 lives were lost to AIDS.

Though the adult HIV prevalence rate appears to be stabilizing, the number of AIDS-related illnesses and deaths will continue to rise, as present UIV cases develop into full blown AIDS. We are, therefore, faced with the challenges of stemming the number of new HIV infections, providing comprehensive care, treatment and psychosocial programmes for those living with HIV and AIDS, and integrating the impact of AIDS in our society.

I am confident that the majority of fellow Zimbabweans are, today, fully aware of how HIV is spread and how it can be prevented. As we meet here, there is hardly any community or family in our country that has not been touched or affected by HIV and AIDS. The evidence lies bare for all of us to see; increasing numbers of hapless orphans and the growing incidence of children being forced to abandon their education in order to become family heads, well before their time.

It is disappointing that the majority of people still choose not to know their HIV status. I hope this Conference will help to disabuse delegates of this stigma and bring the reassurance to our people that knowing your HIV status enables you to live a healthier, informed life.

My Government is committed to tackling the problem of HIV and AIDS. At the start of the epidemic, the Ministry of Health and Child Welfare was at the forefront of this fight. But, as it became clear that the effects of HIV and AIDS went beyond the health sector, a multi-sectoral strategy was adopted to fight the deadly pandemic. In 1999, at this venue, we launched our National AIDS Policy which was to guide the response in the various sectors. This was followed in the year 2000 by the establishment, through an Act of Parliament, of a multi-sectoral National AIDS Council (NAC) to co-ordinate the overall national response to HIV and AIDS.

In the same year, Government created the groundbreaking National AIDS Trust Fund (or AIDS Levy) which is funded by a 3 per cent levy on all taxable income, thus ensuring a consistent source of much needed financial support for AIDS programmes. The National AIDS Trust Fund is shared among communities through District, Ward and Village AIDS Action Committees to support all HIV and AIDS prevention and care, to meet the needs of people living with HIV and AIDS, and to support children orphaned by the pandemic.

From the beginning, our responses to HIV and AIDS have not been through Government channels alone. We note and appreciate the assistance we have received from bilateral partners and the multi-lateral agencies from the United Nations. We also note the growing number of Non-Governmental Organisations formed specifically to tackle the HIV and AIDS epidemic. I am informed that more than 300 NGOs and Community-Based Organisations (CBOs) are today involved in HIV and AIDS work with most of them in the rural areas.

Those involved in HIV and AIDS programmes need to work in a coordinated manner which strengthens the agreed framework of the "Three Ones", namely,

- one National Strategic Plan for the fight against HIV and AIDS;
- one Coordinating Authority and
- one Monitoring and Evaluation System.

Only through this harmonized approach can we build synergies and reduce duplication, in particular, the unnecessary waste of resources. More importantly, by working together, we will be able to take stock of our effective programmes and successfully expand and strengthen them.

Whilst no cure exists yet for AIDS, modern medicine has come up with therapies that can delay the onset of the disease. Antiretroviral drugs improve the quality of life for people living with FIIV, and reduce the morbidity and mortality associated with AIDS. They can also be used to prevent the transmission of HIV from an infected pregnant woman to the unborn baby. Accordingly, the Ministry of Health and Child Welfare has a Prevention-of-Parent To Child-Transmission Programme, which today, covers 43 of the *58* district hospitals in the country.

A sum of Z$ 15 billion ($10 billion from the fiscus and *$5* billion from NAC funds) has been made available for the procurement of antiretroviral drugs in our public sector hospitals. The programme has already started at our major referral hospitals of Harare and Mpilo. Further, it is hoped that it will spread to other central and provincial hospitals by the end of the year. Regrettably, I am informed that at the current drug costs, we can

only reach 10 000 patients. Clearly, there is need to mobilize more resources and build sustainable partnerships so that we can reach more patients.

Two years ago, my Government declared lack of access to AIDS drugs a national emergency in order to facilitate the importation of quality, yet cheaper, generic antiretroviral drugs and allow local companies to manufacture them. I believe there is scope for Government and the pharmaceutical companies to work together so as to bring the prices of the drugs down and enable more of our people to benefit. I wish to assure this Conference that improving access to treatment is one of the priorities of Government. However, access to ARV treatment has to be viewed in the context of comprehensive programmes for AIDS care, that include access to counseling and testing; appropriate nutrition; prevention and treatment of opportunistic infections, Community-Based Care, and orphan and psychosocial support.

There is need also to complement expensive modern ARVs by finding a role for effective traditional medicine in AIDS care. After all, the majority of our people still rely on, and *could benefit* from, traditional medicine, as long as the proposed remedies pass the necessary medicines control tests.

As we take stock, it is pleasing to note that the Ministry of Health and Child Welfare has reported that our HIV prevalence rates are somewhat stable, having reached a "plateau" at around 24,6 per cent. While this is a fitting tribute to our existing prevention programmes~ our challenge remains that of working harder not only to safeguard the gains recorded so far, but also to reverse the tide of the epidemic, reduce new infections, and eventually bring down HIV prevalence to single digits.

We need to continue providing correct and appropriate information, education and communication on HIV and AIDS, fight tirelessly the tyranny of stigma and discrimination, and ensure that more people know their HIV status and are in a position to take positive steps to prevent its spread.

Voluntary Counseling and Testing centres, also called VCT centres, which are currently located in the urban and semi-urban areas, will have to spread out to all rural areas as well.

We all know that abstinence and mutual faithfulness among relationships are the strongest prevention measures and cost nothing. I encourage our young people to delay sex until after marriage and to remain faithful in the marriages. The youth are our future and hold the key to reducing the spread of the epidemic.

There is no doubt that HIV and AIDS is one of the greatest challenges facing our Nation. However, it is not an insurmountable challenge. We can, and we should rise above this challenge, and win this fight.

I am heartened by the fact that, so far, Government, the private sector, bilateral and multi-lateral partners, NGOs/CBOs and ordinary citizens have joined together to tackle the pandemic. I am further heartened to learn that planning for this important Conference has

also benefited from this multi-sectoral approach.

May I conclude by re-affirming my Government's commitment to providing a conducive atmosphere and policy framework for the fight against HIV and AIDS.

It is now my singular honour to declare this, Zimbabwe's first National HIV and AIDS Conference, officially open. May its deliberations enable participants to emerge better prepared for the pressing fight against HIV and AIDS.

Tatenda, Siyabonga, I thank you.

Executive Summary

N.B:

This report is accompanied by other material that the reader should consult for details of some of the conference proceedings. This extra material includes:

a) A book of all the abstracts that were either presented in the oral sessions or as poster presentations. The book is both in print form and as part of the conference CD-ROM.

b) A CD-ROM with all the material that was presented at the conference in easily accessible electronic form. Among other things, the CD-ROM contains the book of abstracts, this report, all the speeches that were given by the various dignitaries and all the Powerpoint presentations given during the conference.

c) A video documentary of the conference.

All this material can be obtained from either the National AIDS Council (NAC) offices or the offices of the AIDS and TB Unit of the Ministry of Health and Child Welfare in Zimbabwe.

Zimbabwe was among the first countries to recognize the HIV and AIDS problem and take organized action on a national level to ameliorate its effects. The first case of HIV was tested positive in 1985 and screening of blood donors for HIV started in the same year. Recognising that in 2004 it would be almost 20 years since the first person tested HIV positive, representatives from the National AIDS Council (NAC), the AIDS and TB Unit of the MOHCW and the Zimbabwe College of Public Health Physicians (ZCPHP) proposed to hold a national conference to take stock of what had been learnt, and use those lessons to improve the response measures. The conference was **held from 15 to 18 June 2004**, and this report summarizes its deliberations and recommendations.

The theme of the conference was: "Taking Stock - Looking to the Future". This theme was discussed under the three main sub-themes of (i) Prevention; (ii) Care and (iii) Mitigation, mirroring the three main ways of addressing HIV and AIDS.

The objectives of the conference were: a) To review the HIV and AIDS response effort in the key sectors of society such as: the public sector, private sector etc and allow cross-sectoral experience sharing; b) To draw up the main lessons from these experiences; and c) To suggest ways to improve the HIV and AIDS response in the country

The conference programme was arranged so that each day focused on one of the sub-themes of 'Prevention", "Care" and "Mitigation", plus a fourth day for wrap-up and recommendations. Each day's deliberations started with key presentations on the theme of the day, followed by panel discussions led by representatives of various sectors to bring out the sectoral experiences and key issues on the theme of the day. Then there were short abstract presentations on researches, studies and evaluations. The day ended with breakout sessions/group discussions to agree on the key issues and recommendations

which came out of the day's presentations and discussions. (**N.B:** The reader is encouraged to read Chapter 6 for the details of the thematic key issues and recommendations).

Day one focused on "HIV and AIDS Care and Treatment". Key presentations were made on the current state of ART implementation in the country and real-world experiences of implementing ART at a hospital setting as well as other aspects of care such as nutrition and opportunities and challenges of integrating TB and HIV and AIDS programmes. Some of the abstracts presented were on "*Increasing Male involvement in home based care"; "Young People and HIV AND AIDS"; "Spiritual Care of HIV AND AIDS Patients"; "Antiretroviral Therapy In Resource Limited Settings"; "Clinical experience in the use of highly active antiretroviral drugs in a community based project" and "Primary Care Counselor (PCC): Developing Counseling Capacity in Health Care Setting ".*

After the presentations, delegates went into breakout sessions/group discussions on the main sub-themes of a) "*ART and OI*", b) "*Nutrition, Treatment and Care*"; and c) "*Home Based Care"*.

While **Day 2** focused on "Prevention" as the main theme, undoubtedly one of the day's highlights was the official opening of the conference by His Excellency, the President of Zimbabwe and the testimonies given by youths during the official opening on their experiences with HIV and AIDS. President Robert Mugabe expressed his disappointment at the continued stigma associated with testing and counseling and knowing one's HIV status. He also expressed the need to work in a co-ordinated manner which strengthens the agreed framework of the 'Three Ones', namely one National Strategic Plan for the fight against HIV and AIDS, one Coordinating Authority and one monitoring and valuating system.

The three youths who spoke during the opening ceremony stressed the need for young people to be fully engaged and empowered, not simply with facts and messages but with real ways to find solutions to their circumstances.

Two Health Ministers from some of the SADC countries, Dr. Manto Tshabala-Msimang, the Minister of Health of South Africa, and the Deputy Health Minister of Angola, Dr. Jose Van-Dunem, gave solidarity messages and shared their countries' experiences. Dr Tshabala-Msimang pointed out that SA's ART roll out plan had not been without difficulties, such as interrupted drug supplies in one of the provinces, even though South Africa is producing its own ARVs. She revealed the existence of an SADC HIV and AIDS initiative to which SA has pledged funds. The Angolan Deputy Minister for Health said that despite the destructive effects of 30 years of war, Angola was determined to fight the HIV and AIDS scourge and prevent its prevalence from rising further than the current 5.5%. It could therefore learn from the experiences of Zimbabwe through this conference.

A sample of some of the abstracts presented included: "*PMTCT Pilot Study: -Single dose nevaripine use, feeding practices and clinical manifestations in infants*"; "Post Exposure

Prophylaxis: Preventing occupational transmission of HIV"; "*Scientific Impact & Process Evaluation Of Integrated Behavioural & Biomedical Interventions In Rural Zimbabwe" and "Early introduction of non-human milk and solid foods increases the risk of postnatal HIV-1 transmission in Zimbabwe"* .

Day 3 focused on the Mitigation aspects of HIV and AIDS and Dr Kenneth Kaunda, the first president of the Republic of Zambia gave a keynote address. He praised the country for the introduction of the "AIDS Levy", the first of its kind in the world. He noted that AIDS does not discriminate, transcending all boundaries such as politics, religion and ethnicity and urged groups to continue to fight the scourge of AIDS together as they had done with the slave trade, colonialism and apartheid and urged more open talk on the subject so as to fight stigma and discrimination. In his view, poverty elimination and good nutrition were the most important factors in the fight against this condition, especially given the expensive nature of anti-retroviral therapy.

Key presentations were made on "*Overview of Zimbabwe's HIV and AIDS Response*", "*Faith-based response to the HIV and AIDS Fight***", "***Zimbabwe's National Plan of Action (NPA) on Orphans and Vulnerable Children (OVC)*","*HIV and AIDS Workplace Strategies in Zimbabwe*" and "*Gender Issues and HI and AIDS*".

Some of the abstracts presented were on: *"Challenges and Incentives for Adults When Considering Taking in Children Orphaned by AIDS*"; "*Girls speak their minds to protect their futures: A study to explore the sexual health needs of young women affected*", "*A Comparative Study Between Assisted and Non-assisted Orphans*", "*Training of Community Based Counselors to Help Communities Cope with Psychosocial Effects of HIV and AIDS* " and "*Adult mortality & erosion of household viability in towns, estates & villages in eastern Zimbabwe*".

Overall Summary of Main Achievements, Lessons Learnt and Recommendations

The following is the agreed overall summary of the main achievements, lessons learnt, areas needing attention and recommendations of the conference.

Main achievements of HIV and AIDS Response So Far

The following were noted as some of the achievements of the HIV and AIDS response so far:

2 The conference noted that there is evidence that the emphasis on prevention in the HIV and AIDS programme was now bearing fruit, as shown by the fact that **the rise in the prevalence rates in sexually active adults has reached a plateau**.

- It was also noted that this has been achieved through broad**-based involvement of all sectors of Zimbabwean society**, from government, the private sector, non-government organizations, bilateral and multi-lateral partners as well local communities and community-based organizations.

- Voluntary counseling and testing (**VCT**) facilities are being set up throughout the country, though it was noted that the rural areas are still under-served.
- With the recent decline in the prices of anti-retroviral drugs (ARVs), a well thought-out **anti-retroviral therapy (ART) implementation scaling up had started**.
- An **overall policy on mitigating the effects of HIV and AIDS on orphans** and other vulnerable children (OVC) had just been concluded and should assist in coordinating mitigation efforts in all sectors.
- Another of the main achievements of the national HIV and AIDS response has been the **visible show of commitment from all partners**, as evidenced by the Creation of a Multi-sectoral National AIDS Council; Establishment of National AIDS Trust Fund which has so far cumulatively collected more than 26 billion ZW$; the declaration of AIDS as a National Emergency to improve access to AIDS drugs; establishment of community based ASOs and the establishment of Business Council on AIDS.

Key Lessons Learnt

- **Coordination is essential**: though the response has involved all sectors, it has not been as coordinated as it should have been, resulting in less than optimal results.
- **Stigma and discrimination persist**: It was noted that despite all efforts, stigma and discrimination persisted and more innovative ways to combat them are needed.

1. **Emphasis on prevention is essential:** it was noted that since prevention efforts are now bearing fruit they needs to remain the mainstay of the response so as to turn the tide of the increase in new cases and lessen the burden on service delivery facilities in all sectors.

1) **ART needs to be comprehensive and planned carefully:** Though care for those with AIDS had started, it has not always been comprehensive and tended to focus on ARVs, neglecting other aspects of care such as nutrition.

- The **nation could learn from the experience in some countries in the region** which show that unless ART scaling up is carefully planned, it could result in periodic stops due to shortages of drugs and other essential materials.

- **Need for involving beneficiaries of programme such as youths, PLWAs and the disabled:** Some specific segments of society (youths, people with disability and PLWA) eloquently spoke of the need to more meaningfully involve them in programmes that are targeted at them and which affect them, at all stages. This also includes refugees and migrant populations.

- **Information dissemination/sharing is essential:** It was observed from though there is a huge amount of information, it has not been well disseminated or shared with relevant others who could benefit from it.
- **Need for regular updates in policies related to HIV and AIDS:** It was also noted that policies related to HIV and AIDS need to be updated regularly to keep them relevant to a changing environment.

Summary of Recommendations

The following is a summary of recommendations, which should be considered in conjunction with the recommendations from each conference session.

N.B: Please see Chapter 6 for more detailed recommendations of the conference which are grouped into the three main themes of Prevention, Care and Mitigation.

1. Improve coordination in all activities and all levels
2. Build on and intensify prevention efforts to start reduction of the number of new cases
3. Improve access to ART by
   - *i. Reaching more clients*
   - *ii. Ensuring uninterrupted drug supply*
   - *iii. Reducing the cost by working with local drug manufacturers to make the ARVs more affordable and exempting raw materials from customs duty.*
   - *iv. Being more comprehensive and including other care aspects such as nutrition and traditional remedies which have been shown to be effective*
4. Improve access of services to women and children
5. Improve services to migrant populations and refugees
5. Involve youths in programmes targeted at them
6. Involve PLWA in all aspects of the response
7. Improve human resource capacity through
   Training and skills development in all aspects of the response e.g during ART scaling up
   More innovative human resource retention schemes
8. Increase uptake of counselling and testing, particularly in rural areas
9. Improve resources for OVCs (incl. children in institutions)
10. Intensify resource mobilisation such as for ART scaling up
11. Regularly update policies related to HIV and AIDS
12. Ensure needs of the disabled of all types (deaf, blind, etc) are taken into account when drawing up interventions
13. Improve the dissemination/sharing of information such as guidelines, policy documents, studies and evaluations.

Recommendations for future Organization of the Conference

1. Need more than six months for preparations – ideally a year
2. Multi-sectoral team should continue to prepare for it
3. To allow time for implementation of the recommendations, future conference should be held after at least two years.

Next Steps

- Finalise and disseminate the report to all sectors, including putting it up on the MOHCW website.
- Ensure that recommendations of the report are disseminated to all relevant authorities and sectors and are implemented.
- Monitor implementation of the recommendations, including twice yearly publishing of progress of their implementation.

Chapter 1

Introduction, Background and Organisation for Conference

Zimbabwe was among the first countries to recognize the HIV and AIDS problem and take organized action on a national level to ameliorate its effects. The first case of HIV was tested positive in 1985 and screening of blood donors for HIV started in the same year. A programme to control HIV and AIDS was drawn up in 1987, led by the Ministry of Health, which emphasized prevention of transmission of the infection and surveillance of its spread. In 1999, Zimbabwe launched a national AIDS policy, and the following year established a multi-sectoral National AIDS Council (NAC) to coordinate the overall HIV and AIDS response. A National AIDS Trust Fund financed by a 3% levy on all income taxes paid to government was subsequently established to finance the national AIDS response.

Recognising that in 2004 it would be almost 20 years since the first person tested HIV positive, representatives from the National AIDS Council (NAC), the AIDS and TB Unit of the MOHCW and the Zimbabwe College of Public Health Physicians (ZCPHP) proposed to hold a national conference to take stock of what had been learnt, and use those lessons to improve the response measures. It was agreed that the conference should be national in the widest sense involving all sectors and levels of Zimbabwean society.

The conference was **held from 15 to 18 June 2004.**

Overall objective of the conference
The overall objective of the conference was to provide a national platform for all sectors and all levels of Zimbabwean society to review the HIV and AIDS response effort and draw up lessons which can illuminate future programmes.

The **specific objectives** were:

1To review the HIV and AIDS response effort in the key sectors of society such as: the public sector, private sector etc and allow cross-sectoral experience sharing
1To draw up the main lessons from these experiences
2To suggest ways to improve the HIV and AIDS response in the country.

Theme
The theme of the conference was: "*Taking Stock - Looking to the Future*", reflecting the need to review existing response efforts and draw up lessons which could be used to illuminate future work.

Conference Duration and Agenda
(see Annex 1 for the conference programme)
The theme was discussed under the three main sub-themes of (i) Prevention; (ii) Care and (iii) Mitigation, mirroring the three main ways of addressing HIV and AIDS. The conference was designed so that each of the first three days focused on a particular theme, with day 1 covering *Care and Treatment*, day 2 being on *Prevention* and day 3 on *Mitigation*. The last day of the conference provided an opportunity to consolidate the proceedings of the substantive three days and present recommendations.

Each sub-theme was covered through keynote presentation on that issue, presentation of selected abstracts covering the theme, panel presentations and discussions on key issues and breakout sessions (group discussions) to wrap up the discussions and come up with recommendations. These varied forms of covering the themes were to ensure maximum participation and comprehensive coverage.

Call for Abstracts
(N.B: All the abstracts, both those presented orally and those which were poster presentations, are available on both CD-ROM and a hardcopy printed book)
In mid-March 2004, a call had been put out for the submission of programme, scientific and performance abstracts. Each type of abstract was to reflect one of the three main thematic areas of *Care and Treatment, Prevention, and Mitigation*, with the appropriate sub-topic areas for each theme. The response to the call for abstracts had resulted in approximately 150 responses. Of these, 36 were selected for oral presentation, 4 performances and 102 poster presentations. Over and above the 102 poster abstracts, four individuals who had been selected for poster presentation elected not to present as they preferred to have made oral presentations. However due to the limitations of time, a limit of 36 orals had been set. The posters depicting the three thematic areas remained on display for the duration of the conference.

Conference Delegates
(see Annex 6 for full list of participants and the organisations they represented)
Conference delegates comprised representatives from all sectors, i.e., public and private sectors and civil society and developmental partners (both bilateral and multi-lateral). Through a process of **multi-sectoral stakeholder mapping,** a total of five hundred participants were identified and invited to ensure equitable representation of all sectors and all levels, as summarised in the following table.

Results of Stakeholder Mapping for Delegates to be invited to conference		
Group/Sector	Sub-group/Sector	Total Participants
Government	Ministry of Health HQ PMDs District Hospitals **(2 per province/city)** Director of Health Services for Cities (Harare, Byo and Chitungwiza **1 each**) Parliamentary Portfolio for health Cabinet Committee on Social Services Ministries of Labour & Soc. Welfare, Youth & Gender, Education, Higher Ed, Agriculture, Finance, Information & Local Govt, Home Affairs, Transport (**HQ level = 2 per Ministry)** Provincial/ District reps of above Ministries **(2 per Ministry)** Rural District Councils (RDCs) OTHER MINISTRIES Uniformed services (Army, Air Force, Police, Prisons **2 each**)	10 8 20 3 7 7 18 24 16 16 8
National AIDS Council (NAC)	National level **(All invitations to NAC HQ)** PAAC (provincial) DAAC (district) WAAC (ward and village)	4 10 20 20 Total NAC = 54
Total Government		**182**
NGOs, Advocacy Groups and Legal bodies	HOSPAZ, NANGO, NASCO WASN, ZACH, ZAN= **1 each at HQ level** ZAN Provincial **(1 per province)** ZACH Provincial **(1 per province)** Faith-based organizations (FBOs) National-level NGOs **1 each at HQ level** Local NGOs at sub-national level Localized groups (CBOs and other grass-roots groups) International NGOs **1 each at HQ level**	8 7 9 10 10 20 20 16
	Legal bodies / advocacy groups	14
	PLWHAs	10
Total NGO		**123**
Private Sector	Umbrella bodies and organisations representing employers and workers	30
Media	Media houses and organisations	5
Health-related Professional assoc.	Representatives of professional associations (1 each)	7
Research Institutions and others	Universities and research institutions	20
Multilaterals	UN agencies and other multilateral organisations	16
Bilaterals	Bilateral partners working in HIV and AIDS	20

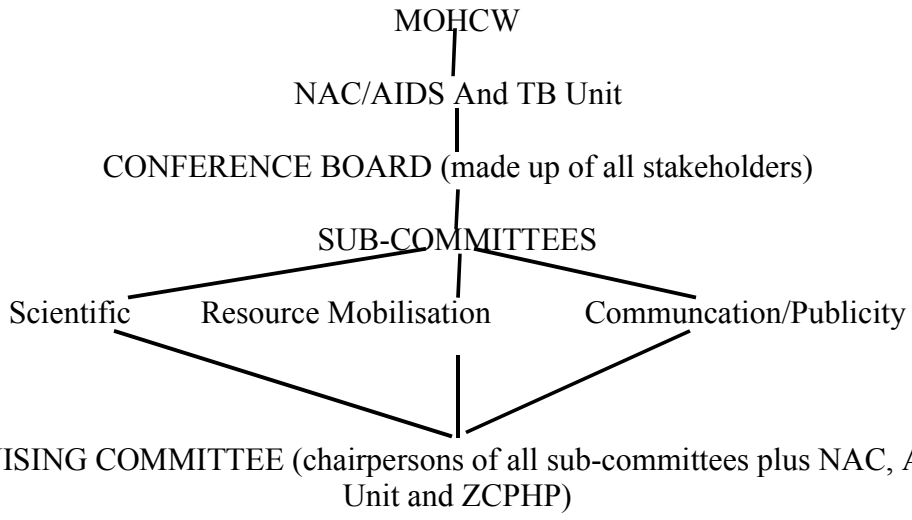
Results of Stakeholder Mapping for Delegates to be invited to conference		
Rural Traditional	Chiefs	8
Traditional medical practitioners	TMPAZ, **see number for each at right** ZINATHA, ZITHA	10
OTHERS	Conference Board and Organising Committee members, etc	12
	Support personnel and secretariat	13
SUBTOTAL		446
Presenters, panelists, etc.		75
GRAND TOTAL		508

While the initial targeted participation level was pegged at 500, due to overwhelming demand more than seven hundred and fifty (750) participants were registered and attended. With the inclusion of non-registered participants, the figure easily exceeds 1000 attending the conference.

Planning for the Conference

It was agreed that the planning for the conference should involve all sectors such as government departments, non-governmental organizations, the private sector, academic and research institutions, and bilateral and multi-lateral partners. Indeed, all these partners were involved in organizing the conference as part of the Conference Organising Board made up of all stakeholders and which oversaw the planning and set the broad framework in which the conference was to be held, and the Organising Committee (OC - a smaller committee of members of the Board) which turned the recommendations of the Board into actions and was involved in the detailed planning (see Annexes 2 and 3 for the composition of the Board and the OC).

Diagrammatic Representation of HIV Conference Preparations Structure



The Conference Board met fortnightly to review progress and give general guidance, while the Organising Committee (OC) met every week. All members of the Board and the OC worked on a voluntary basis and were seconded by their various organizations.

Structure of the Report

The report is divided into the following an introductory chapter (this Chapter), followed by a chapter for each of the days of the conference (Chapters 2 to 5), which follow the main themes of the conference. Chapter 2 is for Day 1 of the conference which focused on Care and Treatment, Chapter 3 for Day 2 which was on Prevention and Chapter 4 is for Day 3 on Mitigation and Chapter 5 is for Day 4 which was devoted to wrapping up and agreeing on the main recommendations. Chapter 6 contains all the issues and recommendations from the breakout sessions/group discussions, grouped into the themes and sub-themes.

This report has a companion CD-ROM, which contains not only the report but also other additional material that could not fit onto the report. For example, the CD-ROM contains all the abstracts that were submitted for the conference, both those that were presented in the main conference and those that were for poster presentations. The CD-ROM can be obtained from the NAC offices from the AIDS and TB Unit of the Ministry of Health and Child Welfare.

N.B:

This report is accompanied by other material that the reader should consult for details of some of the conference proceedings. This extra material includes:

d) A book of all the abstracts that were either presented in the oral sessions or as poster presentations. The book is both in print form and as part of the conference CD-ROM.

e) A CD-ROM with all the material that was presented at the conference in easily accessible electronic form. Among other things, the CD-ROM contains the book of abstracts, this report, all the speeches that were given by the various dignitaries and all the Powerpoint presentations given during the conference.

f) A video documentary of the conference.

All this material can be obtained from either the National AIDS Council (NAC) offices or the offices of the AIDS and TB Unit of the Ministry of Health and Child Welfare.

CHAPTER 2
CARE AND TREATMENT
DAY 1

2.1 Summary of day's proceedings

The day's proceedings focused on "Care and Treatment", starting with a presentation on "*The Current State of the Anti-Retroviral (ART) Programme in Zimbabwe*" by Dr C Chakanyuka in which she gave the background to ART in general and in particular for Zimbabwe (in particular-delete). She noted that whereas previously ARVs were mostly being offered in the private sector (mostly due to the high cost), this had now shifted to a public – private mix. It was estimated that about 5 000 patients were currently on ARVs in Zimbabwe. Plans for the Public Sector ART Programme were in place. An integrated model was going to be used and scaling up of the programme was through a phased out approach, with the initial learning sites being Harare Central Hospital, Mpilo Hospital, Howard, Bulawayo City, Triangle hospital. It was intended that once enough experience had been gained, adequate financial resources where in place and adequate human capacity built, the programme would expand to other central, provincial, mission and district hospitals six to twelve months after the initiation of the ARV programme. The presenter noted that there were many challenges in the scaling up of the ART programme so that the service reaches all, including the poor and the vulnerable groups in society. She emphaisized that participation by all stakeholders was vital for the success of the programme in Zimbabwe. **(See 2.2.1.1 below for the full presentation)**

Dr C Chakanyuka

Dr P. S Makurira of the CPCPZ and Mrs M. Mwonzora of the PSZ presented on "*HIV and Aids –Challenges on the use, availability and affordability of anti-retrovirals in Zimbabwe"* and they outlined the resolutions of The College of Primary Care Physicians of Zimbabwe and the Pharmaceutical Society of Zimbabwe 18th Annual Congress 2004. Concerning the use of ARVs, it was noted that i) there is need to increase training at all levels in the health delivery system; ii) there was need to improve the coverage of HIV and AIDS interventions such as PMTCT, VCT, ART and related support services such as the laboratory; and iii) guidelines for ART were to be widely disseminated available and there was need to improve public awareness on ARVs and other treatment options. On

the issue of availability and affordability the congress resolved that: i) more local pharmaceutical companies should be involved in the manufacture of generics; ii) government should waive duty on raw materials for ARV manufacture; iii) there should be controls on the mark-up for drugs at each level; and iv) that PLWHA who have relatives abroad should avoid receiving finished products, but instead get assistance in the form of cash so as to be able to buy drugs that have been quality tested in the country. **(See 2.2.1.2 below for the full presentation)**

Mr P. Chipepera's paper on "*Nutritional Care and Support For PLWHA*" outlined the special nutritional needs for PLWHA and the challenges for maintaining them, the use of locally available foods as well as the role of a counsellor in assisting PLWHA to have a balanced diet. **(See 2.2.1.3 below for the full presentation)**

Dr Robert R. Makombe gave a presentation on "*HIV and AIDS and TB: Opportunities and challenges in integrating care*". He pointed out the relationship between HIV and TB, the rationale for integrating TB and HIV care; the necessity for integrating TB and HIV care as well as the possible challenges that can be faced during the process **(See 2.2.1.4 below for the full presentation)**

Two presentations were made on experiences of implementing ART at a hospital setting by the "*DART, University of Zimbabwe Clinical Research Centre, Parirenyatwa Hospital*" by Dr. Pascoe and "*Evaluation of the efficacy of an antiretroviral programme at the Luisa Guidotti Hospital"* by Dr. Nigro. Both experiences were mainly from an evaluation/research background. The DART study, which is still ongoing, is looking at whether clinical monitoring of patients on ARVS is as safe and effective compared to laboratory monitoring of illness remission or progression. Another component of their research is comparing the effects of intermittent 3 month interruption of treatment (Structured Treatment Interruption- STI) to continuous ARV treatment. The Luisa Guidotti study looked at the efficacy of generic ARV combinations. Interestingly, while efficacy was high at both sites, patient compliance at the DART study was said to be very high (93%), while at Luisa Guidotti it was said to be low (23%). *Editor's note:* This could be due to different methodologies for measuring compliance and different study settings (urban vs rural). **(See 2.2.1.5 and 6 below for the full presentation)**

These key presentations were followed by short presentations of abstracts covering the theme of "Care And Treatment". The following abstracts were presented:

- *Increasing Male involvement in home based care* by C. Chipere and N. Matinhure - Africare
- *Counseling and Communication Psychosocial Support model for community based ART initiatives: Zimbabwe's experiences* by S. Moyo,
- *Young People and HIV AND AIDS* by Lovemore Magwere
- *Integrated Nutrition Gardens* by Mugove Walter Nyika
- *Spiritual Care of HIV AND AIDS Patients* by Pastor Major Mereki
- *Antiretroviral Therapy In Resource Limited Settings***:** The experience of MSF at an international level

- *Clinical experience in the use of highly active antiretroviral drugs in a community based project* by Gerard Kadzirange Zijenah LS, Tobaiwa O, Kufa T, Moyo S, Matsikire E, Musingwini G, Maponga C, Gonah N, Chirenje ZM, Bhattacharaya D, and Katzenstein DA
- *Use of Antiretrovirals in a Mission Hospital Setting* by Dr. J. Mbangani, K. McCarty,
- *Care for HIV and AIDS Prevention and Positive Living (CHAPPL) Network*
- *By Sithole EGV, Alfredo C, Chitimbire VTS, Mbengwa A, Hader S*
- *Primary Care Counselor (PCC) : Developing Counseling Capacity in Health Care Setting* by VTS Chitimbire, EGV Sithole, C Alfredo, A Mbengwa, S Hader
- *HIV & AIDS Quality of Care Initiative (HAQOCI)*
- *By Dr R A Kambarami*

See 2.2.2 below for the full abstracts.

The panel discussion which followed covered the experiences of Treatment and Care in the various sectors. The following were the panelists: Lynde Francis, The Centre, Mr Hercules Maguma of the Pharmaceutical Manufacturers' Association, Dr Kandzirange of ZAPP, Dr. Dhene of UNAIDS, Mrs. Julia Tagwirei of the National Nutrition Council, Mrs R Madzima of the National Nutrition Unit in the MOHCW and Sebastiane Nyakapanga who is n ART recipient. Audience Participants were: Mr. Mukweli the GFATM Coordinator, Dr. Bwakura, Dr. Njelesani the WHO Representative, Mr. Mwaramba of Natpharm, Dr. Chakanyuka, Dr Charity Alfredo of CDC=Zimbabwe and Dr. Pascoe. Prof. Hakim facilitated the panel discussion..

The breakout sessions/group discussions covered the three main sub-themes of a) "*ART and OI*" facilitated by Dr. Mark Dixon and Dr. Bwakura, b) "*Nutrition, Treatment and Care*" facilitated by Mrs. Julia Tagwireyi and Mr. Percy Chipepera; and c) "*Home Based Care"* facilitated by Ms Eunice Garanganga and
Mrs. Muteiwa, Zimbabwe Red Cross.

The following were some of the key issues raised:

a) Key issues in Anti-retroviral Therapy (ART) and Opportunistic Infection (OI) Treatment

- Zimbabwe developed the National AIDS Policy and the National Strategic Framework for the National Response in 1999. Guided by this policy, government has embarked on an ART programme that is in line with WHO's goal to treat 3 million people by 2005. Clinical Guidelines and Training Manuals have been mobilized from local and international partners.
- However, laboratory capacity in terms of resources and equipment needs to be improved.
- It was felt that access to VCT services is limited access and needs to be expanded, particularly to growth points and other rural service centers.
- Delegates pointed out that while distribution of anti-retrovirals is inadequate especially at grassroots level, pediatric HIV and AIDS managements and treatment is lacking for

most of the time, raising the need for attachments for clinical experience at centers where ARVs are being offered.

- The need for government coordinate all OI and ART initiatives at all levels, with continued participation and collaboration by NGOs, bi-lateral and multi-national organizations was stressed.
- Public awareness and patient literacy needs to be improved and increased with special consideration on the needs of women and children who are especially vulnerable
- Delegates were concerned that with the scaling up efforts now gathering momentum, suppliers might run out of drugs. Related to the question of availability was the issue of affordability.
- Delegates noted the fact that locally produced drugs appeared to be more expensive than some imported ones, probably because of customs duty on imported raw materials for locally produced ARVs. Government was therefore urged to take appropriate measures to ensure that raw materials for the production of ARVs are exempted from import duties as well ensuring the availability of foreign currency for the procurement of these supplies.
- Manufacturers were urged to also prioritise the production of paedriatic formulations of ARVs.
- There was discussion on the question of whether or not to charge for ARVs , with panelists agreeing that some cost recovery charge is necessary for those who can afford, while ensuring that the disadvantaged are not neglected.
- The need for all doctors to undergo training for HIV and AIDS management was debated, with representatives from ZIMA urging that this be done urgently.
- The call was made to make all this information available in Braille, sign language and other appropriate mediums of communication to reach people with disabilities.

b) Key Issues in Nutrition, Treatment and Care

- Since good nutrition has the capacity to prolong life and improve quality of life and minimize the effects and impact of HIV and AIDS, the challenge is how to mainstream nutrition, integrate it into the HIV and AIDS.
- Nutrition Guidelines are necessary and these guidelines must recognize the multi-sectoral dimension of nutrition so as to harness all stakeholders in this regard.(**N.B:** the National Nutrition Guidelines were launched by the Minister of Health and Child Welfare on the last day of the conference and are available form the Ministry of Health and Child Welfare – NNU)
- Concern was expressed on developing policies when there are no people on the ground to implement them. Staff retention and recruitment are therefore essential to raise the capacity to implement.
- It was felt that the issue of children and nutrition had been neglected, particularly children from 2 years onwards. There is a large incidence of malnutrition in this group after mothers stop breastfeeding. Guidelines are necessary for mothers at this stage.
- The nutritional habits of health professionals may seem to contradict nutritional messages in rural communities, particularly with the emphasis on locally available foods (and professionals seem to want processed “Western” foods). There is need good role models.

- The need to restore belief in indigenous foods was stressed. Traditional foods must come to the fore.
- There need to integrate nutrition into all research was raised. How can people produce cheap nutrition?
- It was felt that the issue of micronutrients has been neglected.
- Poor handling of food throughout Zimbabwe was also raised as an issue which needs to be addressed.
- Industry was felt to be lagging behind in issues of HIV and AIDS.

c) Key Issues in Home Based Care

- It was stressed that the National Home-Based Care Policy and the HBC standard produced by the MOHCW should guide all HBC initiatives in the country.
- However it was noted that a number of organizations are conducting HBC programmes, including training of caregivers, using their own standards and manuals and that this has led to disjointed efforts and differential impact. For instance, some organizations will offer incentives while others will not. This has led to some programmes being more 'popular' than others.
- It was also noted that volunteer work in HBC is often done by women, in addition to their many other responsibilities, though they are not paid for it. The need for guidance and standards on this and other issues was therefore underscored.
- The role of traditional healers in HBC has not been properly defined or integrated even though they are involved.
- It was observed that some health service providers are not following the requirements of the patient discharge guidelines. The MOHCW was urged to make HBC standards widely available to ensure their utilization by the different providers.
- It was noted that while substantial financial and other resources had been expended on HBC activities countrywide, more funding is required owing o the magnitude of the problem.

2.2 Presentations of the day

2.2.1 Invited Speakers

2.2.1.1 "**The Current State of the Anti-Retroviral (ART) Programme in Zimbabwe**" by Dr C Chakanyuka

Dr Chakanyuka gave an overview of the current state of ART in Zimbabwe, which is outlined below:

Introduction

- There are 42 million people living with HIV and AIDS globally
- Of these, 6 million require ARVs and
- 4 million of these are from Africa but
- Currently only less than 100 000 are on ARVs in Africa

Zimbabwe HIV and AIDS Statistics, 2003

The following is a summary of the HIV and AIDS situation in Zimbabwe:

- HIV prevalence amongst adult pop. 24.6 %
- People living with HIV and AIDS 1 800 000
- Estimated new HIV infections 166 000
- Estimated new AIDS cases 138 000
- AIDS deaths 135 000
- Children orphaned by AIDS 761 000

The vision of the Ministry of Health and Child Welfare is:

- to provide a comprehensive package for HIV and AIDS prevention, care and support

This package includes:

- Voluntary Counseling and Testing (VCT)
- Information, education and Communication (IEC)
- Condom promotion and Family Planning
- Prevention and treatment of STIs
- Prevention of parent to child transmission of HIV (PPTCT)
- Prevention and management of Opportunistic infections
    - Cotrimoxazole prophylaxis (OI clinics established)
    - Diflucan
- Universal precautions
- Treatment of other HIV related conditions and complications
- Adequate nutritional support
- Adequate psychological support
- Provision of ARVs for
    - Post exposure prophylaxis for health workers
    - Therapy for the general public

The Role Of The Government (MOHCW)-Ministry of Health and Child Welfare plays a *central role in coordinating and providing stewardship in HIV and AIDS care.*

Roles of government and the MOHCW:

- Coordination of all efforts to provide ARVs

- Setting and monitoring standard of care for those with HIV and AIDS
- Production of treatment guidelines on ART and AIDS care
- Production of training manuals and facilitating training
- Mobilization of resources in partnership with the private sector
- Protecting the poor and vulnerable groups

Government commitment to the fight against HIV and AIDS
Government commitment has been shown through:

- Development of the National AIDS policy and the National Strategic framework for the National Response
- Formation of the National AIDS Council (NAC)
- Creation of the National AIDS Trust Fund
- Declaration of AIDS as an emergency
    - This paved the foundation for
        - Increased access to ARVs resulting in improved AIDS care
        - Authority to import generic drugs
- Declaration of lack of access to ARVs as an emergency
- Establishment of National Emergency Task Force on AIDS (NETA) to guide implementation
- Development and dissemination of Clinical guidelines
- Training manuals are now available and training is ongoing
- Mobilization of financial resources
    - Govt budget allocation to ARVs ($10 billion-2004)
    - Govt AIDS Trust Fund (AIDS Levy raised $ 7billion in 2004)
    - Application for Global Fund Against TB,AIDS and Malaria (GFTAM – 1st and 4th round)

ART in Zimbabwe- Current Situation
Whereas previously ARVs were mostly being offered in the private sector (mostly due to the high cost). At the moment there is now a public –private mix. It is estimated that about 5 000 patients are currently on ARVs in Zimbabwe.

Plan for the Public Sector ART Programme

- This is being implemented in the public institutions
- An integrated model is being used
- A phased out approach is being implemented, with the initial learning sites being Harare Central Hospital, Mpilo Hospital, Howard, Bulawayo City – Pelandaba clinic and Triangle Hospital
- However it is intended that once enough experience has been gained, and adequate human capacity built, the programme will expand to other central, provincial, mission and district hospitals six months after the initiation of the ARV programme.

Progress to date
Five sites have been assessed and are now ready to initiate ART, a further 14 sites have undergone the initial assessment. Authority granted to procure ARV drugs using the

special formal tendering process, but in the meantime the process for international tendering is being initiated. Progress has been registered in the following key areas:

- Involvement of the hospital authorities since the inception of the programme
- Encouraging the formation of ART teams
- Quantification of the ARVs for the sites has been done, some have been delivered to health facilities
- **Infrastructure**
    - Minimum requirements for space have been set
    - Space has been identified for the services
    - Renovations have been done in stages
    - Space has been created so that the OI/ART services can start
- **Human Resources**
    - Minimum staff requirement standards have been set
    - Staff has been identified from the current establishment with a few external recruitments taking place
- **Training**
    - Staff (Clinical and laboratory) has received training on OIs, rapid HIV testing and ART (locally, regionally and internationally)
    - Attachments for clinical experience at centres where ARVs are being offered e.g DART project
    - Training will be on going for the staff
- **Laboratory support**
    - The two labs have been upgraded with assistance from partners and upgrading will need to be extended to labs in the provinces and districts
    - The NMRL at Harare hospital is now equipped to perform CD4 counts, viral loads (resistance testing)
    - The Bulawayo lab currently can do CD4 counts and it is hoped that in the near future it will perform similar tests to the NMRL
    - Laboratory staff has been trained on the use of this new equipment
- **Data base for the ART programme**
    - Electronic data base developed (paper data base)
    - Being pilot tested and modifications are being in-cooperated
    - Data collected is linked to the national ART indicators
- **Community participation**
    - The community and PLWHA have been involved as they play a paramount role especially when it comes to
    - Identifying patients that may require ART
    - to adherence and patient follow up
    - Support in general

Critical components for the ARV programme to be successful

The following issues need to be addressed if ART implementation is to be successful:

- Continued leadership & strong commitment
- Improvement and development of human resources
    - identify & recruit extra human resources

- try to retain the remaining medical personnel
- identify training requirements & train accordingly

- Continued production & distribution guidelines for care & treatment
- Critical components for the ARV programme to be successful (2)
- Continued improvement of infrastructure
- Continued improvement of laboratory capacity
- Improve logistics for the procurement and distribution of ARVs, test kits and other medical sundries
- Programme monitoring and evaluation
- Patient education and community participation
- Continued participation by NGOs, bilateral and multilateral organization

2.2.1.2"**HIV and Aids –Challenges on the use, availability and affordability of anti-retrovirals in Zimbabwe**" by Dr P. S Makurira of the CPCPZ and Mrs M. Mwonzora

Dr P Makurir,

Mrs M Mwonzora

The following are the resolutions of a joint conference attended by 230 members of the College of Primary Care Physicians of Zimbabwe (CPCPZ) and the Pharmaceutical Society of Zimbabwe (PSZ) from 22-25 May 2004 at Great Zimbabwe Hotel in Masvingo, during their 18th Annual Congress 2004 on "CHALLENGES ON THE USE, AVAILABILTY AND AFFORDABILITY OF ANTI-RETROVIRALS IN ZIMBABWE".

Challenges faced on the USE of anti-retrovirals

	Constraint	Possible Solutions
1	Shortages/non-dissemination of treatment guidelines	Treatment guidelines to be distributed equatably throughout the nation using existing distribution networks

	Constraint	Possible Solutions
2	Guidelines on post-exposure prophylaxis also not readily available to health personnel and public (rape, needle-prick injuries etc)	‘’ ‘’
3	PPTCT programme not reaching all sectors of society.	Information and guidelines to be disseminated down to all centres including the private sector
4	Lack of training at all levels	Government involvement is very important in the facilitation of training. Training should start in the health sciences colleges. Diploma in HIV Management through distant education to be introduced eg ZOU. Readily accessible information centres established
5	Poorly educated public on availability of anti-retrovirals and treatment options	Public awareness should be increased through the normal channels ie print/electronic media, schools, educational pamphlet.
6	Lack of support facilities eg laboratories, support groups of infected, side-effects monitoring,reporting and treatment.	Laboratories to be adequately equipped.Establishment of support groups. DOT’s strategy to be used for anti-retrovirals as well.
7	Limited access to voluntary counseling and testing centres.	VCT to be expanded down to growth points.
8	Patient and health service provider stigmatisation	Make HIV and AIDS a notifiable disease
9		

Challenges faced on the AVAILABITY of anti-retrovirals

	Constraints	Possible Solutions
1	Dearth of local manufacturers- only Varichem is manufacturing	More manufactures to be involved. Government to support local manufacturing eg tax incentives, zero duty on raw materials-as there are many advantages of local manufacturing such as price reduction, economic empowerment and technological transfer for Zimbabwe.

	Constraints	Possible Solutions
2	Registration of imports is slow and delays experienced at port of entry. Forex is limited	Empower local manufacturers. Registration of imports to be speeded up (MCAZ). Donations must also be of acceptable quality. Retention fees for registered products to be paid for in forex.
3	Post Marketing Surveillance for imports provided by relatives from abroad is inadequate	Public education campaigns on the need to consult registered health services and practitioners and the reality of counterfeits to be run. Relatives to be encouraged to send cash rather than drugs.
4	Distribution of anti-retrovirals is inadequate	Existing structures such as NatPharm ,wholesalers and Public Institutions (District Hospitals) must be pursued and strengthened .Equity in distribution must be disease burden based. Good rapport between public and private sector players must be established
5	Fluctuating costs	Mark-ups and handling fees by dispensers, wholesalers and all other players involved must be standardized.
6	Hospital beaurocracy leading to shortages and patients giving up	Tendering and payment system to be speeded up. Penalties to non-performing companies. Harare Central and Mpilo experiences
7	Unavailabilty at grassroot level	Availability and logistics of distribution must be down to clinic level eg NatPharm
8	Treatment of opportunistic infections	Drugs must be made available and reasonably priced
9	Capacity building	Training at all levels essential. NatPharm/Private sector co-ordination must be strengthened.
10	Low staff motivation	Adequately fund health delivery services. Support availability/accessibility of anti-retrovirals and opportunistic infections 01 drugs

Challenges faced on the AFFORDABILITY of anti-retrovirals

	Constraints	*Possible Solutions*
1	Duty on raw materials for local production	Government to remove duty on pharmaceutical raw materials importation
2	Exchange rate (Forex) too high for local pharmaceutical industry	Preferential exchange rate should be given to pharmaceutical industry when importing raw materials and finished products

	Constraints	*Possible Solutions*
3	Bidding process (Forex) too cumbersome	MOH & CW should be part of bidding process so that the reserve bank understands the need and urgency of procuring raw materials and finished products
4	Distribution costs too high	Should have monitored/controlled mark-ups at each level of the distribution channel (from manufacturer to the end user)There is need for the pharmaceutical companies to expand distribution centres.
5	MCAZ registration process	MCAZ should reduce the registration and retention fees for locally produced products and fast track the registration of anti-retrovirals.
6	Health Insurance Funders	Health Insurance Funders to increase reimbursements of anti-retrovirals to patients. Companies should join Insurers with special anti-retrovirals schemes. Schemes already in place to be improved
7	Production costs too high	Companies to form buying groups to enjoy economies of scaleGovernment to join other countries so there is regional purchasing of raw materials or manufacturing of anti-retrovirals
8	Funding local industry	Government should assist by funding the productive sector for anti-retrovirals. NAC should assist local industry with funds tp procure raw materials
9	Ownership of schemes	Community mobilization on co-payment system to be pursued to instil sense of ownership in the programme – people want to be responsible for their own health and life
10	Anti-retrovirals unaffordable to the majority of the nation	Government to foot the bill as with TB drugs or subsidise at importation or local production and pursue UN Global Fund on HIV and AIDS and other bilateral and multilateral agencies.

2.2.1.3**Nutritional Care and Support For PLWHA" by** Mr P. Chipepera

Mr Chipepera made the following presentation to show that good nutrition can make a difference to a person infected with HIV.

Mr P Chipepera

Nutrition is the study of foods and how our bodies use them. Food contains nutrients that are used by the body to :

- Build tissues and for growth
- Produce energy
- Protect the body from infections

A balanced diet should contain:

- Proteins, Carbohydrates and Fat are needed in large quantities (macronutrients)
- Vitamins and Minerals are needed in small quantities (micronutrients)

Carbohydtrates:

- Are starchy foods which are a good source of energy and they should make up the biggest part of a meal.
- Good examples are: soghurm, rapoko, miillet, wheat, maize, potatoes, yams
- They provide energy and some protein
- Whole, unrefined grains also contain some vitamins and minerals

Proteins:

- Are for growth, repair of body tissues and building of the immune system
- Good sources are pulses, meat and meat products
- Pulses are also good sources of vitamins and minerals

Vitamins and Minerals

- For normal body functions such as making blood, cells, enzymes and the immune.
- Some are part of the immune system (antioxidants)
- Good sources are vegetbles and fruits. Especially the indegenous.

The relationship between Nutrition and HIV and AIDS

- Food does not cure HIV infection
- It is a co-therapy in combintion with
- Drug therapy
- Herbal therapy
- Psycho-social support

- Malnutrition affects 90% of HIV and AIDS patients (trujillo et al)
- Also responsible for 60-80% AIDS deaths
- The immune system depends on Nutrition.
- When ever there is infection, intake and absorption is reduced, work output is reduced. This whole process forms vicious cycle

The vicious cycle between malnutrition and HIV infection

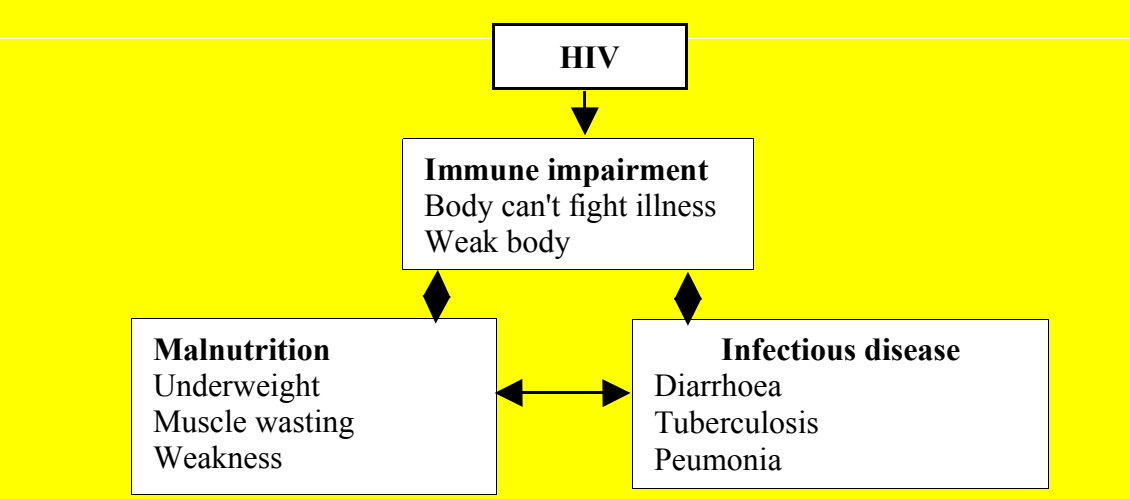


Figure adapted form FANTA 2001.

Special needs for PLWHA

- The average energy needs of a non-active person is 2070C a day. Extra requirements for infected person is 10-15% if asymptomatic and 20-30% if symptomtic
- Protein requirement is 45g in non-infected and 50-100% more if infected
- Vitamins and minerals, about 100% more is required during infecton

Food Basket to meet basic requirements for one month.

- The basket should be complimented by variety of vegetables and fruits for vitamins and minerals

Food	Energy	Protein
10 kg mealie meal	34 000	930
1.5 litre vegetable oil	13 350	----
4 x 275 ml peanut butter	8 550	375
3 kg beans/cowpeas/lentils/ matemba	9 600	660
1.5 litre honey/2kg sugar	4 000	---

Conditions that can be managed using the diet

- Candida;
- Loss of appetite;

- Weight loss
- Fever;
- Heartburn and fulness;
- Colds, flu and coughs

Challenges
- It is very difficult to maintain dietary intake during infection
- There is generally food shortage with our diet already deficient in proteins and micronutrients
- The AIDS deaths are mostly affecting the productive age group such that food production is reduced
- Management of food and drug interaction is very difficult

Food and drug interaction
1) FOOD: medication absorption affects metabolism, distribution
2) MEDICATION: nutrient absorption affects metabolism, distribution
3) MEDICATIONS' SIDE EFFECT: affects food intake and nutrient absorption
4) MEDICATION + CERTAIN FOODS: causes unhealthy side effect

The role of counsellor
- To identify possible options to address drug-food interactions and enable effectiveness of both drugs and Nutrition
- Works with the client to help identify possible nutritious and locally available food and make up a balanced diet
- To provide the client with detailed information, alert and encourage to pay close attention to any dietary changes due to side effects
- The counselor should meet regularly with the client to follow up on implementation of options and assessing how successful the client is in implementing their choice-Good Nutrition can make a difference

2.2.1.4"**HIV and AIDS and TB:Opportunities and challenges in integrating care**" by Dr Robert R. Makombe

The following is an outline of Dr Makombe's presentation on the opportunities and challenges in integrating TB and HIV and AIDS programmes.

Dr R Makombe

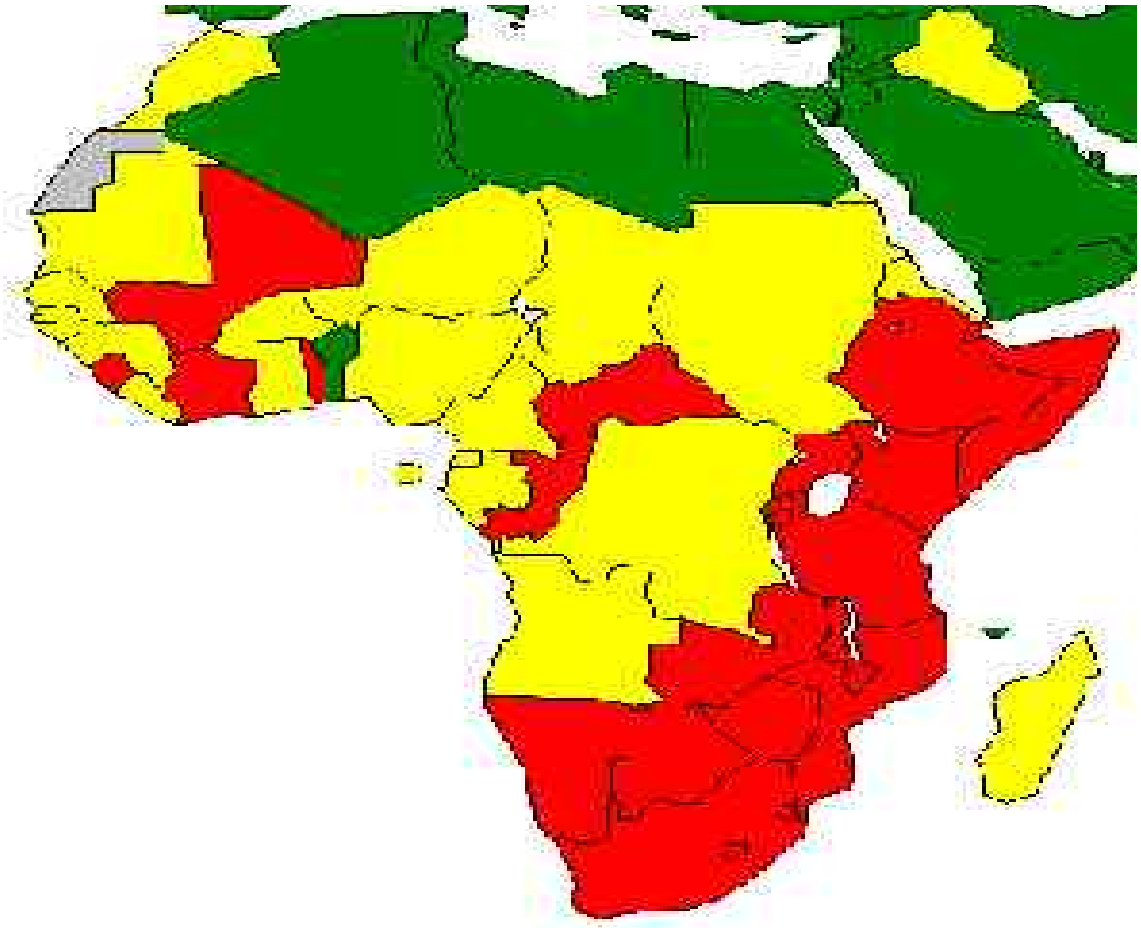
He started by stating that:

- HIV prevention and care should be a priority for TB control programmes
- TB care and prevention should be a priority for HIV and AIDS control programmes

The following map shows the TB epidemics in Africa.

Tuberculosis Notification rates in WHO African Region, 2002

N.B : green = < 100; yellow = 100 – 300; red = > 300; grey = no estimate

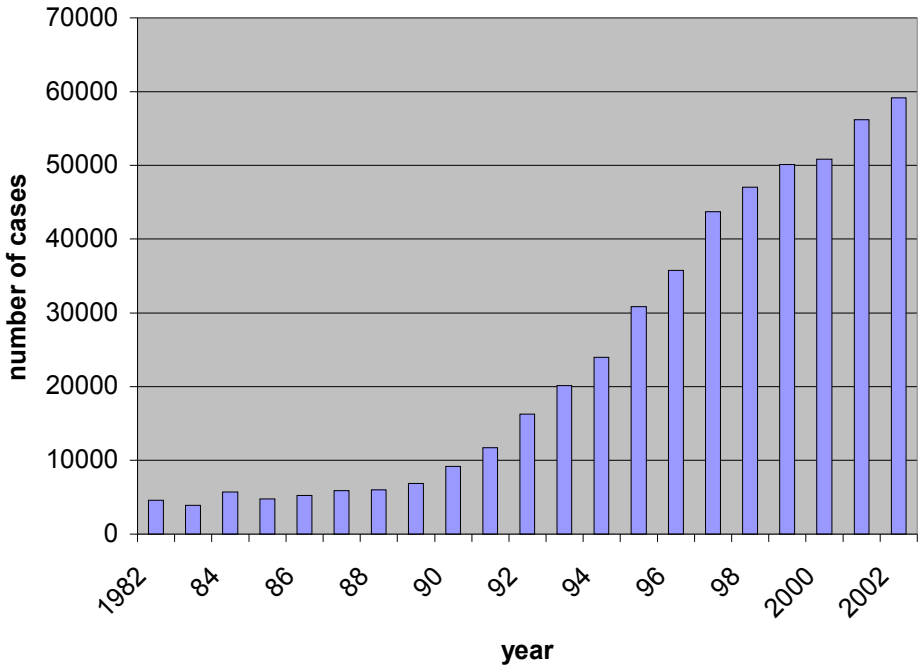


The epidemic in Southern Africa has the following characteristics:

- the region has <5% of world population, but 35% of global population of PLWHA
- it has 30% of Africa's population, but 70% of all TB cases
- there has been a four fold increase in number of TB cases over past decade
- Even countries with strong NTPs have recorded increasing number of TB cases

In Zimbabwe, the trend of TB notifications is as shown in the graph below:

TB notifications in Zimbabwe: 1982-2003
The following data shows there is a correlation in the rise in TB notifications and the proportion of those patients who had TB



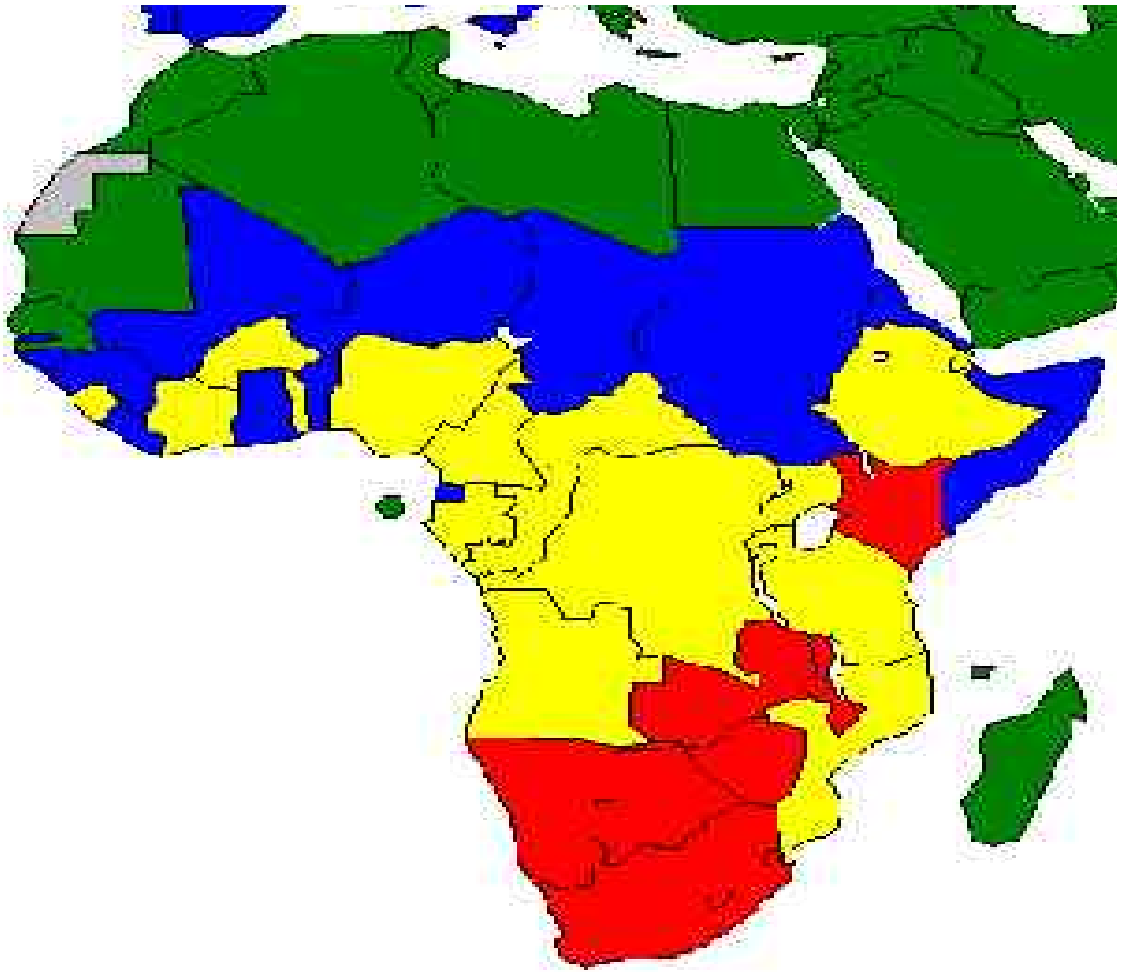
TB Notification rates in Zimbabwe: HIV prevalence in TB patients

(cases per 100,000 population)

1982	*68*	
	1990	*<45%*
2003	*462*	
	2002	*>75%*

The following map shows the regional the Estimated HIV infection in TB patients in Africa in 2002

N.B: green = <5%; blue = 5-20%; yellow = 20-50%; red = > 50%; grey = no estimate



Impact of HIV epidemic on TB epidemic

- HIV is the single most important factor for the resurgence of TB in Africa
- HIV is the most potent factor for progression of latent TB infection to active disease
- PLHA more susceptible to infection when exposed to TB bacilli
- Annual risk of developing active TB is 5-15%
- Increased rate of recurrent TB
- Rising number of cases leads to increased transmission of TB within the general community

Impact of HIV on clinical course of TB

- Increasing proportion of smear-negative and extra-pulmonary disease
- Increased mortality among TB patients from other HIV-related diseases
- Loss of credibility of TB control programmes leading to avoidance by the community
- Delayed diagnosis due to stigma and discrimination

Impact of HIV on TB control programmes

- Overstretched human and infrastructural resources
- Increased risk of nosocomial infection
- Higher HIV-elated mortality in patients and staff
- Low staff morale
- Stigmatisation and discrimination

Impact of TB on HIV control programmes

- TB is the most common serious infectious complication associated with HIV infection in sub-Saharan Africa
- About 1/3 of PLHA die from TB
- Late diagnosis of TB in PLHA contributes to higher death rates
- TB may accelerate progression of HIV-related immunosuppression

Current approaches to TB and HIV Control Programmes

- Currently they are separate programmes with different approaches
- TB control strategy
  - DOTS strategy
  - Recent initiatives
  - Community based TB care, Collaborative TB/HIV care, Private-public partnership, DOTS plus
- HIV and AIDS control strategy
  - Prevention and health promotion
  - Treatment and care
  - Health standards and systems
  - Other interventions

Part B- Rationale for integrating TB and HIV care

Looking back at TB and HIV and AIDS control efforts

TB programmes have longstanding experience in:

- Provision of chronic care
- Well-developed documentation systems
- Well-developed M&E systems
- Family involvement in care
- HIV and AIDS programmes have longstanding experience:
- Social mobilisation, BCC
- Partnership development
- Community level involvement

Scope of TB/HIV interventions

- Responsibility of NTP
  - DOTS and DOTS expansion
- Responsibility of NACP

- PMTCT, VCT services, safe blood supply, ART
- Overlapping
  - Increased community involvement in TB diagnosis and care and in HIV and AIDS care and prevention
- Reciprocal synergies at service delivery level
  - Screening and treatment of STIs among TB patients
- Screening of TB among VCT clients
  - VCT services to TB patients
- HIV prevention and care should be a priority for TB control programmes
- TB care and prevention should be a priority for HIV and AIDS control programmes

Rationale for collaborative TB and HIV care

- TB and HIV are intricately linked biologically
- Many patients with TB/HIV are already being treated at community level
- Even with effective TB treatment, HIV-related TB is associated with higher case fatality rates
- HAART may have a substantial beneficial impact on HIV-related TB
  - HIV care (especially HAART) may substantially impact HIV-related TB
  - About 1/3 of TB patients have WHO Stage III/IV disease and are thus eligible for HAART initiation.
  - Effective NTPs are well placed for identifying those TB patients who are HIV-infected, those eligible for HAART, and for initiating therapy or referring such patients.

Part C : Challenges to integrating TB and HIV care

Challenges for collaborative TB/HIV care

- Scaling up interventions with limited resources (human, financial, drugs, logistics and other)
- NTP battling to cope with increased TB cases
- Health facilities overwhelmed by HIV-related diseases
- Ensuring supportive policy environment and health infrastructure
- Developing and implementing appropriate interventions at different levels of the health system
- Lack of planned phased implementation of collaborative TB and HIV activities
- Lack of tools to support district implementation (recording, reporting, monitoring, evaluation)

Opportunities for scaling up

- Existing local partnerships in health: public, private, public–private, community
- Funding e.g
  - AIDS Levy

- Existing and emerging international partnerships, e.g., StopTB, GFATM, "3x5" initiative, NEPAD
- Imminent increased availability of ARVs

Part D : ARVs and TB

ARV therapy for TB patients (1)

General objective:
To prolong life and improve quality of life

Specific TB control objectives:
- Reduction of HIV-related morbidity during anti-TB treatment
- Reduction of HIV-related fatality
- Thereby increase cure and reduce recurrence of TB

Considerations
- Follow-up of TB patients
  - Should ARV clinics give anti-TB drugs?
  - Should TB clinics give ARVs?
  - Can DOT of anti-TB drugs and/or ARVs be effectively practised in the community?
  - Laboratory or clinical assessment of side-effects?
- End of TB treatment
  - Maybe INH prophylaxis?

Conclusion
- Recent developments (GFATM, 3x5) present a rare opportunity to turn back the tide and recover lost ground in TB control
- Integrated TB/HIV care and treatment is an opportunity to scale up access in resource-constrained settings.
- Feasibility of this strategy should be fully explored
- Definitive scientific data on benefits and risks should be compared to present separate approaches for each disease.
- Provision of HIV care to those TB patients who urgently need it should not be delayed.

2.2.1.5 "**DART University of Zimbabwe Clinical Research Centre, Parirenyatwa Hospital**" by Dr Margaret Pascoe, On behalf of UZ-DART Team

Dr Pascoe made the following presentation on behalf of the DART team, which is presented in outline.

Dr M Pascoe

DART stands for ”Development of Anti-retroviral Therapy” and is an international collaborative research study with 3 300 patients on ARVs at 3 sites at the UZ, the Joint Clinical Research Centre and Academic Alliance Mulago Hospital Kampala, Uganda and the MRC Entebbe, Uganda. It has 2 research questions, looking at:

- Clinical Monitoring vs Laboratory (CD4, FBC and LFT) and Clinical Monitoring
- Continuous Treatment vs Structured Treatment Interruption (3 months on and 3 months off)

History

In February 2001 Treatment Access Initiative Conference, UZ College Health Sciences Prof Brian Gazzard cast vision for clinical monitoring of people on ARVs and Zimbabweans proposed a research study. In April 2001 at the Treatment Access Initiative Conference in Kampala, Ugandans proposed a study on STI (Structured Treatment Interruption – STI). DART study was born as a marriage of two ideas i.e – Clinical monitoring and STI and was a collaborative study from start.

Collaborators-

- University of Zimbabwe;
- JCRC, Kampala;
- MRC Entebbe;
- MRC (UK)

Partners

- Pharma GSK, Gilead, BI first line drugs;
- DIFID money for second-line;
- Rockefeller Foundation

UZ-MOHCW Partnership

- Prof Ahmed Latif, Prof James Hakim Zim; Prof Mary Bassett
- Investigators Prof Val Robertson, Dr Andrew Reid
- MOHCW partners- Minister Dr Parirenyatwa and Perm Sec Dr Xaba

Dr E Xaba

UZ-DART Multidisciplinary Team

Clinic Team	Inpatient Care Team;	Lab Team	Trial Centre Team	Admin Team
5 doctors	7 nurses	4 full time lab scientists	Trial Manager	Administrator
2 clinic managers	4 nurse aids	12 part-time lab scientists	Senior Data Officer	Finance Officer
8 trial nurses	6 bedded ward-A6	UZ – biochem, anem, micro	3 Data Capturers	2 secretaries
5 counsellors		NMRL-Harare Hospital		2 drivers
1 dietician				5 general hands
2 pharmacists				
1 pharm tech				
3 receptionists				
1 nurse aid				

Zimbabwe Site is composed of:

- Clinic: University of Zimbabwe Clinical Research Centre, Psychiatric Annexe, Parirenyatwa Hospital
- Six-bed Inpatient Care Unit Ward A6 Pari
- Labs- UZ-biochem, micro, haem, NRML Harare Hospital

Enrolment Process

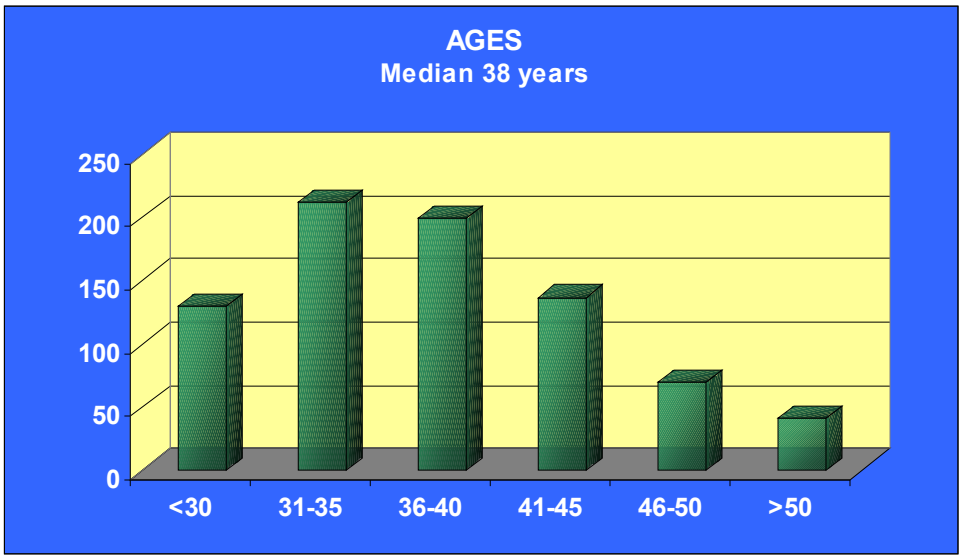
- Average daily workload = 84

- Prescreening – WHO clinical staging
- Screening – OI and laboratory screen; Enrolment ;
- Follow-ups;
- Extra-visits;

Enrolments : Figures as at 11 June 2004

- Enrolment started 10th June 2003
- Total screened 1900
- Total Enrolled 978
- Screening / Randomisation ratio 2:1
- Enrolment Demographics : Female = 57 %; Male =43 %

Ages



WHO stages at randomisation
Stage 250%
Stage 339%
Stage 411%

The Median **Baseline CD4** was 79 cells/ml

First Line ART Regimen –
Total patients randomised = 978

- On ZDV/3TC/TDF = 883
- On ZDV/3TC/NVP= 95

Drug related side effects

ZDV-related	d4T-related	NVP-related
Anaemia = 22;	Peripheral neuropathy =1	Rash = 2
Neutropaenia= 2		Hepatotoxicity = 1
Anaemia & Neutropaenia= 2		TB diagnosed = 2

Inpatient Admissions were for the following reasons

- Cryptococcal meningitis
- Bacterial sepsis
- ZDV-related anaemia
- Socioeconomic
- Few admissions for TB !!!!!!

New or Recurrent WHO stage 4 had the following conditions

Cryptococcosis	24
TB	15
Candidiasis	6
PCP	3
KS	2
CMV	1
Total	**51**

Adherence to therapy

Based on drugs missed in the last 4 Days and idenified through a nurse administered questionnaire. Based on this methodology, 93.7% had not missed a dose!!!

Structured Treatment Interruption Pilot

- Has enrolled 130 patients across 3 sites
- CD4-driven randomisation (300)

New Developments

- Have started a children's DART clinic
- Also a DART patient support group
- Have also started sub-studies:
  - Virology,
  - Metabolic
  - 2nd line Rx
  - Stopping and starting Rx
- Training and capacity building is ongoing

2.2.1.6 "**Evaluation of the efficacy of an antiretroviral programme at the Luisa Guidotti Hospital***" by* M.E. Pesaresi*, C. Spagnolli*, V. Brisolese°, E. Sanfilippo°, L. Nigro, oLuisa Guidotti Hospital, Mutoko, Zimbabwe,

° Infectious Diseases Unit, University of Catania, Italy

Dr L Nigro

The following is an outline of what Dr Nigro presented on behalf of Mutoko hospital.

Background

"Luisa Guidotti" Hospital is a rural missionary hospital in Mutoko District of Mashonaland East province, with Dr. Maria Elena Pesaresi as the Medical Superintendent. Following local Medicine Control Authority approval, the Guidotti Hospital introduced an ART Programme starting in 2002 and 784 patients have been treated so far. Of these:

- 90 or (11.5%) are dead
- 173 or (22.1%) have been lost in the follow-up
- 521 or (66.4%) are still on treatment
- 179 or (22.8%) have not complied to treatment

Since July 2003, the hospital adopted generic drugs produced by the Cipla Pharmaceuticals of Bombay (lamivudina-zidovudina-nevirapina).We have also tried to evaluate the efficacy of the drugs.

Objective of the evaluation of efficacy:

- to evaluate and efficacy compliance and toxicity of lamivudina-zidovudina-nevirapina combination on HIV-positive adult patients

Patients and Methods

- From July 2003 to March 2004, all patient were treated with the combination of lamivudina-zidovudina-nevirapina
- Age, sex, body weight, WBC, lymphocytes and haemoglobin were recorded at: baseline, after 3, 6 and 9 months
- Improvement, side effects and compliance were also recorded

Enrollment criteria were HIV positive patients who:

- experienced O. I.

- had lymphocytes <600/mmc
- had weight loss, chronic diarrhoea and/or fever

Results

- From July 2003 and March 2004
  - 223 patients were enrolled
  - 10 experienced rush
  - 9 are dead
  - 49 were lost in follow-up
  - 155 are still on treatment
  - 40 have low compliance

Characteristics of the 118 patients who complied to treatment:

	Body Weight (kg)	WBC/ml	Lmphocytes/ml	Hb g/l
Baseline	49	2950	1100	10.2
3rd month	60	4100	1740	12.8
6th month	58	4530	1900	13
9th month	59	4550	1820	12.6

Current situation

- 155 patients are still on treatment
- 40 have low compliance
- 20 reported mild symptoms

Conclusions

- Our data showed that this regimens is:
  - efficacious in terms of reconstruction of haematological parameters, decreasing the incidence of O.I. and increasing the body weight
  - not toxic and has few side effects
  - but there is low compliance

Recommendations

- increase health services to treat AIDS patients
- provide counseling to support compliance
- Guidelines to strictly decide when, how and who treat should be developed.

2.2.2 Abstract Presentations

The following are the descriptions of the abstracts which were presented in oral sessions. Some of the abstracts were exhibited as poster presentations. All the abstracts, both oral

and poster presentations, can be viewed on the CD-ROM which accompanies this report, and can be obtained from the AIDS and TB Unit of the MOHCW or the NAC offices.

2.2.2.1 Increasing Male Participation in Home Based Care Work.

C. D. Chipere (Main Presenter)
N. Matinhure (Co- presenting)

Introduction

In rural communities, the burden of care falls overwhelmingly on women, traditionally; care of the sick has largely been the task of women. Hence, most HIV and AIDS care and support projects have been directed toward women as primary and secondary caregivers. This approach hoists even greater workloads on already overburdened women and neglects the role that men can play in providing basic nursing care and emotional support, particularly for other men. AfriCare launched a project in February 2002 in Mutasa District in Manicaland. The overall focus of this project is to encourage men to take greater responsibility for caring for people living with AIDS, both within and beyond their immediate family structures. Education on gender sensitivity is a central element of the male empowerment groups; hence the project has a significant impact not just on men, but on their spouses and children as well. In the three years of operation, the Male Empowerment Project recorded a number of achievements such as:

- Contributing to the quality and quantity of home-based care in Mutasa;
- Profiling and promoting male involvement in HIV prevention and supporting behavior change;
- Assisting in the reduction of stigma against PLWA; and
- Increasing income for households affected by AIDS.

By targeting scarce resources to male VCGs and male clients, the project inadvertently reduced services available to women living with HIV and AIDS. Hence, the project underserved female clients. Therefore, Africare revived groups of female VCGs to work in compliment with the male groups. This was based on the need to address the issue of further marginalizing women as found during project implementation.

The project has trained 120 male and 120 female home care volunteers in taking patient history, providing basic nursing care and infection control, caring for sick children, positive living, preparation of wills and bereavement counseling.

Lessons learnt

Through quantitative and qualitative evaluations, Africare has identified critical elements, which can make men more effective caregivers. Associating caring, nursing, and protection of family from HIV transmission with traditionally male characteristics like strength, masculinity, and empowerment can help men to take on more proactive roles in AIDS prevention and care.

Recommendations

Africare hopes that by supporting male volunteers as secondary caregivers, more men will be willing and able to provide primary care to their own family members, thereby reducing the burden on women and increasing the quantity and quality of support and care for people living with HIV and AIDS in rural communities.

2.2.2.2 Counseling and Communication Psychosocial Support model for community based ART initiatives: Zimbabwe's experiences

S. Moyo,

Issues:

1. The diagnosis of HIV infection for women presenting at the ante-natal clinic already pregnant, is associated with considerable psychosocial distress.
2. Their main concerns will include the need for social and psychological support, access to medical care and treatment, disclosure and planning for the future. Added to the distress is the knowledge that the woman has a disease that carries stigma, fear, and discrimination.
3. The current PPCT in the country addresses issues of pre-test and post test counseling and other basic bio-medical care for mothers and infants. Psycho-social aspects, crucial to facilitate other interventions in PPTCT are given little consideration or hardly ever strategically integrated into existing ante-natal services.

Program description:

Zimbabwe AIDS Prevention Project- Call To Action (ZAPP-CTA) has been working in collaboration with Chitungwiza Health Department to PMTCT program. Four sites have been operational since 2002. During this time the ZAPP-CTA has been mobilizing support groups for HI+ mothers. At the moment there is at least one support-group (SG) organized at each clinic. Out of 713 women with + HIV test about 216 (30%) have joined support groups. Mothers are informed about SG or encouraged to join during the ANC health education by community mobilizers (CM). Needs based psycho-social SG are established. These SGs are facilitated by CM who themselves graduated from the PPTCT program, with technical guidance from a professional counselor. SG meetings are held on weekly basis. Some interpersonal communication interventions in place include: disclosure issues; condom skills; relational skills (negotiation of safer sex; sexual negotiations, assertiveness; problem management) decision making, promoting behavioural change; and enhancing the quality of life.

Lessons learnt:

1. Psycho-social support interventions should be needs based.
2. Psycho-social needs of people living with HIV and AIDS (PLWH/A) should generally fall on sufficiently trained and supervised facilitators.
3. Improved relationships with important others.
4. Increased disclosure to important-others.
5. SG acting the social facilitation role.
6. Solidarity
7. Empowerment

Recommendations:

1. When initiating PPTCT projects PSS should be considered priority and an integral component of the service.
2. PLWH should play a central role in setting up PSS initiatives.
3. Appropriate and effective referrals must be established to integrate counseling with community support systems to break down social stigma and help PLWHA lead socially productive lives.

4. Further training of support group facilitators for more understanding of group dynamics

2.2.2.3 Young People We Care Programme

Judith Sherman and Lovemore Magwere
John Snow International – UK, Standards Association of Zimbabwe, Northridge, Borrowdale. Tel. 850265/6/7

Programme description

An increasing number of new HIV infections in Zimbabwe are occurring in younger age groups. At the same time, the number of young people caring for sick parents and of orphan-headed households has escalated to alarming proportions. Responses in Zimbabwe have tended to address these two crises as separate phenomena. Numerous organisations work with young people on prevention-oriented activities, while others are supporting home-based care clients and orphans. Few programmes have bridged the gap between prevention and care, yet the same young people being encouraged to 'prevent AIDS' are living in households and communities where people are sick and dying from AIDS-related illnesses.

To address this gap, John Snow International-UK (JSI UK), with DFID funding, is working with six local partners to implement a programme called "Young People We Care" (YPWC) aimed at assisting both HBC organisations and youth groups to train youth in providing support to children and young people affected or infected by HIV in their communities.

Issues addressed

The YPWC training programme addresses a range of issues and activities that young people can undertake, such as helping households, providing basic care and psychosocial support to people who are ill, learning what to do in the case of sexual abuse, making memory boxes, providing bereavement support and advocating for better access to social services.

Lessons learned to-date

- Engaging in consultative processes from the beginning with young people, HBC caregivers, orphans and vulnerable children, and the relevant community leaders has ensured community support.
- Non-material incentives such as training skills development, recognition etc. are just as important as material incentives.
- There are few materials available specifically suggesting ways in which young people can provide HBC and psychosocial support.

Recommendations

- When working with youth groups, basic issues around HIV and A IDS, sexual and reproductive health, and peer education need to be continually addressed.

- Children and young people affected and infected should be supported and cared for – to improve their quality of life and reduce the stigma and discrimination around AIDS.
- Both young people and adults need training in discussing death, grief and bereavement.
- Organisations should begin bridging the gap between prevention, care and mitigation by integrating 'youth prevention,' 'home-based care' and 'orphan support' programmes.

2.2.2.4 Integrated Nutrition Gardens

Mugove Walter Nyika

ISSUES ADDRESSED

The SCOPE Programme has taken a holistic approach to the challenges presented by the HIV and AIDS pandemic. Our response to the pandemic is focused on promoting prevention, support and mitigation through poverty alleviation in the affected communities. We believe that poverty lies at the centre of many of the problems faced by communities including those problems that are linked to the pandemic. Our interventions therefore seek to empower communities to fight the pandemic through poverty alleviation, securing livelihoods and enhancing food and nutrition security. Skills' training in the relevant fields is an integral part of our work.

Programme Description

The Schools and Colleges Permaculture (SCOPE) Programme is a practical Environmental Education and Management Programme that uses Permaculture as a tool for promoting sustainable land-use systems. We have developed a step-by-step process for planning and implementing sustainable use of land-based resources that we call Integrated Land-Use Design (ILUD). The ILUD process has been used by pilot school communities to set up integrated nutrition gardens over the last ten years. Disadvantaged families apply low-external input and environmentally friendly agricultural techniques in these gardens to produce organic produce that they consume and market

Lessons Learnt

A holistic approach to the HIV and AIDS pandemic offers more hope because it tackles the problem from many different angles. Schools have substantial pieces of land that can be used to showcase the integrated nutrition gardens. Communities need to be empowered to combat the HIV and AIDS pandemic on their own.

Recommendations

Home-based caregivers should be trained in ILUD so that they can assist their target groups to set up integrated nutrition gardens that would help communities to be more self-reliant and nutritionally secure. The SCOPE Programme has a large capacity to train the trainers of the Home-based caregivers in these approaches.

2.2.2.5 Spiritual care of HIV and AIDS patients

K. McCarty, M. Mereki

Issues addressed: Spiritual pastoral care is a vital part of care of HIV and AIDS patients. When spiritual care is included with physical care of HIV and AIDS patients they are better able to cope with the diagnosis as well as live with the disease in a positive manner.

Program description:
Chidamoyo Christian Hospital is an 85-bed mission hospital located in Hurungwe District of Zimbabwe. Holistic care is provided for each patient. Patients are considered as unique people with both physical and spiritual needs and assessments are made of each patient by qualified staff. Five full-time counselors have been trained and hired to do pre and post test counseling for HIV and have been trained in spiritual care of such patients as well as physical care. Praying for patients as well as physical care is offered to all patients. The works of these counselors are an integral part of the HIV and AIDS program of the hospital.

Lessons learned:
Patients are not forced into any spiritual activity but come seeking spiritual help in the crisis they face in being HIV and AIDS positive. Counselors are readily available to meet those needs. Patients expressed through interviews that they felt better to cope with their disease and accept their disease because of spiritual care provided. They felt support of their churches and fellow Christians helped them in living positively with HIV and AIDS. Patients stated that they specifically sought out the hospital because of spiritual care being offered, and felt that they improved better because of prayers by the staff. Patients are spiritual beings as well as physical beings and are anxious to have all of their unique needs met at the hospital. We cannot avoid the spiritual care of the patient in providing care for HIV and AIDS patients. Spiritual care as well as physical care can work hand in hand to provide the best care of patients.

Recommendations:
All institutions doing counseling of HIV and AIDS patients should include spiritual care as a vital component to HIV and AIDS care. Considering the whole person with unique spiritual and physical needs that can be met and supported throughout
HIV and AIDS care is important in helping patients to accept and deal with their HIV and AIDS status.

Amen.

2.2.2.6 Clinical experience in the use of highly active antiretroviral drugs in a community based project

- G Kadzirange, L Zijenah, T Kufa, N. Gonah , C Maponga, G Musingwini , E Matsikire, S Moyo, ZM Chirenje, O Tobaiwa, D Bhattacharaya, DA. Katzenstein

Chitungwiza General Hospital[1],University of Zimbabwe College of Health Sciences, Departments of Immunology[2], Community Medicine(ZAPP)[4], Pharmacy[6] and Obstetrics and Gynaecology[7], Harare, Zimbabwe, [2] MSF Barcelona, Spain[3] and Stanford University[5], Stanford, California, USA.

Background
Highly active antiretroviral therapy (HAART) is becoming increasingly accessible to resource poor limited countries such as Zimbabwe. These are available predominantly as generic formulations. It is extremely important to assess how feasible it is to offer a comprehensive HIV care including HAART in a community based model.

Objective
To look at the feasibility of treating AIDS using generic antiretroviral drugs in a resource poor setting .

Methods
HIV positive, women, their male partners and infants were recruited for the program. Those with CD4 counts of <200 or WHO clinical stage >3 were offered Cotrimoxazole prophylaxis and initiated on generic antiretroviral therapy comprising of Duovir (ZDV/Lamivudine) and Nevirapine. All individuals had a baseline complete blood count, renal and liver function, CD4 counts and virus load. Drugs were issued on a weekly basis for the first month and thereafter monthly. Clinical monitoring for progress and adverse events was conducted by nurses and lay counselors. Individuals who fell sick were referred to the study clinicians.

Results
A total of 82 individuals were recruited between July 2003 and March 2004. 51 were females, 29 were males and 2 infants. Of these a total of 75 were on continuous ART at the end of March 2004. 4 individuals were lost to follow up, and there was one death due to pneumonia. At enrolment 47 were asymptomatic, 12 had WHO stage 2 disease and 23 had >stage 3 disease. Adverse events prompted 98 visits to the clinics. 10/82 (12%) had pneumonia, 9 of which had good response to antimicrobials. CNS events occurred in 10 (12%) individuals (2 had peripheral neuropathy, 1 had herpes zoster and 7 had headches). GIT events predominantly vomiting occurred in 8/82 (9.7%) cases. Skin rashes were reported in 10(12%) individuals, 9 of which were drug related. In three cases the rash was severe enough to warrant change of antiretrovirals combination. 3(3.6%) individuals had anaemia attributed to drug therapy and had treatment change. 1 individual developed Kaposi sarcoma 4 weeks after starting ART. Overall adherence to ART was >95%.

Conclusion
Monitoring for HIV related morbidities and treatment is feasible at the community level through the use of nurses and lay counselors.

2.2.2.7 "Use of ARVs in a rural mission hospital"

Dr. Jono Mbangani **mbangani@mweb.co.zw**
Kathy A. McCarty, Kmccarty@mweb.co.zw
Chidamoyo Christian Hospital

P.O. Box 330, Karoi; Tel 064-7200/6519

Issues Addressed: People living in rural areas in Zimbabwe are affected with HIV and AIDS. Resources in order to provide antiretrovirals (ARVs) for such patients have not been within the reach of most hospitals in Zimbabwe. However with the cost of ARVs decreasing and more patients seeking treatment of HIV and AIDS, Chidamoyo Christian Hospital began treating patients with ARVs in November 2003.

Program Description: All patients who were pre and post-test counseled at a rural hospital in Zimbabwe were told about ARVs. During post-counseling patients were identified who would benefit from ARV treatment and special counseling would be given to them and their family concerning the benefits and side effects of ARVs. Patients would have to pay the cost of the medication at $136,500, the cost of medicine to the hospital. Patients who were determined to be in Category 4 WHO grading system for HIV and AIDS would be started on Stalanev 40 one tablet twice a day. To date 12 people are enrolled in the program and benefiting from this program, 2 died within the first month of treatment and 10 are living well on the drugs.

Lessons Learned: More people are aware of ARVs and want to use them. People are traveling from all over the country to seek treatment from the hospital. Some families, even in rural areas, have resources to afford the drugs and are demanding their use. Staff morale has increased dramatically since the start of ARVs, as they are now able to see patients improve and live normal lives, instead of only dealing with patients who die. Patients on ARV's are able to speak out to the community and tell them about the drugs and how they work. They are the most enthusiastic supporters of this program, and encourage people to be tested and treated. More patients are willing to be tested since we have offered ARV testing (increase of 32%). Side effects have been minimal and patients are doing well on the drugs.

Recommendations: All patients in Zimbabwe should be offered ARVs. We cannot sit back and say there is nothing we can do because we are a third world country with no resources. Patients can afford ARVs and it is possible to provide such services even in rural hospitals in Zimbabwe. The time to act is now; we can prevent death in HIV and AIDS patients, and help them in living longer, more productive lives which benefit everyone in the country.

- *2.2.2.8* **Care for HIV and AIDS Prevention and Positive Living (CHAPPL) Network**

  - EGV. Sithole, C. Alfredo, VTS. Chitimbire, S. Harder, A. Mbengwa

Mission hospitals in Zimbabwe provide about 45% of hospital beds in the country's health system, translating to 68% of hospital beds in the rural settings. The Zimbabwe Association of Church Hospitals (ZACH) with support from the Centres for Disease Prevention and Control (CDC) in Zimbabwe embarked on a programme to bring

improved health service provision to the rural populations in HIV prevention and care through work with mission hospitals.

Programme Description:
Ten mission hospitals were identified to form a network known as CHAPPL . Selection was based primarily on demonstrable evidence of innovation in improving HIV and AIDS care and prevention services as well as balance in geographical and denominational distribution in the country. Each province in the country has at least one CHAPPL Network hospital. Through meetings and sharing experiences, the strategies formulated for the CHAPPL Network were: expansion of counseling capacity in rural hospitals, enhancement of HIV care services that includes management of Opportunistic Infections, setting up PEP programmes, strengthening PPTCT and the Community Home based Care programmes, and documentation of all activities for replication to both mission and non mission hospitals. Through consultations and meetings with stakeholders including the MOH and CDC, the network has been able to develop a counseling programme, renovate spaces for counseling services, establish a PEP programme and ensure availability of OI drugs and formalized follow up system for patients on continued HIV care and treatment. The next steps are expansion of the network to include more hospitals.

Lessons learned:
-Documentation to capture HIV and AIDS activities at institutions still needs to be improved.
-With improved HIV care, there is an increased demand for counseling services
-Implementation of good practices in HIV care is possible through coordination of efforts and focus on specific key activities.
-Training and provision of PEP drugs, will not necessarily improve self reporting after accidental exposure.
-Continuum of care after discharge is an important component of HIV management. Coordination of activities allows for better results without necessarily introducing new interventions.

Recommendations:
The programme can be used to prepare for introduction of ART in rural settings.
While stand-alone OI clinics are ideal, institutions can provide similar care if allowed to be innovative depending on their resources.
The CHAPPL Network should be expanded to cover other institutions through mentoring by the core group of hospitals.
Documentation needs strengthening for improved monitoring and evaluation and capturing the best practices.
-Improved coordination of activities will allow for better results

2.2.2.9 **Primary Care Counselor (PCC) – Developing Counseling Capacity in health care settings – ZACH**

VTS Chitimbire, EGV Sithole, A Mbengwa, C Alfredo, S Hader;

Issues addressed
Zimbabwe Association of Church Hospitals (ZACH) is an umbrella organization for mission health institutions representing them at various I on issues that affect their service delivery. ZACH with support from CDC formed the CHAPPL Network to assist a core group of ten hospitals in identifying best practices in HIV and AIDS care.
The lack of counseling capacity was identified as a major set back to provision of comprehensive HIV care particularly in rural health facilities.
With the concurrence of the MOHCW it was recommended that "lay counselors" later known as Primary care counselors (PCC), be trained based on a curriculum that would be developed in liaison with CONNECT, a local NGO that offers counseling services. The PCC would need to be skilled and competent enough to provide counseling services for both hospital patients and any other clients.

Programme Description:
Recruitment of these cadres was done at the institutions where they will work. The entry requirements were passes in five O-level subjects, with or without previous professional training in counseling. Training for PCC consisted of an initial three week residential training followed by a two-month practical attachment at respective hospitals during which time the PCC would be under supervision of trained senior nurse counselors. There was an additional two weeks of residential training followed by another two and half month's attachment before a final written examination and oral presentations in June. Continuous assessment points accumulated during the training period will contribute to the final mark.

Lessons Learned
1. In all institutions, this cadre has been greatly welcomed and appreciated
2. Like all new cadres, it is important to have clear job descriptions and orientation to reduce conflict.
3. Supervision was difficult due to lower staff establishment
4. There is need for constant follow up trainings.

Recommendations

1. This cadre needs to be introduced in all institutions and their position formalized in the health system.
2. This cadre will still need to work under the supervision of a qualified counselor
3. Regular updates and follow ups are still needed even after qualification
4. There is need to develop a clear career path as well as develop mechanisms to avoid burn-out.

2.2.2.10 Antiretroviral therapy in resource-limited settings: the experience of Médecins Sans Frontières at an international level.

Background: The international medical organization Médecins Sans Frontières started introducing ARVs in 2001 and is presently having 42 HIV and AIDS projects in 20 different countries all over Africa, Asia, Latin America and East Europe. The projection of patients under treatment for June 2004 is to have 25.000 patients under treatment by expanding access

to Highly Active Antiretroviral treatment (HAART) through simplification of protocols and decentralization of HIV and AIDS care at primary health care level.

Methods: Monitoring of patients has been done through a standardized software data base program developed by Epicentre (Fuchia®). We analyzed the biological and clinical results till November 2003 from 6869 patients who were getting triple generic ART, more than half of them under Fixed Dose Combinations (FDCs), following WHO recommendations.

Results: The median age of patients included in the analysis was 33 years (IQR 29-40), being 55% of them women. At inclusion in the project, 94% were ARV naïve, 91% of patients at WHO stages III or IV; a proportion of 90% (5194) with less than 200 CD4 and 43% (2451) less than 50 cells/mm^3. The median follow-up of patients was 4.7 months (IQR: 2.0-10.4), being 2934 (43%) monitored for more than 6 months, 1397 (20%) for more than 12 months and 623 (9%) more than 18 months. Treatment protocol: 97% of patients initiated a NNRTI regimen, mainly under 3TC/d4T/NVP (51%) or any other alternative combination using AZT or EFV (45%). There were 4.6% of patients on second line with a Protease Inhibitor. Biological results showed a median CD4 count of 67 cells/mm3 (IQR:19-139) and there was a progressive CD4 count increase of 149 cells/mm^3 at 12 months and 191 cells/mm^3 at 18 months (IQR:120-290). Patients with 200 cells/mm^3 or more varied from 37% to 54% and 67% at 6, 12 and 18 months respectively. Outcome: 8% deaths, 0.7% patients stopped treatment, half of them due to intolerance, and 4.6% were lost to follow-up for more than 60 days.

Conclusions: Antiretroviral therapy is feasible in resource-limited settings; the biological efficacy and outcomes have been proven successful even in severely immunocompromised patients and therefore live saving ARV treatment should be introduced as soon as possible in ant HIV and AIDS program. Simplified treatment by the use of generic ARVs on Fixed Dose Combinations improves adherence and allows expanding access to HAART

2.3 Recommendations from breakout sessions

2.3.1 Recommendations on ART

- Government should coordinate OIs and ART Treatment initiatives at all levels
- VCT services should be expanded down to growth points.
- ART should be decentralised down to district level, maintaining quality of care and good follow up in the process of scaling up
- Documentation needs to be strengthened for improved monitoring and evaluation
- Government should mobilize and include communities in planning and implementation of ARV initiatives. Public awareness should be increased. Patient literacy should be improved
- Treatment guidelines should be distributed equally throughout the nation using existing distribution networks for all sectors of health, including traditional healers and AIDS service organisations.
- There should be greater coordination between public and private sectors,
- Laboratories should be adequately equipped to fully support ART scaling up.

- Government should remove import duties for raw materials for the production of ARVs, while prioritising foreign currency allocations to the manufacturers.

2.3.2 Recommendations on Nutrition

- Government should consider a policy to improve the nutritional status of the whole country from kindergarten children to schools and workplaces to ensure that good nutrition is available to boost immunity.
- Nutrition must be mainstreamed and become an integral part of the HIV and AIDS agenda.
- Nutrition must be provided as part of a holistic strategy under HIV care and support.
- The printing of a manual on nutrition is recommended. This manual must be taken to the grassroots communities in a form that is accessible.
- A conference on nutrition and HIV and AIDS should follow as part of a development strategy

2.3.3 Recommendations on Home Based Care

- Government should coordinate HBC initiatives at all levels.
- There should be a clear definition or roles and responsibilities for NAC, NGOs, Hospitals, and government structures.
- The Ministry of Health should appoint a National Home-based Care Coordinator. The District Nursing Officer could be mandated to coordinate at district level.
- Training for HBC should be standardized using the MOHCW standards. The training should be a package that includes topics on nutrition, drugs, ethics, communication etc. There is need to monitor the quality of such training offered.
- Training guidelines at all levels of HBC interventions should be standardised, including that for medical personnel, traditional healers, and especially for primary care givers.
- The HBC policy needs to be updated and used as the framework for all HBC activities.
- There is need to implement and revive the discharge plan, involving HBC programmes where the patients will be assisted.
- The MOHCW should standardize incentives given to HBC volunteers to ensure that they remain motivated and not exploited.
- Government should mobilize and include communities in planning and implementation of HBC initiatives. Part of the National AIDS Trust Fund could be used to scale up activities needed for an expanded HBC programme.
- OVC services should be expanded to all OVC, including those in care homes.

CHAPTER 3
PREVENTION
DAY 2

His Excellency, President R G Mugabe

3.1 Summary of day's proceedings

While Day 2 focused on "Prevention" as the main theme, undoubtedly one of the day's main highlights was the official opening of the conference by His Excellency, the President of Zimbabwe and the testimonies given by youths during the official opening on their experiences with HIV and AIDS. President Robert Mugabe noted that "Though the adult prevalence rate appears to be stabilizing, the number of AIDS related illnesses and deaths continue to rise, as present HIV cases develop into full blown AIDS" and that combating the epidemic remained a major challenge for the country. He also expressed his disappointment at the continued stigma associated with testing and counseling and knowing one's HIV status, and expressed his hope that the conference would "help to dispel stigma and bring the reassurance to our people that knowing your HIV status enables you to live a healthier, informed life". He also expressed the need to work in a co-ordinated manner which strengthens the agreed framework of the 'Three ones', namely one National Strategic Plan for the fight against HIV and AIDS, one Coordinating Authority and one monitoring and valuating system. **(See full text of His Excellency, President Mugabe's speech above)**

The three youths who spoke during the opening ceremony stressed the need for young people to be fully engaged and empowered, not simply with facts and messages but with

real ways to find solutions to their circumstances. For example, the illness or loss of parents turned children into parents and caregivers, a role for which they are not fully prepared.

Two Health Ministers from some of the SADC countries, Dr. Manto Tshabalala-Msimang who is the Minister of Health of South Africa and the Deputy Health Minister of Angola, Dr. Jose Van-Dunem, gave solidarity messages and shared their countries' experiences. Dr Tshabala-Msimang pointed out that SA's ART roll out plan had not been without its difficulties, such as interrupted drug supplies in one of the provinces, even though South Africa is producing its own ARVs. She also noted that a recently released report indicated that approximately 50% of women had shown resistance to Nevirapine, prompting the vital need for review of the prevention of mother to child transmission (PMTCT) programme. She revealed the existence of an SADC HIV and AIDS initiative to which SA has pledged funds. **(See 3.2.1.1 below for the full text of her remarks).**

The Angolan Deputy Minister for Health said that despite the destructive effects of 30 years of war, Angola was determined to fight the HIV and AIDS scourge and prevent its prevalence form rising further than the current 5.5%. It could therefore learn from the experiences of Zimbabwe through this conference. **(See 3.2.1.2 below for the full text of her remarks).**

*Dr Agnes I. Mahomva, the National PMTCT Technical Coordinator, gave a key presentation on "*Experiences With The National PMTCT Programme". She revealed that by the end of 2003 there were 43 out of a total of 58 district hospitals (74%) implementing PMTCT in the country. A total of 74,704 women had been pretest counseled for HIV in PMTCT sites in 2003. Of those who were tested, 56% had received nevirapine prophylaxis for MTCT compared to 35% in 2002. Some of the programme challenges included limited community and male partner support (only 4% of male partners were pre test counseled in 2003), limited access to counseling and on site HIV testing, difficulties with follow up of mothers and babies and limited infant feeding alternatives (most women therefore opted for exclusive breast feeding). The way forward was to introduce initiatives that would help improve programme uptake and to provide comprehensive care and follow up of mothers and babies. **(See 3.2.1.3 below for Dr Mahomva's presentation).**

Trevor Matambudziko, a young person (16 years) who had been affected by HIV and AIDS at an early age, presented on "*HIV Prevention Among Youth*". He highlighted that youths are not only suffering from the consequences of the disease through the loss of parents but that they also are at greater risk of being infected. He said that though there are many youth interventions underway, such as youth friendly services, lifeskill education in schools, peer education and youth groups, young people must be fully engaged and empowered, not simply with facts and messages but with real ways to find solutions to their circumstances. The focus should shift from adult-led to youth-led interventions and the interventions must go beyond solely focusing on the individual as the target, but must also address the social and policy environment where youth live to better address their circumstances. He also urged adults to lead by example, especially in their sexual behaviour. **(See 3.2.1.3 below for his full presentation).**

The issues from the presentation and the main theme were further elaborated in a panel discussion in which the following led the discussions: Believe Dhliwayo a PLWA advocate, Mr Simon Gregson, Ms Grace Osewe, Mr Isidore Guvamombe of the Zimbabwe Union of Journalist, Dr. Simon Chihanga and Dr. Richard Davy of Hippo Valley Estates. Audience Participants were: Mr. Bowora of the MOESC, Ms Evelyn Serima of ILO, Ms Vimbai Mdege of NAC, Mrs. Bakasa the PNO Mash West, Mrs. Hungwe of ZAPSO, Mr. Samuel Tsoka and Mrs. Mangwende of Delta Corporation. Dr Agnes Mahomva moderated the panel discussion.

Oral abstracts were presented on:

- *Comparative evaluation of ultrasensitive p24 antigen assay and CD4/CD8 ratio, versus DNA PCR for diagnosis of HIV-1 infection in infants under the age of 2 years, in Harare, Zimbabwe* by Lynn S. Zijenah[1*], DA Katzenstein[2], KJ Nathoo[3], S Rusakaniko[5], O Tobaiwa[1], C Gwanzura[4], A Bikoue[6,7], M Nhembe[3], P Matibe[3], G Janossy[6].
- *Early introduction of non-human milk and solid foods increases the risk of postnatal HIV-1 transmission in Zimbabwe* by Dr Peter Illif- ZVITAMBO Project,
- *PMTCT Pilot Study: -Single dose nevirapine use, feeding practices and clinical manifestations in infants* by Dr F. Tarwireyi
- *Post Exposure Prophylaxis: Preventing occupational transmission of HIV by C Ndalama-Alfredo- CDC-Zimbabwe*
- *Nurse's Knowledge of universal precautions and perception of personal risk of infection-Occupational/Health care Worker Exposure* by Mrs Sibabili Chadenga, Teaching Assistant, Department of Nursing Science, Co- Author-Dr Rose J. Ndlovu
- *Safer Sex For Pregnant Women In Zimbabwe: A Continual Challenge By Mavis Kahwemba, Jennifer Wells, Francis Jaji, 046 Team*
- *David Whitehead Workplace Prevention Programme By* ***Mr Edward Katerere***

- *HIV and Aids and Life Skills Program By A. Mavise* , Ministry Of Education, Sport & Culture
- *Behaviour Change Communication : Youth Peer Education And Practice, Jesuit Aids Project By* Rev. Dr. Edward W. Rogers, S.J.
- *Scientific Impact & Process Evaluation Of Integrated Behavioural & Biomedical Interventions In Rural Zimbabwe: Manicaland HIV/STD Prevention Project*
- *By* Simon Gregson, Saina Adamson, Spiwe Papaya, Tendai Chimbadzwa, Geoff Garnett, Constance Nyamukapa, Peter Mason, Geoff Foster, Roy Anderson, Stephen Chandiwana
- *STI/HIV and AIDS Prevention, Control, Care and Support Programme* by BB Homela and P Muchemwa, NATIONAL RAILWAY OF ZIMBABWE (NRZ)

See 3.2.2 below for the full abstracts.

Participants then went into breakout sessions/group discussions covering the three sub-themes of a*)* "PMTCT" facilitated by Dr. Anna Miller and Dr. Rose Kambarami; b) Youth Programmes facilitated by Ms Tsitsi Dangarembizi and Mr Trevor Matambudziko; and c) Workplace Programmes facilitated by Mr Matthew Ncube and Dr. Richard Davy.

The following issues were raised:

Key issues from breakout sessions

a) Issues on Prevention of Mother to Child Transmission of HIV (PMTCT)

- Though PMTCT programmes have been initiated by the Ministry and client registration into the programme has been done at 43 out of a total of 58 district hospitals, it was however, noted that while there is large participation by women in PMTCT health centers, where training and other programmes are based is not male friendly.
- There is a shortage of programmes targeting men and this is hindering prevention efforts since men are significant in the spread of the disease. This was evidenced by the fact that only 4% of male partners were counseled in 2003. There is therefore a need for programmes to include men in prevention work.
- Delegates also expressed concern that while it is commendable that the Ministry has a strategic framework for expansion of PMTCT, the programme seems to concentrate on children under 18 months of age. It was stressed that there is need for follow-up not just of the children, but also of the mothers even beyond this age.

b) Issues on Youth Programmes

- Questions were raised about the role of the youth in HIV and AIDS prevention programmes. Youth representatives noted that there is need to be innovative and involve the youth themselves in the formulation of youth programmes and build the capacity of the youth to run these programmes. Examples of successful national youth programmes were cited from countries such as Zambia and Kenya, which start from the grassroots and go up to national level.
- Youth delegates felt that issues of concern to them had not been adequately covered during the conference e.g issues of youth and sexuality and empowerment programmes.
- Organizations need to set up youth friendly centers, to enable the youth to access information.
- It was suggested that there is need to convene a conference targeted at the youth where all issues concerning the youth would be addressed fully.
- The need for good adult role models for the youth was noted. On the other hand, there was also need for the youth to behave responsibly.

c) *Issues on* Workplace Programmes

- It was noted that Statutory Instrument 202/98 needs to be amended. The delegates emphasized the need for involvement of all stakeholders for example business, government and non-governmental organizations.
- Delegates expressed concern at the problems of employees who after having served at a company for years and contributed to medical aid, sometimes find themselves destitute after they leave work. The need for post retirement care and social safety nets was therefore stressed.
- The informal sector was singled out as needing particular attention in HIV and AIDS prevention work, especially in view of the fact that the informal sector is increasingly becoming a major employer in Zimbabwe. Among the suggestions made was to learn from the Tanzania experience where a comprehensive social security programme is in place for the informal sector.
- Delegates also stressed the need for incentives for companies operating workplace programmes, as well as to coordination of the effort of industry. In this regard it was suggested that the Zimbabwe Business Council on HIV and AIDS could play a central role in coordinating the industry's effort.

3.2 Presentations of the day

3.2.1 Invited Speakers

3.2.1.1 Remarks by Dr. Manto Tshabalala-Msimang, Minister of Health of South Africa

Dr Manto Tshabalala-Msimang

Well, Good Afternoon everybody.

I would like to recognize my colleague the Hon Minister of Health and Child Welfare of Zimbabwe Dr Parirenyatwa, the Deputy Minister of Health of Angola. The Chairperson of the National AIDS Council, Colleagues, Friends, Senior Officials, Ladies and Gentlemen. Programme Director allow me to say it is indeed an honour and privilege for

me to give a statement on this auspicious occasion, Zimbabwe's first National AIDS Conference. I thank my colleague Dr Parirenyatwa for the kind invitation that he extended to me. Unfortunately I have to leave pretty soon, as I have to participate in the Budget Vote debate on Health tomorrow. But I hope it will all go well. What I have decided to do is not to talk about the same things that we obviously have heard from Dr Parirenyatwa and His Excellency Comrade Robert Mugabe because they are almost the same things that we do. I thought what I should share and I am not going to be an alarmist but really to share the things that we are grappling with, because I think we can then find some kind of some synergies on how we can support each other in trying to battle with those problems. But also to say the SADC region has been grappling with the spread of HIV and AIDS and its impact for a long time now. As SADC countries we have tried to share experiences and to learn lessons from the different parts that we have embarked upon as individual countries.

In June last year SADC Heads of States and Governments adopted and signed the Maseru Declaration on HIV and AIDS. The declaration identified several areas of priority actions, including in my view, which I thought, was absolutely critical, the establishment of regional HIV and AIDS Fund. We now need to move quickly to make the fund a reality. This is in line with the decision of the African Health Ministers in Geneva last month that Africans need to make contributions, however small for their own development. To demonstrate this commitment I therefore pledge at this conference that South Africa will make the first contribution to the SADC HIV and AIDS Fund and I hope that others will follow suite.

South Africa launched its second five year HIV and AIDS Strategic Plan in 2002. Most of you will recall that of course we never had a plan before 1994, and so when some of us came back from exile, we started the initiative of setting some kind of a plan but we soon realised that we needed to elaborate on our plan and this why we call this the strategic plan of 2000, the second plan in South Africa. The plan had four components, Prevention, Treatment and Care, Legal expertise and Research. We purposefully moved cautiously in the implementation of this strategy, as we wanted to ensure that at all stages of our implementation the interests and health of our people were protected and assured. We are now implementing the last stage of our plan and that is treatment with ARV's through the comprehensive plan for HIV and AIDS Care Management and Treatment and this was adopted by Cabinet in November last year. Of course for us prevention still remains the key intervention in our fight against the spread of HIV and the impact of AIDS. We still emphasize the ABC, Abstinence Be faithful and Condoms Campaign. We believe that condoms play a big role in the prevention of sexually transmitted infections including HIV and AIDS.

Two years ago I launched our branded condom called Choice, which replaced our old Government Issue non-branded condom. Its slogan is No Choice No Play and I have the pleasure to give Dr Parirenyatwa a box of those. They now know No Choice No Play and of course it is linked to the 2010 World Cup Slogan for the youth 2010. Will you be there? This will still be distributed free to our public because if they don't make choices they will not play the World Cup. I am talking about the real World Cup. As I mentioned before, I hope there is no media here, when I was launching these Condoms, one young

person stood up and said how the condom was lubricated and was very nice and it was all over in the newspapers in South Africa. The headlines were Manto Sex Tips. So that's why there is no media that is going to misquote me. Well as I mentioned before we are cautious in introducing the ARV's into our system. In addition to ensuring the safety of this intervention, we also wanted to be certain that the intervention we introduced were sustainable and affordable.

We followed the principles governing the negotiations with the pharmaceutical companies in the provision of ARV's that had SADC Member States and particularly the Ministers of Health developed in the year 2000. Most of these requirements for the provisions of ARV's were already articulated in those principles that we developed as Ministers of Health. We had many questions to be answered around how we would provide human resources, whether we had adequate laboratory support for CD4 count and viral low count. The treatment options we would offer, provision of uninterrupted drug supply, compliance by patients and system for detection of the resistance of the ARV's. You know we were under a lot of fire but we stuck to our guns, because as I said we were very much interested to ensure that we were protecting the lives of our people in their health.

We thus embarked on a process of accreditation in this regard of our health facilities that will provide ARV's and I am sure very few countries have done that. Our aim was to ensure that one health facility per District was accredited that by the end of the first year of implementation we actually would have one health facility per district. The process has been very instructive in terms of showing us the need for robust health systems for the delivery of such a complex intervention. Some of them were revealed during the accreditation process. They were the serious shortage of well-trained and knowledgeable human resources in the form of doctors and nurses, counselors and pharmacists. The lack of a patient health information system with the patient identifier that would track patients across the country and prevent unnecessary duplication and defaulting, because I wanted for an example if I am sitting in Cape Town and a patient comes from Limpopo I should immediately know what the patient is on, so that there is no interruption. So we have been working very hard on developing the patient health information system in South Africa and one of the lessons that we learnt was that the long turn around at the laboratories could affect the uptake and compliance. I know some people would seem to think we have a very good health care system. But once we did the accreditation we were surprised to find the state of our laboratories in the country. And so as I am standing here, I am so proud that we didn't rush into this intervention.

But let me share with you some of the key achievements of our comprehensive plan. Treatment guidelines for adults and paediatrics were developed with expert input and have been distributed in the country. Introductory course on the use of ARV's drugs has been developed and training has commenced. Additional nutritional supplies and supplements have been purchased to ensure people who enter the programme have access to these nutritional supplements. Patient information forms have been developed and distributed to service points. The monitoring and evaluation indicators have been finalised after broad consultations. We have also three Pharmacy Vigilance Centres, one in Bloemfontain, one in Medunsa and in the Western Cape and we are monitoring the

drug safety in these Pharmacy Vigilance Centres. CD4 testing capacity was established in twenty facilities and the viral load testing capacity in six sites. A number of challenges still remain especially around pharmaceutical supplies. The challenge of providing uninterrupted drug supply is already being experienced in South Africa. For an example in the Northern Cape Province our programme had to be interrupted due to the shortage of paediatric drugs, as there was no guarantee of adequate supplies. So we have started experiencing some problems already. Never mind that we are also manufacturing ARV's, we just didn't have enough supplies and so we had to interrupt the Programme in the Northern Cape. Planning for the ARV's treatment in my view is complex as it is difficult on one side to accurately determine the uptake and numbers of the AIDS patients that will be treated and on the side the suppliers do run short of treatment s leading to interruptions in treatment.

Additionally we now have a kind of a report indicating to us that resistance to a single dose of Nevaripine in some of our PMTCT sights is around 50%, so that is quite worrying. This is a very high figure that will necessitate a total review of our PMTCT protocols. We need to take into account that women who develop resistance while exposed to Nevaripine or other drug through the PMTCT Programme will be able to use certain drug regiments for the treatment of HIV and AIDS. This will thus reduce their options for treatment and considering the large number of women that are on PMTCT Programme. This indeed represents a significant challenge for us. I am representing all these problems just to highlight the need for a careful analysis before embarking on complex programmes as well as the need for innovative solutions. Some of the solutions I propose are therefore local manufacturing of drugs, harmonisation of registration requirements in the SADC region and the use of traditional medicines. I believe that as Africans we have not fully explored the potential benefits of traditional medicines in the treatment of most illnesses including HIV related conditions. I am not implying that traditional medicines can cure HIV but I am not implying that traditional medicines can cure HIV but I am simply indicating that there are compelling empirical evidence that these remedies do boost the immune of HIV positive people and other persons for that matter. The problem is the treatment with traditional medicines is not documented and not scientific followed through. We therefore need to document and conduct clinical trials on traditional medicines to provide scientific proof of their value. In doing so however we also need to safeguard our intellectual property, so that our heritage is not exploited. I again call that South Africa will co-ordinate the documentation of traditional medicines as this will assist in getting them recognised by the scientific world.

Stigma and discrimination against those who are HIV infected continue to hamper our efforts in reaching as many people of those in need of treatment as possible. Without a safe and supportive environment for disclosure few will come forward for treatment. Nutritional support is another neglected area in the continuation of care for HIV. I very pleased with the inclusion of traditional medicines and nutrition in the resolution of HIV and AIDS adopted at the recent World Health Assembly.

In conclusion Chairperson, it is significant that the developed countries have also accepted the principle of three ones; one strategy, one co-ordinating body, one monitoring and evaluation tool. This principle will go a long way in ensuring that country strategies

guide all sectors in the field of HIV including donors themselves. It is only through support of country driven initiatives and strategies that partners will be able to empower governments in addressing our own health problems and needs, not health and needs as defined for us by people outside our countries. Co-ordination of donor support also has to be led by Governments to respond to our country's needs. Governments can ensure that there is equity in the allocation of resources, between levels of care and across regions and provinces. Programme Director once more let me thank my colleague Dr Parirenyatwa for the invitation for me to come and speak this afternoon and I trust that our experiences as South Africa even though there are for a very short time were worth sharing with you. We look forward to a successful and informative conference and I thank you very much for listening to me. Thank you.

3.2.1.2 Remarks by Dr. Jose Van-Dunem, Deputy Health Minister of Angola

Dr Van Dunem

Dr Magure, Madame Thandiwe Dumbutshena, Members of the Civic Society, Dear Participants, Ladies and Gentleman.

First of all I would like to thank the Government of Zimbabwe through the Minister of Health and Child Welfare for the invitation to participate at the First National HIV and AIDS Conference.

As you all know our sub-region is being ravaged by the pandemic of AIDS, so it is a privilege for me to participate in this meeting. Angola has lived more than thirty years of war that has destroyed the health facilities in almost 70% of the country, created big slums around the main capital, provincial capitals with persons living in deficient conditions, but the war had also reduced the movement across the borders with neighbouring countries and within the country increasing the possibility of the epidemic. However the country has a rate of prevalence of 5.5% in the prevalence ratio between women and men of 2 per 1.

The weakness of our information system advises us to look for the trend more than the figures and unfortunately the trend shows an exponential growth for the epidemic. To answer this situation we established the National Commission to fight against AIDS and other epidemic diseases headed by the President of the Republic. We created a National

Strategic Plan to fight against AIDS in collaboration with NGO's, UN Agencies, PLWA and the private sector in order to obtain a broad participation. Based on strategic plan, we implemented centres for counseling and voluntary testing, improved knowledge about the disease, set up a daily hospital in the mother to child transmission programme in more than three maternity hospitals in which we offer free of charge anti retrovirals drugs and we are strengthening our information systems to monitor the trend of the epidemic.

In spite of these efforts, the spread is quicker than our efforts and this is one the reasons why I am very happy to be here to learn with our Zimbabwean brothers how they are facing the epidemic, their success and lessons learnt in order to speed up our fight against AIDS.

Yesterday we had an opportunity to watch the commitment of NGO's and the Private Sector and the leadership of the Ministry of Health and Child Welfare in this common fight for a better future in this friendly country and I would like to use this opportunity to congratulate all partners involved in this task to rid Zimbabwe free of AIDS. Your fight is our fight. Your success will be the success of SADC sub-region and you must be sure that success is built up daily and past for the dedicated work of each of you.

Thank you once more for the opportunity, Dr David Parirenyatwa, to participate in a so important meeting for our common goals. Thank you so much.

3.2.1.3 "**Experiences With The National PMTCT Programme**" by Dr Agnes I. Mahomva

Dr A Mahomva

The following is an outline of Dr Mahomva's presentation.

In her presentation, she thanked the following people and organizations:

- The National PMTCT Team
- District and Provincial Implementers
- Financial and Technical Partners
- Women, their babies and families

She gave **the impact of HIV and AIDS on children 0-14 years age** as follows, by the end of 2003:

- 40,000 estimated new infections
- 36,000 estimated new AIDS cases
- 36,000 estimated AIDS deaths

- 165,000 estimated living with HIV and AIDS
- 761,000 estimated HIV and AIDS orphans

Source: National AIDS Estimates 2003

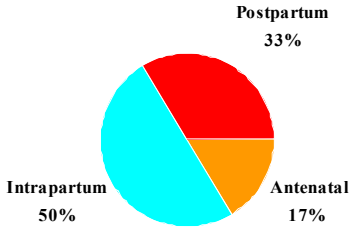
According to the "2002 ANC HIV Prevalence Survey"
it was estimated that 25.7% of women attending ANC in Zimbabwe were HIV positive

The risk of MTCT is:

- Transmission rates range from 15-45%
- Overall transmission rate in breastfeeding populations (such as Zimbabwe) is estimated to be about 33%

The following chart shows the points at which PMTCT is carried out:

Points at which PMTCT occurs



Risk Factors for MTCT

- Maternal-
  - High viral load
- Labour and Delivery-
  - Prolonged rupture of membranes
  - Vaginal delivery
- Infants
  - Prematurity
- Breast Feeding

- Prolonged (duration)
- Mixed feeding

Why is MTCT critical and a Critical Public Health Priority in Zimbabwe?

- HIV prevalence in pregnant women is high
- Transmission risk is high and
- **Over 90% of HIV infection in children is due to MTCT**

What is PMTCT?

PMTCT is the use of a number of interventions before and during pregnancy as well as during labour and delivery and soon after delivery in order to reduce the rate at which HIV is transmitted to the infant. **It is more than just using ARV drug prophylaxis (eg Nevirapine)**

Zimbabwe PMTCT Programme : From a Pilot Project to an Expanded National Programme

Programme Goal

- To contribute to the reduction of infant morbidity and mortality by providing pregnant women and their families with integrated comprehensive and high quality PMTCT services that are linked to care and support

Zimbabwe PMTCT Strategic Approach aims to:

- Prevent HIV infection in women (primary prevention)
- Prevent unintended pregnancies among HIV infected women
- Prevent HIV transmission to infants of HIV infected women ("traditional" PMTCT)
- Provide care, follow up, and psychosocial support to HIV infected women and their babies

The Expansion Targets are:

- To Expand and integrate comprehensive PMTCT services into all referral institutions by the end of 2004
- To have all other health institutions offering basic PMTCT services and referring for comprehensive services by the end of 2004

Comprehensive PMTCT Package

- To be carried out at all Referral Health Facilities and
- Consists of all of the "Basic Package" Plus Appropriate training, support and supplies to allow for:
  - Pre and post test counseling for HIV
  - On site rapid HIV testing and Quality Assurance
  - Comprehensive M & E tools
  - Counseling for infant feeding and support for chosen options
  - Infant diagnosis (antibody testing)

Basic PMTCT Package

- To be carried out at all Primary Health Facilities
- Should have the following characteristics:

Health workers trained in:	Health Facilities to have:
PMTCT	Male and female condom
Group education	NVP syrup and tablets
Relevant M & E	Adequate supplies for cotrimoxazole prophylaxis.
Community mobilization	IEC materials
Supportive follow up counseling	At least one trained nurse
Equipped to refer to nearest site to testing and counseling	Relevant M & E tools

The National PMTCT Programme

The programme has gone through the following phases:

1. Pilot Project (1999-2001)
2. First Phase Expansion (2002-2003)
3. Programme Assessment (2003)
4. Second Phase Expansion (From 2003)

The National PMTCT Pilot Project (1999-2001)

The pilot project was carried out from 199 to 2001 at three urban sites using short course AZT : Harare City ; Chitungwiza City ; Bulawayo City

Three rural sites using Single dose nevirapine

There were also three rural sites at:

St. Alberts Rural Mission Hospital
Murambinda Rural Mission Hospital
Epworth peri-urban Clinic

First Phase of Programme Expansion (May 2001-May 2003)

Expansion of PMTCT started in May 2003 and involved:

- Using renewable donation of nevirapine with
- Ongoing donation of test kits
- Development of training manuals
- Development of laboratory testing capacity
- Site registration mechanism established
- PMTCT partnership forum established
- Rapid geographic expansion but low uptake

National PMTCT Expansion Assessment, June 2003

Further expansion was faced with rapid expansion in face of limited coordination and management at all levels. These challenges led to an assessment being carried out.

Assessment findings

- Identified 12 key priority areas for Phase 2 expansion

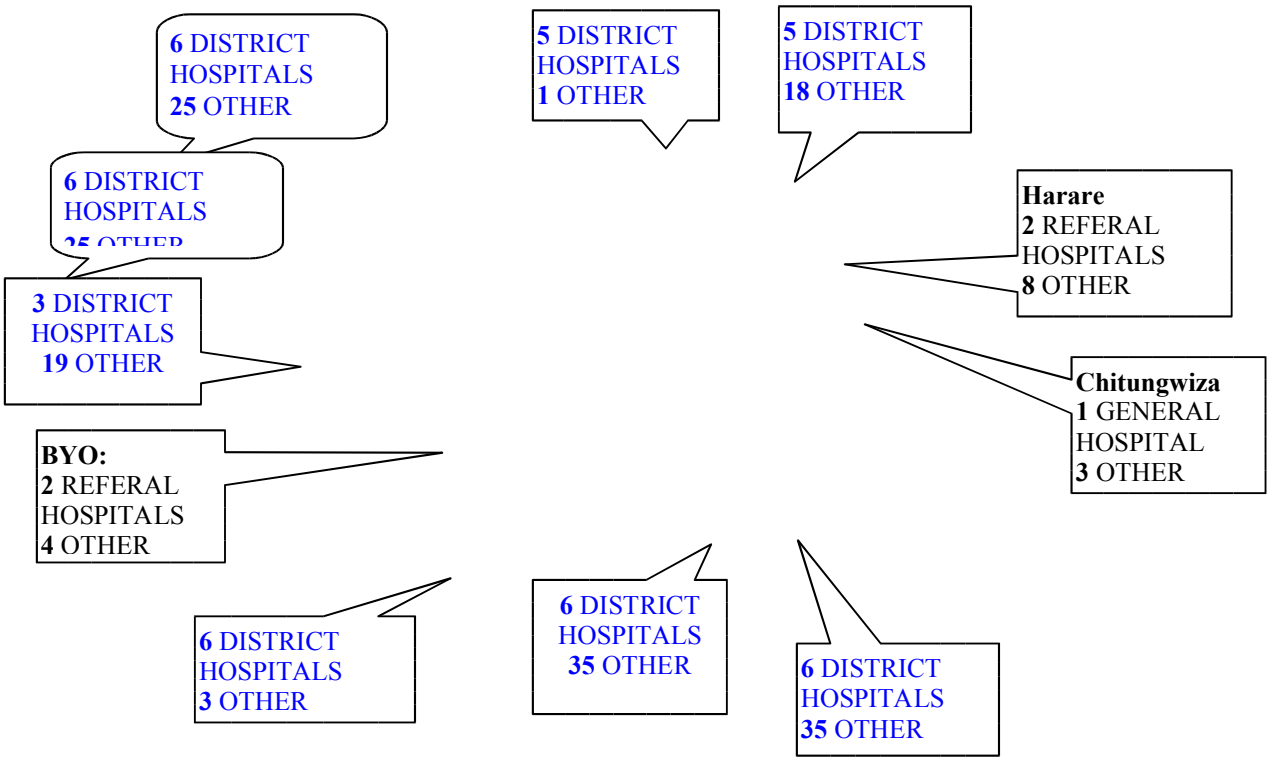
- The main Priority Areas were:
  - Strategic planning
  - Integration of services
  - Address counseling and testing capacity
  - Address follow up and support
  - All partners to buy into MOHCW plan

Programme Achievements

- Strategic frame work for expansion in place
- Commitment from MOHCW very high
- Commitment from district and provincial implementers also high
- Commitment from local and international partners assured
- Regular partnership forum meetings for networking and collaboration being held
- Access to nevirapine donation consistent
- Access to test kit donation

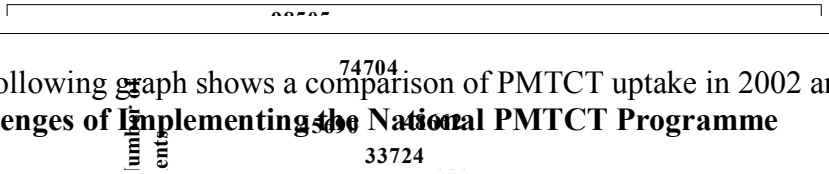
Geographic Expansion: Registered PMTCT sites by the end of 2003

- 43 out of a total of 58 district hospitals (74%) currently carrying out PMTCT and
- 205 Health Institutions out of a total of 1300 health institutions (16%)
  - **Note:** Several Health Institutions not registered as PMTCT sites were referring to the registered district hospital sites for PMTCT services by the end of 2003



PMTCT Registered Sites : Zimbabwe, 2002

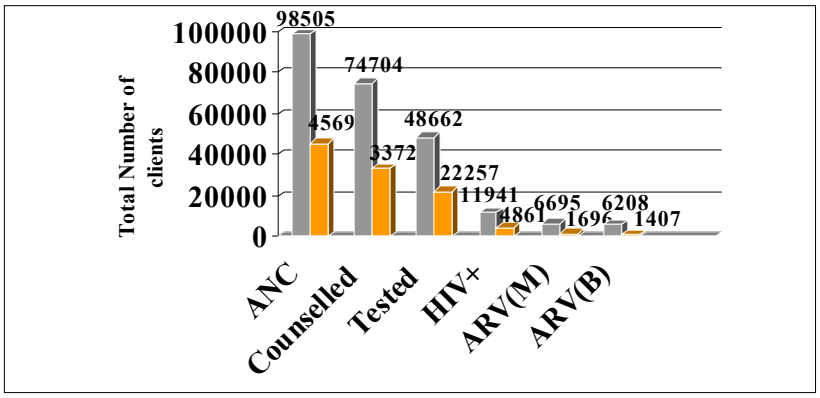
Uptake of PMTCT in 2002 and 2003



The following graph shows a comparison of PMTCT uptake in 2002 and 2003.

Challenges of Implementing the National PMTCT Programme

Uptake of PMTCT in 2002 and 2003



- Limited community and male partner support (4% of male partners were counseled in 2003)
- Limited human capacity (high staff attrition)
- Limited access to Counseling and on site testing

- Centralized commodities and logistics

- Limited Infant feeding alternatives (most women therefore opt for exclusive breast feeding
- Evaluating program impact (limited testing of identified exposed babies)
- Follow up of mothers and babies not yet well established.

Way forward

- Address identified challenges and gaps
- Improve programme uptake
- Evaluate Programme impact
- Provide comprehensive follow up and care to mothers and their babies (including ARV drugs for treatment)
- Criteria for Selecting Primary Health Facilities to offer "Comprehensive Package"

3.2.1.4 "**HIV Prevention Among Youth**" by Trevor Matambudziko

Trevor, a young person who was orphaned early by HIV and AIDS, started his presentation with the following quotation from **UNAIDS (2000):**
"The youth of Africa are at the frontline: -They are the most vulnerable to HIV and AIDS, not just in terms of infection but in taking the brunt of the epidemic"

Mr T Matambudziko

The following is an outline of his presentation:

HIV in Youth in Zimbabwe:

- HIV infection in women aged 15-29 is 22% in women whereas it is 11% in males
- HIV is highest in women because they have:
    - less education;
    - lower socio-economic status

Impact of HIV and AIDS on Youth

- Youth are affected and infected with HIV
- Infected – through:
    - Childbirth, forced sex and abuse

- Affected – because of:
    - Sick and ailing parents/guardians
    - Death - leading to Orphans
    - Having to assume care roles
    - Increasing poverty & need to engage in productive labour at an early age
    - Stigma and discrimination
    - The risk of exploitation

HIV prevention in Youth:

- were slow to start
- programmes were adult/expert driven
- Had limited opportunities for youth participation
- Programmes were targeted at the "person" as the agent of change – not the wider community
    - BUT
    - **Youth are considered the window of opportunity**

Interventions for youth in Zimbabwe

Several types of interventions targeted at youths exist, such as:

- National programs
    - Mass media
    - National youth friendly policies
- **Church/Faith-based**
    - Life Skills training
    - HBC, care of OVC
    - Youth clubs, youth counseling
- **In-School**
    - Min of Education Life skills training
    - Anti-AIDS clubs
    - Print media
- **Workplace**
    - Theatre groups led by youth
    - Peer education groups
- **In the wider community:**
    - Youth friendly services
    - Youth corners for reproductive health services
- **Community based**
    - Resource/Recreational activities
    - Income generating projects
    - Peer education
    - Sensitization/awareness sessions
    - Youth counseling

An example of a Youth Friendly Project : Youth Station Day at Tsungirirai:

- A monthly one-on-one counseling session by different youth on a range of topics

- Engages youth in a dialogue on their problems and possible solutions
- Provides a forum for ongoing peer support
- Referrals to social welfare and other organizations

Youth Station Day at Tsungirirai – Outcomes

- Complements existing prevention initiatives – HBC & OVC
- Empowers youth through genuine participation
- Helps to identify gaps in overall program
- Creates linkages to the wider community
- Goes beyond providing information
- Youth programmes most likely to succeed
- Are community based with youth represented at every level

- Go beyond facts and messages and help youth to assess their situations and find possible solutions

- Assist youth to develop skills they need to avoid/cope with HIV infection

Way Forward!

- Acknowledge the Youth!
- Adults should be good role models!
- Respect the <u>needs</u> of the child for care & support
- Respect the <u>rights</u> of the child
- Raise the <u>voice</u> of the girl child
- Engage in making policies to assist youth
- And please help us!-<u>To:</u>
    - Shift the focus from adult led to youth led interventions
    - Go beyond the individual as the target of interventions and address social and policy issues; Provide linkages and access to prevention, treatment, care and support services

Thank you

3.2.2 Abstract Presentations

3.2.2.1 Comparative evaluation of ultrasensitive p24 antigen assay and CD4/CD8 ratio, versus DNA PCR for diagnosis of HIV-1 infection in infants under the age of 2 years, in Harare, Zimbabwe.

<u>Lynn S. Zijenah</u>[1*], DA Katzenstein[2], KJ Nathoo[3], S Rusakaniko[5], O Tobaiwa[1], C Gwanzura[4], A Bikoue[6,7], M Nhembe[3], P Matibe[3], G Janossy[6].

Dr L Zijenah

University of Zimbabwe College of Health Sciences Departments of Immunology[1], Paediatrics[3], Community Medicine[4], Haematology[5], Harare, Zimbabwe, Division of Infectious Diseases and AIDS Research, Stanford University, Stanford, California, USA[2], HIV Immunology, Department of Immunology and Molecular Pathology, Royal Free and University College Medical School, London, UK[6], MFN International, Asmara, Eritrea[7] .
***Presenting author**

Background:

The gold standard for diagnosis of HIV-1 infection in infants aged <2 years is DNA or RNA polymerase chain reaction (PCR). However, these tests are expensive and require considerable infrastructure, training and continuing quality assurance that is limited in resource-constrained settings. There is an urgent need to develop cheaper and simpler laboratory methods for diagnosis of HIV-1 infection among infants who may benefit from early co-trimoxazole prophylaxis and highly active antiretroviral therapy (HAART). We evaluated two alternative diagnostic methods, the CD4/CD8 ratio, and the ultrasensitive p24 antigen assay using DNA PCR as the reference standard.

METHODS:

Whole blood was collected in EDTA from 156 infants aged between 0 and 18 months who were enrolled in the Pediatric AIDS definition study and short course AZT project for prevention of MTCT.

PCR and ultrasensitive p24 antigen assays were conducted following the manufacturers' instructions.

T lymphocyte subset profiles were determined using a haematological analyzer and a Coulter Epics XL flow cytometer.

Results

85/156 were PCR positive and 71/156 were PCR negative. T lymphocyte counts were enumerated for 136/156 infants; 76 were PCR positive while 60 were PCR negative. Mean CD4 counts for PCR negative were higher than for PCR positive infants, $p < 0.001$. Inversely, mean CD8 counts were higher for PCR positive than for PCR negative infants, $p< 0.001$. Mean CD4/CD8 ratio and %CD4 of PCR positive were lower than for PCR negative infants $p< 0.001$ and $p = 0.02$ respectively.

75/76 PCR positive infants had CD4/CD8 ratio <1 and 59/60 PCR negative infants had CD4/CD8 ratio ≥1. Specificity and sensitivity of the CD4/CD8 ratio were 98.3% and 98.7% with PPV and NPV of 96.3% and 99.4% respectively and a test efficiency of 98.5%.

80/82 PCR positive infants were p24 antigen positive. 69/74 PCR negative infants were p24 antigen negative. Overall specificity and sensitivity of p24 antigen assay were 93.2% and 97.6% with PPV and NPV of 86.5% and 98.9% respectively, and a test efficiency of 95.5%.

When p24 antigen and CD4/CD8 ratio results were compared, all evaluated parameters were similar with no statistically significant differences, except for the PPV of the p24 antigen assay that was lower than that of CD4/CD8 ratio, *p=0.029*.

Conclusion

Both tests showed high sensitivity and specificity for infant HIV diagnosis infection with only minor differences. Both tests are cheaper than DNA PCR and can accurately identify infected infants who may benefit from cotrimoxazole prophylaxis and/or HAART.

3.2.2.2 Early introduction of non-human milk and solid foods increases the risks of postnatal HIV-1 transmission and reduces HIV-free survival

Peter Iliff, Ellen Piwoz, Naume Tavengwa, Clare Zunguza, Edmore Marinda, Kusum Nathoo, Lawrence H. Moulton, Brian Ward, ZVITAMBO Study Group, and Jean Humphrey. ZVITAMBO Project; University of Zimbabwe College of Health Sciences; Johns Hopkins Bloomberg School of Public Health; The Research Institute of the McGill University Health Center; The Harare City Health Department: The SARA Project, Academy for Educational Development.

Background

In the context of a trial of post-partum vitamin A supplementation we obtained prospective information on feeding practice and infant outcomes (infection with HIV, and infection or death).

Methods

14,110 mother-newborn pairs were followed from delivery for up to 2 years. Mothers were tested for HIV infection using ELISA and Western Blot tests. Babies were tested by DNA PCR or antibody detection depending on age. Detailed information was obtained on infant feeding practices during the first 3 months of life. All infants were breastfed. Practices were classified into Exclusive (EBF: only breastmilk), Predominant (PBF: breastmilk+non-milk liquids), and Mixed (MBF: breastmilk+solids and/or non-human milk) breastfeeding groups.

Results

2060 babies of the 4,496 HIV+ mothers were alive and PCR negative at 6 weeks, and provided complete feeding information to 3 months. Overall PNT (defined by a positive HIV test following the 6 week negative test) was 12.1%, 68.2% of which occurred after 6 months. Compared with EBF, early MBF was associated with a 2.02 (95% CI: 1.07-3.82) greater risk of PNT or death, and PBF with a 1.40 (95% CI: 0.71-2.78) trend towards greater risk.

Conclusions

Delayed introduction of solid foods and non-human milks may substantially reduce breastfeeding-associated transmission of HIV.

3.2.2.3 PPTCT Pilot Study: Single Dose Nevirapine Use, Feeding Practices And Clinical Manifestations In Infants.

- Felix Tarwireyi, Kapnek Charitable Trust

Mr F Tarwirei

Background

Transmission of HIV from mother to child has been observed to be the second most common route after sexual transmission. In Zimbabwe HIV prevalence among women attending antenatal clinic was 29.5% in 2001. The Mother-to Child transmission rate has been observed to be 20-25% during pregnancy and delivery and 15% during breastfeeding. To date there are very few publications in Zimbabwe on nevirapine adverse effects and clinical presentations of HIV and AIDS in babies exposed to single dose of nevirapine. This paper describes the findings on nevirapine adverse effects, clinical manifestations and infant feeding practices in babies who received a single dose of nevirapine. The objective of the study was to determine the adverse effects, infant feeding practices and clinical manifestations in babies exposed to a single dose nevirapine.

Methods.

A descriptive study within a prospective project aimed at reducing Mother- To- Child Transmission of HIV was conducted at Epworth clinic (a peri-urban primary health care center), in Seke district, Mashonaland East province, Zimbabwe. Two hundred and forty two babies exposed to a single dose of nevirapine who were aged between one day and nine months were studied from January 2002 to January 2003.

Results:

All the 242 studied had received a single oral dose of nevirapine at birth. None of the babies showed signs and symptoms of nevirapine adverse effects. 73.3% of the babies were mixed fed by the time they reached six months. The commonly occurring clinical manifestations were, upper respiratory tract infections and skin rashes within the first three months of life, upper respiratory tract infections and failure to thrive between three and five months and upper respiratory tract infections and diarrhoea in babies between five and nine months.

Conclusion:

Nevirapine seemed to be a well-tolerated drug in the studied babies. The commonly presenting clinical manifestations were upper respiratory tract infections, skin rashes, failure to thrive and diarrhoea. If the administration of nevirapine should yield positive results, a strong program on safe infant feeding practices must support it.

3.2.2.4 Post Exposure Prophylaxis (PEP) Programme

C Alfredo, S Hader, EGV Sithole, VTS Chitimbire

Issues addressed:

The risk of HIV transmission in occupational settings through needle stick, mucous membrane or skin exposure ranges between 0.01 to 0.3% per episode. One of the interventions to prevent occupational transmission of HIV in health settings is provision of antiretroviral drugs in the event of accidental exposure.

Programme Description:

The Zimbabwe Association of Church Hospitals (ZACH) with support from the US Centres for Disease Control (CDC) in Zimbabwe established a programme to improve HIV-related health services in a core group of ten mission hospitals. An assessment of the hospitals in February 2003 showed that the annual rate of needle stick injuries reported per hospital ranged from two to five. Senior staff from each hospital was trained in PEP prior to the issue in September 2003, of five person months per hospital of anti-retroviral drugs for PEP. Tools for follow up and assessment of each reported case were provided by the programme.

During the first 6 months of program initiation, 12 staff from all the ten hospitals had accessed the drugs provided, representing a 24% uptake of PEP at all hospitals. Uptake varied between hospitals and ranged from 0 to 4. Four out of ten hospitals had no reported cases of needle stick or other exposure to HIV during the same period.

Lessons learnt:

1. Training and issuing of drugs are important components but not enough in starting an effective PEP programme.
2. Intensive and ongoing information and education may be needed to encourage health care workers to report needle-sticks and participate in PEP programs
3. Expiration of PEP drugs is an expected outcome of starting up such programmes that have variable uptake and rely on self report of injury

Recommendations

1. There is need to assess barriers to health care workers reporting needle-sticks and accessing PEP programs.
2. Information, education and communication materials such as posters and pamphlets may be useful constant reminders to staff to access PEP programs.
3. A focal person must be available to be responsible for PEP program record keeping, follow up and ensuring confidentiality.
4. Stock management of PEP drugs needs to take into consideration that uptake may be variable and should develop mechanisms that enable re-distribution of drugs to sites with higher uptake where possible.

5. Management should consider provision of ART for staff testing positive on initial testing.

3.2.2.5 Nurse's Knowledge of universal precautions and perception of personal risk of infection-Occupational/Health Care Worker Exposure

Mrs Sibabili Chadenga, Teaching Assistant, Department of Nursing Science, Co- Author-Dr Rose J. Ndlovu

Ms S Chadenga

Introduction and Background

Nurses constitute the largest group of health care providers within the various levels of health care delivery. Their knowledge concerning HIV and AIDS disease, prevention and proper management of those infected is key to ensuring high quality care. Universal precautions in clinical settings has been adopted as a policy governing all clinical practices. Assumptions have been made that the basic principles governing the concept of universal precautions is understood by all.

Methods

One hundred and fifty four nurses conveniently selected responded to a self administered questionnaire covering several questions related to HIV and AIDS disease and prevention. Two of the six sections of the questionnaire were designed to elicit information on the nurses' knowledge of universe precautions and their perception of risk to being infected with HIV and AIDS or other associated illnesses such as Tuberculosis. All the nurses participating in the study were providing direct care to in-patients or patients attending out patient or clinic services. Ninety three percent were Registered nurses while 7% were State Certified Nurses, Twenty three percent had experience of 1-5 years while 77 has experience of over 5 years to over 10 years.

Results

When asked to give three reasons for adopting universal precautions only 21% were able to give the three reasons, 15% gave two reasons , 14% could only give one reason while 50% were not able to give even one correct reason.

Asked to indicate perceived risk for self and cross infection among patients, sixty six percent of the respondents believed that their risk of being infected was high and 51% believed that the risk of cross infection among patients was high.

Conclusion
It was noted that the nurses' knowledge of universal precautions was low which may explain why the majority – 51% and 66% perceive that the risk of cross infection among patients is high and that their risk of being infected by patients is also high respectively.

High levels of fear of being infected are likely to compromise the quality of care provided for patients with whom the nurse needs to be in close contact. The findings suggest an urgent need to re-enforce knowledge and practice of universal precautions for all health care providers.

3.2.2.6 **Behaviour Change Communication**
Youth Peer Education and Practice; Jesuit AIDS Project.

" Knowledge is not enough". Properly designed and implemented peer education programmes can change behaviour (UNAIDS Report, 2002)

Issues to be addressed.
The National HIV and AIDS Strategic Framework of Zimbabwe, 1999, estimated that youth aged 15 to 24 years accounted for 60% of all infections and that girls 15-19 years of age are 5 times more likely to be infected than boys of the same age group. This is mainly due to the physiological structure of young female and also to the targeting of girls by "sugar daddies".

Youth need more accurate information about HIV and AIDS
Youth today lack adequate role models of positive sexual behavior
Lack of community support discourages youth initiative.
Socio-economic problems make youth more vulnerable towards infection.
Youth norms and culture, also influenced by Western media, are lax towards sexual involvement.

Programme description.
The programme has run for six years and Anti-AIDS clubs have been set up in 25 government and non-government schools, 4 orphanages and 8 communities/parishes. The clubs are run by the youth themselves with the assistance of trained Peer Educators whom we train at our campsite at Lake Chivero. Training consists of a day of updated knowledge and group work , a day of self awareness, another of life skills and behaviour, the fourth of social, gender, cultural and moral issues affecting HIV and AIDS and the last of organisational skills and planning.

These Peer Educators become role models and influential members of their clubs but they are not left in isolation. An essential part of the programme is the weekly follow-up of the local clubs by 5 staff and 12 trained Youth Project Facilitators, who are youth themselves, as resource people. More distant clubs are followed up once a term.

Lessons learned.

Youth built up their own set of positive norms and outreach in the community.
The majority makes a commitment to abstain from sex until marriage and then to remain faithful to their spouse,
They are influenced by gender considerations and show more respect to each other. Mixed gender clubs are necessary (there is a small majority of females).

Intensive and regular follow-up is essential.

Recommendations

More clubs should be established.
It should be accepted that intensive input is required, rather than extensive.
A district affiliation of clubs be established, and later, a national one. But stress should always be on the clubs themselves, not structures..
Training of more personnel for Peer education is required.

3.2.2.7 Safer Sex For Pregnant Women In Zimbabwe: A Continual Challenge

Mavis Kahwemba, Jennifer Wells, Francis Jaji, 046 Team

Introduction

In Zimbabwe, pregnant women's sexual and reproductive health matters are the concern of their partners, families, the community and friends. Their influence, while meant to be supportive in nature, often serves as an obstacle to remaining HIV-negative.

Method

200 pregnant women presenting for antenatal services at primary health care level were offered VCT in Chitungwiza, Zimbabwe. During the counseling sessions, women were asked questions about STIs, their own sexual behavior, their partners' sexual behavior and discussions about HIV and AIDS.

Results

- 84% of women knew and were worried that their partners had other sexual partners
- 54% of women had had a sexually transmitted infection within the last twelve months
- 73% of the women reported having been forced to have sex by their partners
- 69% of these women had sex with their partners even when they had sexually transmitted infections. The reasons were fear of abuse, which could be physical, psychological or economic.
- Only 20% discussed issues of HIV and AIDS between themselves.
- Reasons for staying with abusive or high-risk partners included fear of violence, partners' desertion or eviction from the marital home, women's limited ability to refuse sex or negotiate for safe sex and cultural and religious taboos on the discussion of sexual matters between husband and wife.

Conclusion

Male partners and other family members must be included in the antenatal VCT process to facilitate communication about sexual issues. Individual counseling sessions with women must include tactics for the negotiation of safe sex. Failure to do so will render pregnant women and their unborn babies vulnerable to HIV infection, and because of the partner's control within a relationship those already infected may face obstacles to adherence to PMTCT regimens.

3.2.2.8 HIV, AIDS and LIFE SKILLS PROGRAMME

Ministry of Education, Sport and Culture

Issues Addressed
Prevention:

- HIV,AIDS, and life skills education for in-school youths
- AIDS at the workplace for teachers and Ministry support staff
- Peer education training
- Materials development
- Support for orphaned and vulnerable school children

Program Description
The programme began in 1992 with funding from the Royal Netherlands Embassy through UNICEF in response to the rapid spread of HIV and AIDS in Zimbabwe. The HIV,AIDS and Life Skills curriculum, developed and administered by the Ministry, is taught from grade four to form 6 as a compulsory subject in all schools. HIV, AIDS and Life Skills education is also integrated into other subjects and activities including guidance and counseling lessons, sports and cultural activities. Training for teachers in the teaching of HIV, AIDS and Life Skills education is carried out in teachers colleges and through in-service programs through a standardized curriculum. Participatory methods of teaching and learning such as songs, poetry, drama, and quizzes are used in the process. To address the needs of orphaned and vulnerable children, the Basic Education Assistance Module (BEAM) has been designed, which provides financial and material assistance according to need.

Lessons Learned

- HIV, AIDS and Life Skills education is not yet an examinable subject and as result, it is not taken seriously in most schools.
- Awareness has not always translated into positive behaviour change because of socioeconomic constraints in families
- Bio-medical research/education programmes re:HIV, AIDS in the schools are not recommended because they benefit the researcher more than the students
- There is an inadequate supply of books and teaching materials in the schools to support the program

Recommendations

- A comprehensive monitoring and evaluation plan should be implemented
- Socio-economic situations of students must be addressed for a successful outcome of the HIV, AIDS and Life Skills Programme.
- Need to increase the production and provision of teaching materials on HIV and AIDS\

3.2.2.9 Scientific impact and process evaluation of integrated behavioural and biomedical interventions in rural Zimbabwe

Simon Gregson, Constance Nyamukapa, Geoff Garnett, Saina Adamson, Spiwe Papaya, Peter Mason, Stephen Chandiwana, Roy Anderson

Background: Scientific trial to evaluate integrated behavioural (bar- and workplace-based peer education and condom distribution) and biomedical (symptomatic STI treatment) interventions in high HIV-prevalence but relatively low STI prevalence rural communities in Zimbabwe.
Methods: Randomised controlled community trial in a cohort of 9,843 adults recruited in 6 matched pairs of sub-communities in Manicaland province followed over 3 years. Statistical analyses of data on impact, outcome and process indicators.
Results: No evidence was found for a reduction in HIV incidence in the intervention communities (2.04 – 124 cases in 6075.4 person years of observation) as compared to the control communities (1.56 – 94 cases in 6043.9 person years of observation) – incidence rate ratio adjusted for age and sex, 1.23 (95% CI 0.94-1.61). Respondents in the intervention communities were more likely to have attended local peer education and clinic-based HIV and AIDS meetings (RR, 1.85; [95% CI 1.68-2.05]) and had better knowledge about HIV and AIDS (OR for index score above median, 1.16; [95% CI 1.04-1.30]) and higher personal risk perception (OR, 1.16 [95% CI 1.03-1.31]). More of the STI patients in the intervention communities had received counseling (RR, 1.17; [95% CI 1.00-1.37]) and condoms (RR, 1.28; [95% CI 0.99-1.66]) and more reported cessation of symptoms following treatment (adjusted OR, 1.39; [95% CI 0.95-2.03]). There was no evidence for faster adoption of sexual or healthcare seeking behaviours believed to be protective against HIV infection in the intervention communities than the control communities.
Conclusion: The intervention strategy was implemented in a population with low prevalence of curable STIs during a period of rapid behaviour change and stabilising HIV prevalence. In this context, the coverage and intensity of the intervention activities were insufficient to accelerate behaviour change or reduce HIV incidence.

3.2.2.10 STI/HIV and AIDS Control, Prevention And Care Program

NATIONAL RAILWAWAYS OF ZIMBABWE

Issues Addressed

- STI/HIV and AIDS, family planning, PPTCT education in a highly mobile population
- HIV and AIDS counseling
- Behavior change issues
- Home-based care for HIV positive employees and families
- Stigma and discrimination issues
- Loss of production due to absenteeism

Program Description

The NRZ has 9,300 employees, primarily men who together with their families form a population of 39,000. The STI/HIV and AIDS national program was formed internally to support government efforts in 1992, and has been fully functional since 1994. Additional funding has been provided by AIDSCAP and SIDA. The program provides access to HIV and AIDS information, counseling services, free condoms, home based care, and referrals to community services. The program is headed by an AIDS Program

Coordinator, two full time staff, and twenty-six site coordinators. Four hundred volunteers selected by fellow workers have been trained as peer educators.

Lessons Learned

- Internally funded and coordinated programs are effective as they involve the commitment of everyone, including management
- Outside funding is important to support internally conceived programs
- Peer education and counseling is a powerful media as it is always available
- A holistic approach which involves the entire family is more effective than focusing solely on the employee
- Behavior change must take into account cultural, gender and religious issues in addition to knowledge of HIV and AIDS

Recommendations

- Women should be empowered in order to make informed decisions
- Further training for peer educators in counseling, gender and issues, advocacy, and behavior change strategies is important
- Peer Educators need incentives (meals, travel allowances, tee shirts, etc.) to support self esteem
- Adequate teaching resources are important to support Peer Educators
- Support of management for HIV and AIDS intervention programs must be ongoing and consistent
- Behavioral research should be ongoing to monitor the impact of the program

3.2.3 Recommendations from breakout sessions

3.3.1 PMTCT Recommendations

Short-term recommendations:

- Infant feeding and HIV guidelines should be revised, taking into account all research and practical considerations
- Accelerate training for all Family and Child Health service providers in six-day training course in infant feeding counseling (utilizing infant feeding and HIV guidelines)
- Expand training and role of Primary Care Counselors (PCC) to include infant feeding and HIV, and general nutrition issues (minimum six days training)
- Develop an IEC strategy and best practice on involving men in Family and Child Health care at all levels, including in health institutions
- Consider introducing a revised child health card (including PMTCT "alert" in the at risk box, and integrated follow up care of HIV exposed infants) – to be accompanied by training for health workers and assessment of impact
- Ensure Traditional Midwives and Ambuyas are trained/sensitised in PMTCT issues
- Develop/revise training materials to ensure integration with all FCH programmes, in particular family planning

- Urgently develop system for tracking and follow up of PMTCT mothers and infants
- MOH/CW to contact Boheringer-Ingelheim for national donation of pre-packaged single dose NVP for infant

Longer term recommendations

- Advocate for expansion of cadres allowed to perform HIV rapid testing, e.g. PCC, microscopists, laboratory assistants
- Form a working group to develop protocols for early infant diagnosis of HIV infection
- Address issue of maternal resistance to single dose nevaripine regimen;
- Ultimately advocacy and resource mobilization for ART for those pregnant women, mothers, partners and children requiring treatment using PMTCT as an 'entry point' (family centred care/"MTCT Plus")

3.3.2 Youth Programmes Recommendations

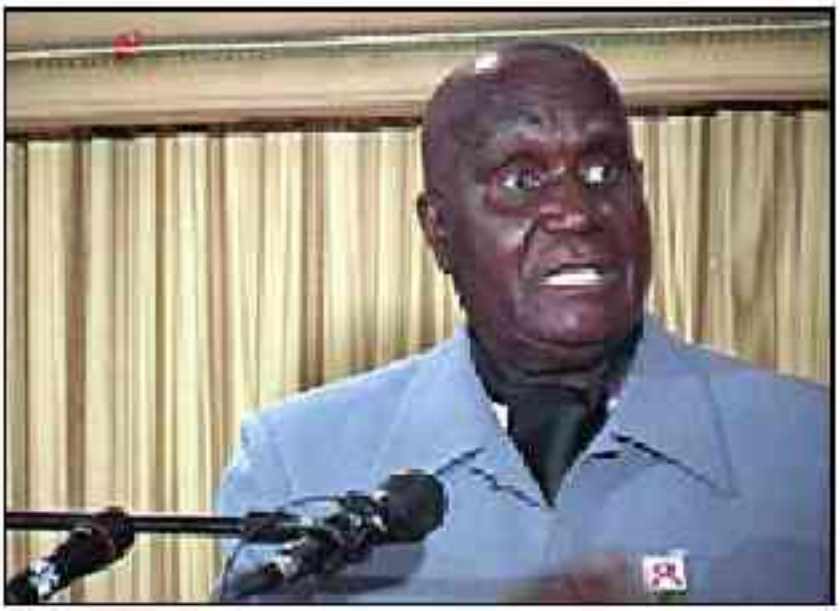
- There is need for baseline information on youths (suggested to expand the Young Adult Survey)
- There is need for the scaling up and out of the stand alone Youth Friendly Centres (NB: not Corners). The centres should have sporting activities and income generating projects. The content of IEC materials should have the input of young people.
- The next AIDS conference should have a Young People Conference / Activities around HIV and AIDS running parallel to the main conference.
- There is need to disseminate information on the National Youth Policy – how it is being implemented. The Ministry of Youth, Gender and Employment Creation needs to take the lead role in this activity. Tied to this is the need to understand the role of the National Youth Council.
- There is need to sensitise all traditional authorities, including the parents, to ensure that all children are encouraged to take part in programmes which are for young people.
- There is need to use existing structures such as the Junior Councils and Parliament to mobilize and provide the lead for youth programming.
- There is need for funding security for the youth programmes.

3.3.3 Workplace Programmes Recommendations

- Because Statutory Instrument 202/98 has a number of gaps, which include, gender gaps, there is need therefore for its complete revision. Such revision should be done with the involvement of all stakeholders i.e. business, government, NGOs.
- Couples should not be separated because of work demands.
- There is need for every company to have an HIV/ AIDS policy. To this end, there should be in place guiding principles as to the minimum expected from a workplace programme.

- Companies should show their commitment to workplace programmes by adequately budgeting for them. In addition there is need for innovation in fundraising. In this regard the suggestion was made that since so much money is being repatriated by Zimbabweans abroad, if a percentage of that money was diverted towards HIV then it would boost the resources available to initiate HIV programmes.
- There is need for companies to put in place for their employees who have reached retirement age or who have had to go on retirement owing to ill health, better post retirement care/ social safety nets. This is because employees, who have been contributing to the national AIDS levy and medical aid, sometimes find themselves destitute after they leave work.
- There is need to come up with effective strategies to involve the informal sector in HIV and AIDS workplace programmes because the informal sector is increasingly becoming a major employer in Zimbabwe. In this regard, suggestion was made to make the existence of HIV workplace programmes as a pre condition for engaging in business with a particular business in the informal sector.
- There is need for social security for the informal sector, i.e. medical insurance etc. In this regard the suggestion was made that Tanzania has comprehensive social security programmes in place for the informal sector and lessons should be drawn from the Tanzania experience.
- There is need generally for interventions to look at the underlying causes fuelling the epidemic and try to address those underlying causes. Poverty and underdevelopment fuel the epidemic and any interventions should also address these issues.
- Because interventions by the private sector and industry in the workplace are fragmented, there is need for greater coordination of effort and interventions by industry. The Zimbabwe Business Council on HIV and AIDS, could play a central role in coordinating industry's efforts.
- There is need for incentives for companies with HIV and AIDS Workplace programmes. This can be in the form of tax breaks to encourage companies to expend more resources on workplace programmes.
- For those companies that have workplace programmes, there is need for them to have nutrition being integral to their programmes, not just for their employees, but also for the dependants of these employees.
- There is need for any workplace programme, e.g. training, to include spouses and partners of employees.

CHAPTER 4
MITIGATION
DAY 3



4.1 Summary of day's proceedings

Day 3 focused on the Mitigation aspects of HIV and AIDS. Dr Kenneth Kaunda, the first president of the Republic of Zambia also gave a keynote address on that day, which was followed by an overview of the situation of HIV and AIDS in Zimbabwe by Dr Owen Mugurungi.

In his keynote address Dr Kaunda praised the country for the introduction of the "AIDS Levy", the first of its kind in the world. He noted that AIDS does not discriminate, transcending all boundaries such as politics, religion and ethnicity. "If you don't fight AIDS, your little room for politics and religion will go and you will be six feet down.", he said. He urged all races to continue to fight the scourge of AIDS together as they had done with the slave trade, colonialism and apartheid. He also narrated how he and his wife, Betty, were among the first people to openly talk about HIV and AIDS when they lost their 30-year-old son to AIDS in December 1986 and urged more open talk on the subject so as to fight stigma and discrimination. Testing was also important, he said while revealing that he, himself, had undergone testing and that even if he had tested positive, he would have disclosed his status and his zeal for the HIV and AIDS fight would not have been dampened. Poverty elimination and good nutrition were the most important factors in the fight against this condition, he stressed, especially given the expensive nature of anti retroviral therapy. He finished his address as he had started it, in song: "We shall fight and conquer AIDS…forward ever, backwards never. In the name of Great

Africa, we shall fight and conquer AIDS." **(See section 4.2.1.1 below for the full transcript of Dr Kaunda's keynote address)**

In his "*Overview of Zimbabwe's HIV and AIDS Response*", Dr Mugurungi traced the response in Zimbabwe from the time the first case was detected in 1985 to the present time. He gave some of the highlights of the response, the achievements and challenges and what he viewed as the critical issues for the current response. For example, he observed that from monitoring trends, the rise in the prevalence of HIV positivity in adults (14 to 49 years) seems to have reached a plateau indicating that the prevention efforts were now starting to bear fruit. He also noted that there were still critical issues to be addressed such as addressing the socio-cultural and gender issues that facilitate further transmission of HIV; encouraging openness, fighting stigma and discrimination associated with AIDS; and reducing poverty. **(See 4.2.1.2 below for Dr Mugurungi's full presentation)**

Bishop Trevor Manhanga presented on "*Faith-based response to HIV and AIDS fight***"** and declared that his church was not against the provision of condoms to the vulnerable in his congregation, as part of the response to the HIV and AIDS epidemic. Although it was his policy to distribute condoms, he said he did not do so "willy-nilly", but to those women made insecure by the "small house" syndrome and others who were HIV positive in a marriage situation. He added that there must be open teaching and discussion of sexual matters in the church. "We must attack the conspiracy of silence, the problem of denial, with all the weapons at our disposal", he said. While faith-based organizations might differ on some of their doctrines, they could still collectively preach on matters of sexual purity for the married and unmarried and attack the frequent perception that men could have multiple sexual partners. He said that his church had an active HIV and AIDS policy, including the mandate that no one could marry without first being tested for the disease. Additionally, no pastor could take office without providing proof of having been tested.

Mrs N Dhlembeu presented Zimbabwe's "National Plan of Action (NPA) on Orphans and Vulnerable Children (OVC)". She said that after a year in formulation, the OVC plan was almost final and waiting Government approval. The NPA for OVC was initiated as part of the nation's commitment to the UNGASS Declaration of Commitment on HIV and AIDS and builds on a national orphan policy that had been in existence since 1999. Its goal is to develop a national institutional capacity to identify all orphans and other vulnerable children by 2005 and to have reached out with service provision to at least 25% of orphans and other vulnerable children. **(See 4.2.1.4 below for Mrs Dlembeu's full presentation).**

Titus Moetsabi presented on "*HIV and AIDS: A Global Problem and Workplace Strategies in Zimbabwe*" and noted that workplaces can make a huge difference in preventing and treating HIV and AIDS; the financial impact of HIV and AIDS in the workplace makes workplace policy and programs necessary and cost-effective; the best approach is to working across sectors; there is need for dedicated resources and involvement of People Living with HIV and AIDS in development and implementation. He gave statistics which show that the size of the labor force in high-prevalence countries

will be 10-30% smaller by 2020 due to HIV and AIDS and that in one country in Southern Africa, 62% of manager deaths are from AIDS-related illnesses. In one company 6% profits lost were due to HIV and AIDS related costs. In some southern African countries, 70% of households have suffered labor losses because of AIDS-related sickness resulting in fewer people and with less income. He said that a workplace HIV and AIDS policy should be formulated around the principles of: non-discrimination; equality; confidentiality; medical accuracy,. While there were models of success in Zimbabwe including, Standard Chartered Bank; Hippo Valley Estates; Cottco; Dairiboard; Unilever and Dyno Nobbel, they were still surprisingly few. **(See 4.2.1.5 below for Mr Moetsabi's full presentation)**

In her presentation on "*Gender Issues & HIV and AIDS- WASN's Experiences In Rural Settings*", Dr Manangazira noted that in Zimbabwe women and girls bear the biggest brunt of HIV and AIDS as affected or infected. In a baseline study carried out in the Chikwaka area of Goromonzi District in Mashonaland Province it was found out that girls and women were unable to manage relationships or negotiate for safe sex; they were subject to physical and sexual violence; there were high rates of STIs and teenage pregnancies; and that women could not communicate with children on HIV and AIDS. Based on the study findings a communication strategy from the qualitative and quantitative findings has been developed; social mobilization has started as well as discussion and community dialogue and institutional training. **(See 4.2.1.5 below for Dr Mangazira's full presentation).**

The panel discussion was led by Ms Siphelile Kaseke representing young people, Rev Chitiyo of Uzumba Orphan Trust, Mr. Siapi of Rio Tinto in Kadoma and Ms Cynthia Kureya of WAG. Audience participants were: Ms Clara Dube of UNICEF, Mr. Chinake of the Ministry of Labour and Social Welfare, Mr. Bowora of MOESC, Ms Veronica Ngwerume of Seke Rural HBC, Rev. Trevor Manhanga, Ms Lindi Choga of HOSPAZ and Mr J. Banda of NAC. The panel discussion was facilitated by Mrs Dlembeu.

The oral abstracts presented were on:

- The Station Day Innovation: Data Collection Made Fun by Jennifer Lentfer, The STRIVE Project, Catholic Relief Services/Zimbabwe, and Justin Mucheri, Precious Somerai and Constance Chasi, Tsungirirai
- *Challenges and Incentives for Adults When Considering Taking in Children Orphaned by AIDS* by Nelia Matinhure and C. Chipere, Africare/Zimbabwe
- *The Extent of Orphan hood and Vulnerability of Children in Two Districts of Zimbabwe* by S S Munyati , B Chandiwana, S J Rusakaniko, P Chibatamoto , F Mupambirei, S Mahati, G Chitiyo, J Mutsvangwa, W Mashange
- *Girls speak their minds to protect their futures: A study to explore the sexual health needs of young women affected* by AIDS in urban Zimbabwe by Elizabeth Jasi and Priscah Makwati. Co-authors: Netsai Mudziwapasi, Sostain Moyo, Abel Zimunya, Tomaida Banda, Isolde Birdthistle, Farirai Mutenherwa, Judith Glynn, Simon Gregson
- *Rapid Assessment, Action Planning Process (RAAPP) for Orphans and other Vulnerable Children in sub-Saharan Africa*, In Zimbabwe Pre-

sented on behalf of the Working Party of Officials of the National Plan of Action for OVC

- *A Comparative Study Between Assisted and Non-assisted Orphans* by C.C.Chakanyuka, Tsungirirai Orphan Project, G.Woelk, M.Tshimanga, W.Nyamayaro, D.Jones,
- *Training of Community Based Counselors to Help Communities Cope with Psychosocial Effects of HIV and AIDS* by UNICEF
- *Supporting The Decentralized Response To HIV Prevention And Aids Care*: Partnership Between UNAIDS And National Aids Council
- *Adult mortality & erosion of household viability in towns, estates & villages in eastern Zimbabwe*
- *By Phillis Mushati, Simon Gregson, Makalima Mlilo, Cleopas Zvidzai & Constance Nyamukapa*
- SHAZ! : Shaping the Health of Adolescents in Zimbabwe, A Randomised Control Trial by S Laver, N Padian (P I), C Maternowska (Co I), M Dunbar, L Sibanda (P Ds), I Mahaka (P C)

See Section 4.2.2 for the full abstracts

Issues from Breakout Sessions

The three breakout sessions/group discussions for the day were on the sub-themes of: a) Orphans and Vulnerable Children facilitated by Ms Victoria James and Mr Francis Tembo; b) Economic, Legal, and Institutional support facilitated by Ms Anna Mumba and Mr Tapiwanashe Kujinga; and c) Work Place Mitigation facilitated by Ms Evelyn Serima and Mrs. Mangwende.

The main issues arising from these discussions were:

a) Issues on Orphans and Vulnerable Children

- Delegates noted that the OVC referral system is not clear and is uncoordinated. Various line ministries deal with OVC, for example, Education, Gender, Health and each has different rules for the children that they assist and this causes confusion and lack of coordination.
- It was noted that though presently there is a lot of research being conducted, it is not being coordinated and is not reaching the people that can operationalise it.
- The gap in both research and interventions for children with disabilities was also noted.
- The ethics of conducting research on children was also considered.
- Delegates considered the need to examine whether OVC interventions were empowering those who assist vulnerable groups, as opposed to just giving orphans handouts. The need to strike a balance between the two was stressed.
- Finally the delegates pointed out that while mobile birth registration teams are going round in the villages, this has not worked for some orphans who have lost both parents and have no access to their birth records and remaining relatives have

no idea of the dates of birth of these children. A solution has to be found for this problem.

b) Issues on Economic, Legal, and Institutional support

- Delegates expressed concern at the difficulties faced by people in trying to obtain birth certificates for their children. The problem is even worse for children who are orphans. The delegates urged government to amend the laws so that the process is decentralized. They specifically recommended that nurses be empowered to issue birth certificates so that each child has a birth certificate before they leave hospital. In addition, they recommended that religious leaders and chiefs should also be empowered to issue marriage certificates. The delegates concluded by recommending that strategies should be put in place to assist children who do not presently hold certificates and that they should not be hindered from taking part in public examinations, for example.
- The point was made that the law has to be amended in order that every person who has a vested interest in knowing another person's HIV and AIDS status is advised of that persons HIV and AIDS status. These people would include caregivers as well as marital and non-marital partners.
- The question of compulsory testing generated much debate. Besides the issue of capacity, the delegates were concerned that this move would have ethical implications. It was suggested that a middle ground might be found in the Botswana experience where routine testing is conducted on people visiting health centers. A person is then given the option of knowing the result of the test. It was decided that a legal taskforce on HIV and AIDS should be established which would consider issues of ethics and human rights in any proposed law reform and advise NAC accordingly.
- It was noted that it was proving difficult enforce the law on willful transmission of HIV and AIDS and that perhaps willfully exposing someone to the risk of HIV infection should also be criminalised. In the latter case the offence would be exposing someone, whether or not such exposure actually resulted in infection.
- Delegates noted there is need for government to put in place mechanisms to ensure that there is exemption from import duty on raw materials and other necessary equipment for the production of ARVs. In the same vein, government was also urged to put in place incentives in the form of tax breaks for companies conducting HIV and AIDS programmes in the workplace.
- The need for Government to make post exposure prophylaxis available to victims of rape and other sexual abuse, as a right, was noted. This is due to the high HIV and AIDS prevalence rate in Zimbabwe and the increasing incidence of rape and other forms of sexual abuse. Delegates noted and agreed that persons accused of rape should be compulsorily tested.
- It was observed that government and other stakeholders need to initiate education and awareness raising campaigns around laws that are already in place as well as proposed reform so that people are aware of their rights.

c) Issues on Work Place Mitigation

- It was noted that Statutory Instrument 202/98 needs to be amended. The delegates emphasized the need for involvement of all stakeholders for example i.e. business, government and NGOs.
- Delegates expressed concern at problems of employees who having served a company for years and after contributing to medical and sometimes find themselves destitute after they leave work. The need for post retirement care and social safety nets are therefore stressed.
- The informal sector was singled out as needing particular attention in HIV and AIDS prevention work, especially in view of the fact that the informal sector is increasingly becoming a major employer in Zimbabwe. Among suggestions made was to learn from the Tanzania experience where a comprehensive social security programmes in place for the informal sector.
- Delegates also stressed the need for incentives, such as tax breaks, for companies operating workplace HIV and AIDS programmes as well as coordination of the effort of industry in this regard. It was noted that the Zimbabwe Business Council on HIV and AIDS could play a central role in coordinating industry's effort.

4.2 Presentations of the day

4.2.1 Invited Speakers

4.2.1.1 Full Transcript of Dr Kaunda's Keynote Address

Dr. Kenneth Kaunda started with a song "Step by step".

Dr Kaunda, President Mugabe and Dr Parirenyatwa

"Comrade Chairperson, Comrade Mugabe and all of you have disturbed me so much I have thrown up my speech because I do not know that I was coming to the rebirth of

Zimbabwe. I came like I have gone too many parts of Africa. But I have come to here to witness once again the rebirth of Zimbabwe how wonderful it is for me. It must be the same for you that after so many years of struggle, hatred curses. Insults across the board now we can see the real situation in Zimbabwe that calls for all us to come together and fight again. How wonderful heartily congratulations I say to you all but only if you continue as you have started when I listened to Comrade Mugabe yesterday rather I read his speech yesterday, I knew I had no right to read my prepared speech. Now Africa has gone through many difficulties as you all know of we know slave trade, we know of colonialism, we know apartheid and now we know of AIDS, HIV and AIDS. I am glad to tell you what you know already when we fought capitalism slave trade it was not one colour which, was fighting. We had many white people, who stood by us the living stones of this world who fought with us against slave trade. Fulfilling the two commandments is a prime in every thing that we think and we do. Love your God the creator with all your strength, all your soul, all your mind and all your strength that is teaching us our relationship with God our creator. He then his wisdom thinks about our relationship. Some has made white, some has made black, yet others brown; yet others yellow but not yet green. But I am sure if he had made some green they would be here today in Zimbabwe fresh beginning they will be here today the green ones. So he says love thy neighbour, is going to be your yardstick, love your neighbour as you love yourself. What is more important? Love your neighbour as you love yourself. Nothing artificial, not even in religion, not in faith stands against that. Some may be Moslems, some may be Hindus, some may be Sikh, some Jews, some may be Christians but love your neighbour across all that it's his command, who are you who am I to fight against that? So fighting slave trade there were some white people, who fought against slave trade, some brown people who fought against slave trade, some yellow haven't read about them yet but they might have been there. If he had some green people by that time they would have been there. Love your neighbour as yourself. Can we doubt it about that in our modern times colonialism, apartheid yesterday President Thabo Mbeki was honouring some white people, some yellow people, and some brown people I was there as a witness. So today Zimbabwe is born afresh.

What an experience for me. Comrade President you have taken this to parliament. You formed the National AIDS Council in parliament. It has been born there in parliament it was born in parliament, it is now here National Council, wonderful, wonderful. Can you see why you throw away my speech you bad people?

Now I have taken long time to introduce what I want to say, don't worry, I am still safe I am still safe. You know my wife and I lost a child of AIDS, 1986 23rd of December. He was 30 he left behind 6 children. At that time it was taboo to mention anybody who died of AIDS. I felt frightened AIDS yah! No don't say anything. Its AIDS, so my wife and I go up two weeks after the boy was buried. I called a press conference and announced our child died of AIDS, has left six children behind. When he felt sick or ill we got him away from his home and brought him to our house. We had to look after him with his wife and children. We looked after him until he died in hospital, Lusaka hospital, University Teaching Hospital (UTH) which we built. He died there. I announced myself the boy died of AIDS. As a result I have been invited to many conferences to discuss AIDS. Comrade President with your permission I am traveling to Chicago this month end if God

is willing, from there I will go to Thailand, President Mandela, President Clinton to discuss AIDS. Can you see, I am saying this to show you the importance of what I you are doing here in Zimbabwe?

I am going there to discuss as we are doing here to find a way together how to fight AIDS. It took away my beloved child a very intelligent boy but I know I am not the only family. Almost all of us have been affected or infected so why are we allowing political divisions, why are we allowing poverty, why are we allowing ethnicity, why are we allowing even religion to stop us from fighting together. As we fought against slavery, as we fought against colonialism I told you they were honoured yesterday, the whites, even if the greens have been made by God, they would have been there yesterday. Let us come together, lets fight together and destroy this thing before it destroys us. So whatever our anxiety is about politics, whatever our anxiety about wealth, whatever anxiety about anything if we allow that to divide us to keep us away from fighting against AIDS we are just fooling ourselves. This thing does not know politics at all; this thing does not know not even religion. It kills across anything artificial. So you have done a great thing you people. Just when I came here I saw you as my colleague; Comrade President pushed me ahead, let's go. I looked around and said "good heavens what a thing". I knew that it was a great day. I cancelled my speech. So my dear sisters and brothers this thing you have started is fantastic. It goes to the roots of the National AIDS Council you made it yourselves. It goes to the roots, its true because AIDS is there at roots. Small pox has been eliminated because the governments of this world cooperated. Small Pox was destroying millions of lives but was defeated. I was sad to learn the other day that some people are saying they can not use some stuff because they felt it was somehow here and there. So Comrade President I don't want to waste your time, but what a day you made for me, what a day you made for Africa as a whole but only if you continue as you are here today. I am not saying forget your politics I am not saying forget your religion. I am not saying all those under one thing fight AIDS. If you don't little room for religion will go, your little room for politics will go you will be six feet down away from here. And they are saying the experts the ages 15-49 are the most delicate ages. Beware, beware. What are you doing about them, 15 and 49? If we don't take care of those people, we don't teach them to be themselves they will be six down, nobody to help us to become headmasters nobody will become ministers, nobody to help us become leaders of your opposition. Its not me who is telling you what to do you have done it yourselves. What I am doing is analysing as I found you have done already. What I am doing is analyse it and repeat it in a way that an outsider sees it.You have done it yourselves. The blacks are here; the whites are here the absent greens that would have been here. We all say the same thing. We have found a way for Zimbabwe. Zimbabweans have found a way for themselves. Why do you leave that for what reason? When the line is to fight AIDS, come, when the fight is to fight politics fight them clean and you would be able to fight AIDS that way. You know world's 70% of people who are dying now are from Africa, Sub-Saharan area. So what you have done here in Zimbabwe is a wonderful beginning please don't let yourself down, continue. You start from the grassroots up to the top. The head of the nation is here we are together with you from the grassroots. The young man who was here I touched my handkerchief on his head was telling us this I don't know how old he is he kept it a state secret. He didn't tell us how old he is but I am sure he is between 15 and 49. So let us therefore look at things that matter in fighting AIDS. First of

all testing I am not telling you my dear sister my dear brother. I have looked around the only one who I think is older than me is the President. Is the Vice President here? He is not. He would have been another one. Is there anyone who is beyond 80 here? Hands up please. You see I can speak with confidence. I am the second oldest. The president is my boss because he is two months older than I am. He is a February boy and I am an April boy but both born in 1924 that year even Carter was a 1924 boy they are few presidents that were born in 1924.

So that man, myself were born in 1924, but he is boss by to months than myself he is February I am April and I am saying this, Com President by his action alone not discussion but action alone has assured me that he is serious in this thing. So testing is very important, we must know what our condition is. All of us must remember testing is very important indeed, I am not telling you what I haven't done. I have been tested and the result came out, I was negative. But I said even if I have been found positive I would have come out and say I have been found positive, then as I have used my negativeness, I would have used my positiveness to fight AIDS. This thing must be fought. So testing is very important. Don't start pointing fingers, that man has AIDS or that woman has AIDS, don't do that. If you do that you are not my friend. All of you here I consider you as my friends, my colleagues, comrades in the common struggle. But If I found you pointing fingers that man is AIDS I would curse you. AIDS people are people like us, they must be helped. The institutions you have established I am not going through them again because they have been established already, I was listening to the Chairman reading them out here. Those are important institutions. See that they work properly and schools, colleges, universities, villages, townships all these places we must invade. We must invade them and talk about AIDS. Comrade President, thank you for what you have done. I am saying go ahead and tell you that you that I fully support. If at any time you want me to go to any village in Zimbabwe please summon me I am ready to go. Not every village is in a good road; we will cycle to get there. We need to eliminate poverty. This little foundation I have established in 2000 has proven clearly that the drugs, yes, very expensive indeed but can be useful. But not as useful please get my message, not as useful as if a patient is properly or nutritiously fed.

You must feed your patient properly and effectively, and then you will see the drugs will work properly. For us this is proven in our own research. The mushrooms we throw away during the rainy season are very useful. Again if you do the research or if you want to see our research we will send them to the appropriate authorities to see how mushroom can be useful in fighting AIDS. Poverty must be fought, poverty must be fought. Without that many millions will perish I tell you. We are witnessing a man coming very frail dying, we feed him with some nutritious food and within in a few days he is walking to our surprise. And we have given him no drugs as yet, just nutritious food a girl, a man begin walking to our surprise. This will need more research and with this wonderful start you have made I am sure you will be getting some doctors to start doing research in some clinics. It's an important thing. Some doctors must start doing these research on these lines and you see that what I am talking about is right. So poverty fighting is extremely important. Comrade President I am excited and therefore if you take an old agitator and give him a free microphone, like this one to a very obedient audience you will expose him to the danger of him continuing and then he keeps these God's people to suffer because they are too

polite to say stop. So please get me right; let me see if I have left a very important point. Comrade President all the points I made after destroying my original speech are covered so I want to say may the good Lord Almighty from our President, to our village headman, to our teachers, to our college leaders, university etc, in hospitals, everywhere in townships may the good Lord continue to guide us along these lines he has set for us. It can't be anything else except God is great with Zimbabwe.

He sang a song "Sons of Africa rise and fight". Thank you.

4.2.1. 2 "**Overview of Zimbabwe's HIV and AIDS Response**" by Dr Owen Mugurungi

Dr O Mugurungi

In the introduction of his presentation, Dr Mugurungi started by recalling that since the first case of AIDS in Zimbabwe was confirmed in 1985, HIV and AIDS has exploded to be pandemic of unprecedented proportions and that Zimbabwe is one of the countries in the world worst affected by HIV and AIDS.

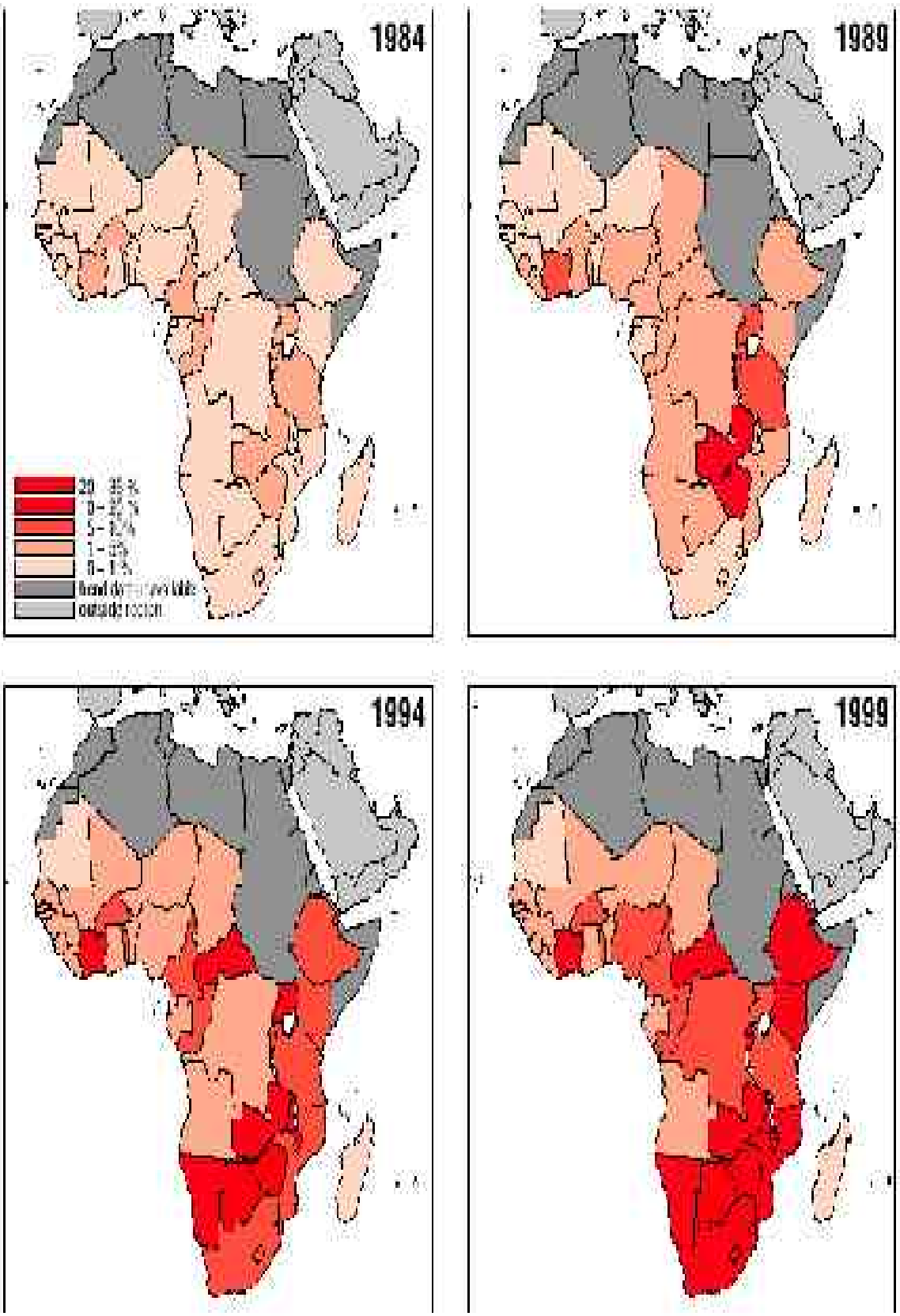
The following is the full outline of his presentation:

National HIV and AIDS Estimates 2003

Produced by MOHCW with collaboration from CSO, UZ, CDC, UNAIDS and Imperial College – UK.

Total Infected (adults and children)	=	1 820 000
Adults (15 – 49)	=	1 540 000
Women (15 – 49)	=	870 000
Children (0 – 14)	=	165 000
Adult HIV Prevalence (15 – 49)	=	24.6%

The following map shows the **Spread of HIV&AIDS over time in sub-Saharan Africa, 1984 to 1999**


1984
1989
1994
1999

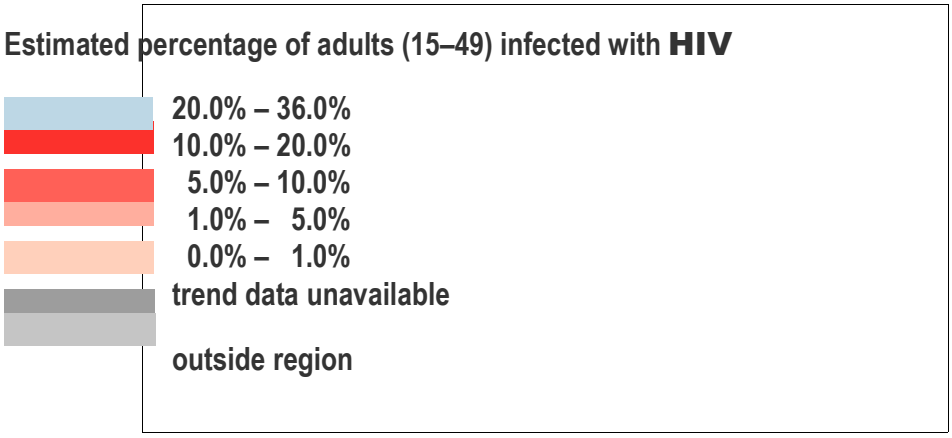


Figure 1 and Figure 3 show trends in the estimated HIV and AIDS prevalence rates in Zimbabwe from the start of the epidemic, which show that the rate of increase has slowed down.

Fig.1 Trends in the estimated adult (aged 15-49) HIV/AIDS prevalence in Zimbabwe, 1980-2003

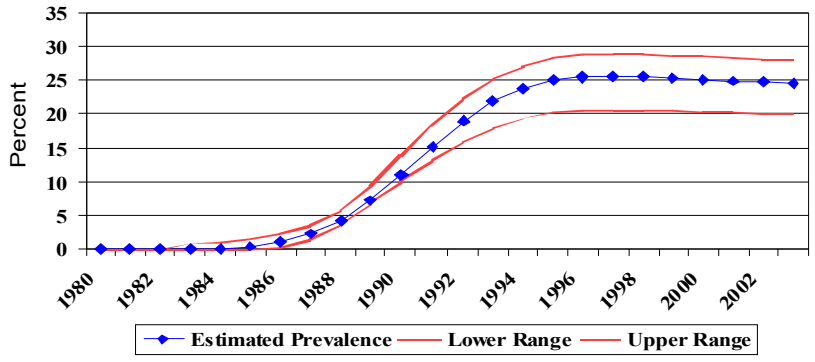
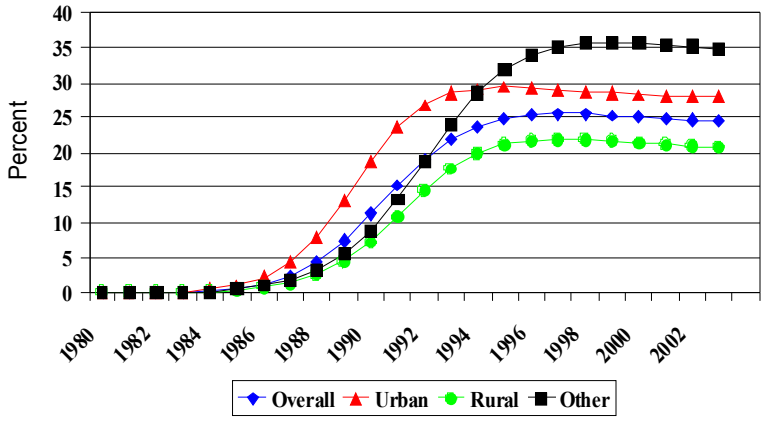


Fig 3. EPP curve fits for Urban, Rural and Other census strata



New HIV Infection 2003

The following tables show the number of new HIV infections and death due to AIDS, by major population groups

Total (adults and children)	=	202 000
Adults (15 – 49)	=	166 000
Women (15 – 49)	=	88 000
Children (0 – 14)	=	40 000

AIDS Deaths in 2003

Total (adults and children)	=	171 000
Adults	=	135 000
Women	=	77 000
Children	=	36 000
Estimated Children Orphaned by AIDS (0 – 14 yrs)	=	761 000

Overview of National Response

- The response dates back to 1985 when 1st AIDS case was identified.
- In the same year screening of blood and blood products for HIV was introduced.
- 1987 – Emergency Short Term Plan
  - National AIDS Control Programme formed
  - . raise awareness through IEC
  - . provide surveillance of the epidemic.
- 1989 – 1994 Medium Term Plan I
  - Focused on expanding interventions to:

- promote behaviour change
- improve access to counseling and testing
- prevent and treatment of STDs
- care and support for people living with
- HIV and AIDS

- 1995 – 1999 Medium Term Plan II
  - Prioritised multi-sectoral response to HIV and AIDS.
  - National AIDS Policy formulated through broad based consultative process.
  - National AIDS Policy launched in 1999.
  - National AIDS Council formed through Act of Parliament in 1999.
  - National AIDS Trust Fund (AIDS Levy) became operational in 2000.
- National Strategic Framework 2000 – 2004
  - Recognises, incorporates and attempts to address the socio-cultural and economic determinants for the spread of HIV and AIDS.
  - Focuses on expanding successful interventions in HIV and AIDS prevention, care & treatment, mitigation and support (i.e VCT, PMTCT, STI, Treatment of OIs, BEAM, Community Response Initiatives, CHBC etc.)
  - HIV declared National Emergency.
  - Care and treatment given more prominence.

Leadership and Commitment

- Governors study tour to Uganda.
- Establishment of HIV Policy in workplace, National AIDS Policy & other policies on Home Based Care, orphan care etc.
- Creation of a Multi-sectoral National AIDS Council.
- Establishment of National AIDS Trust Fund which has so far cumulatively collected + 26 billion ZW$.
- Establishment of District Response through VAACs, DAACs & PAACs.
- Declaration of AIDS as National Emergency to improve access to AIDS drug.
- Funds to treat AIDS in budget since 2002.
- Greater involvement of PLWA, traditional leadership, faith based organisations.
- Establishment of community based ASOs.
- Focal persons for HIV and AIDS in all Govt department.
- Establishment of Business Council on AIDS.
- Stronger partnerships forums (CSAC, GF-CCM etc).

Current Prevention Activities

Prevention is the mainstay of the response to HIV and AIDS;

Objectives

- To prevent new HIV infections
- To reduce further spread of existing ones especially among the youth, women & vulnerable population such as mobile groups, sex workers and their clients.

Prevention- Areas of Focus

- IEC for Behaviour Change Communication

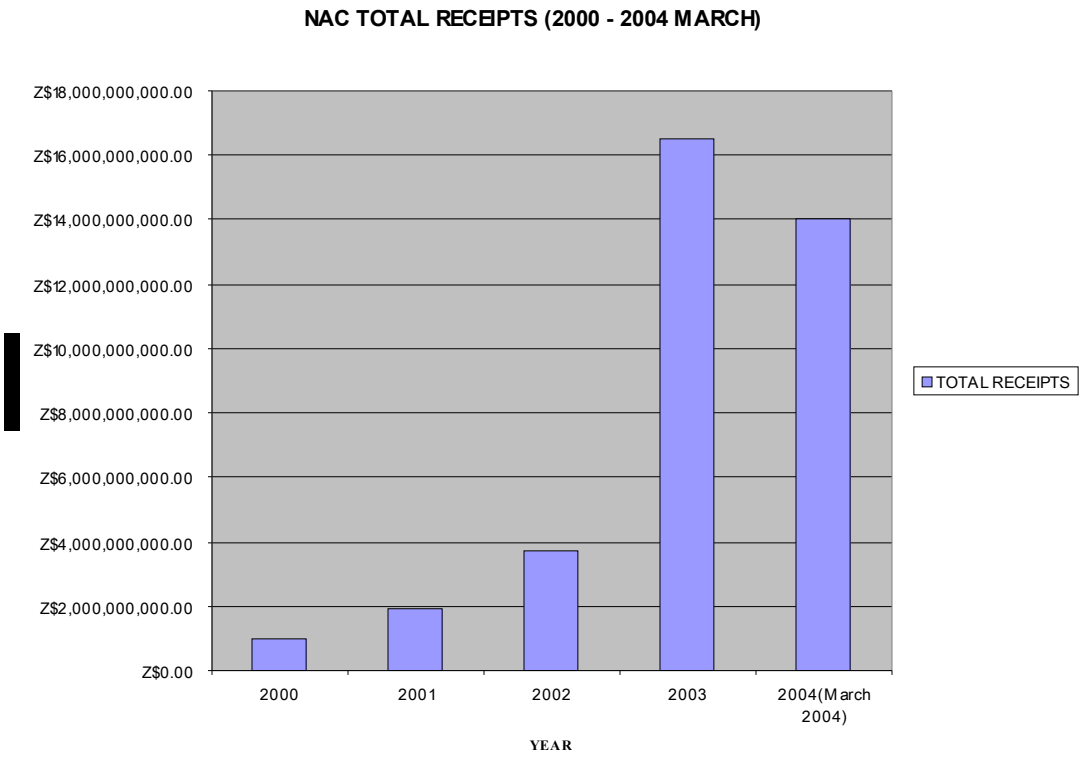
- Mainly through mass awareness campaigns, life skills education, peer education &media
- Voluntary Counseling and Testing.
- Condom promotion and communication.
- Prevention and treatment of STIs.
- Prevention of occupational exposure to HIV
- Screening of blood and Blood products.

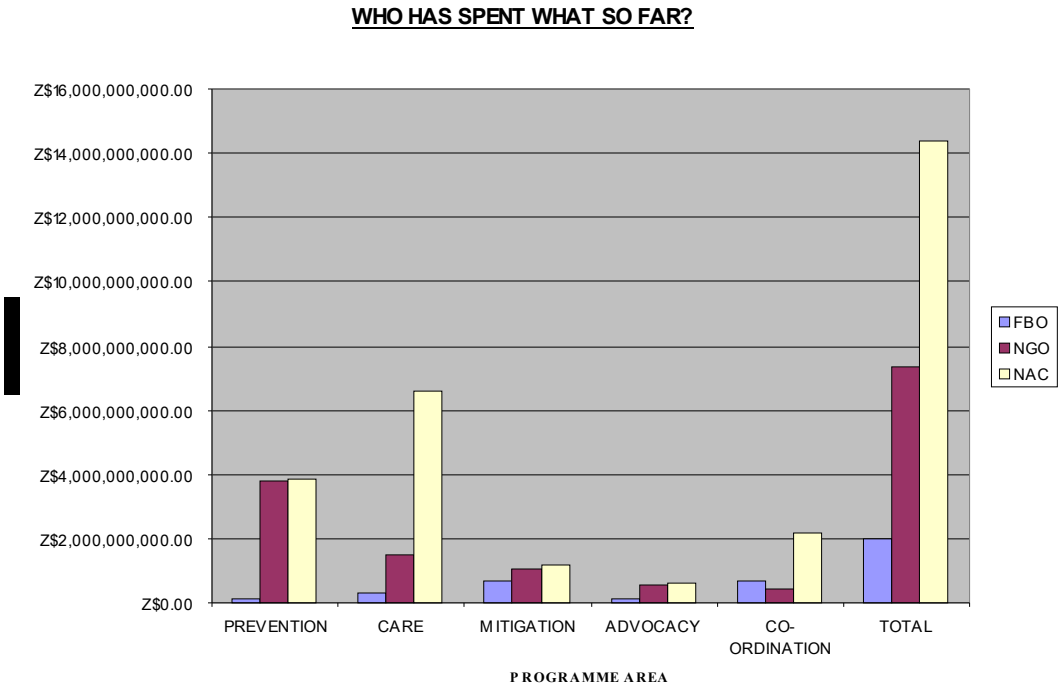
Critical Prevention Issues
- Empowerment of Women especially education of the girl child.
- Addressing socio-cultural & Gender issues that facilitate further transmission of HIV.
- Encourage openness; Fighting stigma & Discrimination associated with AIDS
- Poverty reduction.

Care and Treatment
- **Objectives**
- To reduce morbidity and mortality associated with HIV and AIDS.
- To improve the quality of life PLWA
- Therefore a comprehensive approach to AIDS care and Treatment has been adopted which includes;

Components of AIDS Care Package
- Access to counseling and testing and psychosocial support.
- Prevention & treatment of HIV related OIs.
- Management of AIDS cancers & complications.
- Link clinic and Hospital care to Community Care.
- Access to appropriate Nutritional Care.
- Access to Antiretroviral Therapy.
- Palliative & Community Home Based Care.

Resources Mobilisation
- Government has made immense financial human and material resource contributions to fight HIV and AIDS.
- Sources of funds are
    - fiscus
    - AIDS Levy
    - bilaterals and multi-laterals partners
    - private sector
- communities


NAC TOTAL RECEIPTS (2000 - 2004 MARCH)
Z$18,000,000,000.00
Z$16,000,000,000.00
Z$14,000,000,000.00
Z$12,000,000,000.00
Z$10,000,000,000.00
Z$8,000,000,000.00
Z$6,000,000,000.00
Z$4,000,000,000.00
Z$2,000,000,000.00
Z$0.00
2000
2001
2002
2003
2004(March 2004)
YEAR
TOTAL RECEIPTS



Mitigation and Support

- Provision of psychosocial support in the community.
- Adherence to ILO code of practice
    - no discrimination on basis of HIV
    - all employees eligible for employee benefits, sick and compassionate leave.
- Support for orphans & vulnerable children
- Support for micro credits and income generation schemes.

Challenges

- Reduction of New Infections.
- Human resources.
- Inadequate Financial resources
- Strengthen coordination and max use of available resource.
- Uninterrupted supply of HIV drugs & commodities
- Protection of Orphans and Vulnerable Children.
- Stigma & Discrimination; Openness.

4.2.1.3 "Faith-based response to HIV and AIDS fight" by Bishop Trevor Manhanga

FAITH BASED RESPONSES TO THE HIV and AIDS CRISIS

Bishop Trevor Manhanga

The Honorable Minister of Health, Dr David Parirenyatwa, distinguished guests, ladies and gentlemen. I count it a great privilege to be given the opportunity to address this gathering this morning. Whilst it has taken far too long for a conference of this nature to be convened, the organizers must be applauded for making it a reality, regardless of the lateness of the hour. In a continent already ravaged by wars, mired in poverty and under-development, AIDS is wiping out much of a generation. AIDS continues to sow further instability that in turn ensures the kind of desperation where AIDS flourishes. The HIV and AIDS crisis in Africa may seem to be a purely humanitarian tragedy to the rest of the world, but to those of us for who Africa is home, it is much more. As AIDS wrecks Africa's already crippled political and social institutions, instability on the continent may demand more intervention from the outside than medicines and educational programs.

In January 2000 the then US Ambassador to the UN Richard Holbrooke speaking on the implications of the rising HIV and AIDS crisis in Africa said, " The spread of this disease could not be contained in Africa, and the destruction of Africa from AIDS will not be limited to the continent. If we don't work with the Africans themselves to address these problems …they will get more dangerous and more expensive." Sobering words and ones we as Africans need to give serious consideration to as we "Take Stock: and Look into the Future." I will concern myself this morning with looking at the role Faith based communities have played and what they can be doing, in the fight against HIV and AIDS in the nation.

After years of relative apathy there is an up-swell of interest in the church on the subject of HIV and AIDS. The dire warnings that have been given over the years have become a reality. The hard reality on the ground, of snaking lines outside cemeteries as families wait to bury their loved ones, overburdened mortuaries that operate 24 hours a day, 7 days a week and the growing number of people who have gone into the coffin making business, have starkly brought home the point of the seriousness of the crisis that we have with us. We cannot take responsibility for past crisis and we may argue over past atrocities, hoping to draw lessons. Could Roosevelt or others have done more to save the 6 million Jews from extermination during World War II? What about the almost 1 million people who were brutally murdered in the genocide witnessed in Rwanda? Could the UN not have acted in time to preempt that? Yet my fellow Zimbabweans we have a new holocaust before us – of a very different character, but on an even larger scale of human destruction. I recognize that the war against HIV Aids is not a

traditional war replete with guns, tanks, and landmines. This war is much more insidious but no less deadly.

Presentation to the Inaugural Zimbabwe National HIV and AIDS Conference "Taking Stock: Looking to the Future." Sheraton Hotel Harare 15th – 18th June 2004. – Bishop Trevor E.C.Manhanga

We are disturbed at the number of people who have been killed as a result of political violence in our nation and justifiably so, but more people are dying as a result of HIV related illnesses in a week than have died in the past two elections combined. In Sub Saharan Africa there are 5 500 official funerals per day, 1600 children per day are born HIV positive. In the last 10 years over 9 million children under 15 have lost their mothers to HIV and AIDS and of these 90% are in Sub Saharan Africa. AIDS is the number one killer of youth between the ages of 13 – 24. 22,5 million orphans were projected to be in Africa by the year 2000, life expectancy has been reduced in Zimbabwe from 70 to 40, 50% to 70% of hospital beds are for HIV Aids related illnesses.

Ladies and gentlemen we are facing a tragedy of unprecedented proportions and let me state clearly that the church, if it is to be salt and light, then it cannot ignore a crisis of such magnitude. Let me go further and hasten to add that if the church is not dealing with the issue of HIV and AIDS then it is not fulfilling its God given mandate and is failing the people to whom it has been called to minister.

Why has it taken so long for us in the Faith Based community to get mobilized to fight this disease? Clearly for a long time there has been a lack of leadership from both our political and spiritual leaders. Take the fact that not a single Head of State attended the 1999 World Conference on AIDS held in Lusaka, Zambia – not even the President of the host country. In the face of such apathetic leadership how on earth can we expect to mobilize our people and the rest of the world to come to our assistance in fighting this disease? How will history judge us as leaders? How will history record and justify this deafening silence as millions of African peoples face certain death, entire families destroyed and millions of children orphaned.

How many leaders in the Faith Based community have taken the fight against HIV and given it the priority it deserves? It has taken well over 20 years for MPs in our parliament to make a public step and go for testing, and they must be applauded for that. But does that not show the lack of seriousness, in that it has taken so long to get to this elementary position? How many leaders in the Faith Based community are prepared to do that? Perhaps this illustrates the problem we are faced with, a leadership problem.

In the same way that the slave trade decimated Africa's population, unleashing a downward spiral that set back Africa's development by at least two centuries, so it is with AIDS. This crisis, left uncontrolled, will set back Africa again. Ladies and gentleman, the time to act is now. We can talk, and justifiably so of the devaluation of the lives of Black people when compared to those of Caucasian background, one can only imagine the scale of international intervention if 5000 French or English people were dying of AIDS daily. A quick comparison

of the amount of money the international community spent on refugees in Kosovo, US$1, 50 per day for each refugee, but by comparison spent 11cents per day per refugee for the refugees in the conflicts in Sierra Leone and Rwanda, highlights the point that I am trying to make, but we cannot expect people to do for us what we can and must do for ourselves. As citizens of Zimbabwe we must realize that if we do not take our destiny in our hands then no one else will. This is where leadership, and strong and daring leadership may I say, needs to be exercised.

PREVENTION

What can be done or what do we need to do? Curbing the contagion is hard but it is not hopeless. Can AIDS be stopped in Zimbabwe? The temptation when we are confronted with a crisis of such enormous proportions is to assume it is beyond human control. But it is not. It is possible to stem the tide, and it has been done. Senegal has held its infection rate below 2% and Uganda once the world's epicenter has cut its infection rate by half during the 1990's. Recent reports emanating from the Ministry of Health indicate that HIV infection has stabilized and is starting to go down; even though an estimated 166 000 new HIV cases were registered last year. One thing is clear, we cannot adopt a one-size-fits-all approach as what works in what community may not necessarily work in another. But we can learn from what has and has not worked in other countries and learn from them. Issues that the faith based community can and must address are:

- Denial and the conspiracy of silence.

  Every church, mosque, synagogue, preaching point must become a bastion in the fight against AIDS. Every pulpit must become an education station of enlightenment on AIDS, and every preacher, imam, rabbi, prophet, evangelist, madzibaba must become an activist in the fight against AIDS. We must tackle this problem of denial with all the weapons at our disposal. The bible declares that "my people perish for lack of knowledge" Hosea 6:8. We must go to the root of this denial and put HIV and AIDS in the open. Most people in the faith based community congregate at least once a week, often times more than once a week. We must encourage people to discuss openly this matter of HIV and AIDS whenever and wherever they meet. In Zimbabwe we have only two kinds of people with regard to HIV and AIDS, those affected and those infected. We must encourage people infected with HIV to openly speak about their status. This will mean creating the right kind of environment in our churches for them to feel comfortable to do this. We must also begin to encourage relatives to publicly give the cause of death as HIV and AIDS where this is the case. This conspiracy of silence between relatives, the medical fraternity and the church, where the cause of death is given as everything else but HIV and AIDS related, will keep us from confronting this crisis in the way it should be. Yes people will talk about privacy and the rights of the individual, but ladies and gentleman, when confronted with a tragedy of such gigantic scope surely the time has come to put away such niceties as our rights. There must come a time surely when we take the bull by the horns and make some decisions that may seem to be a violation of some peoples individual rights but are necessary in fighting the crisis on a national scale.

  The war on terror declared by the US in the aftermath of Sept 11 2001 has led to some unpopular steps being taken by the US government, but they have never-the-less gone ahead

and done so in their national interest, irrespective of what other people have said. We need to take some unpalatable decisions in our national interest and not pander to the whim's of others who may feel we are interfering with individual rights. I make the call for all people who are HIV positive to be told so by their doctors even if they have not asked to be tested, and for their spouses to be informed of their status or their next of kin if they are not married, to offer them the opportunity to live positively for the sake of themselves, their families and others. The faith based community must take a bold step in this regard and advocate for this to happen.

Denying one is HIV positive has many implications, not only for the individual's health, but also for the prevention of further transmission to others. When a person knows and acknowledges that they are HIV positive they can prevent others from getting infected and as a result help in halting the spread of the epidemic.

- Open teaching and discussion by the church on sexuality.

  95% of the HIV and AIDS infections in our country come about as a result of heterosexual transmission. We cannot effectively deal with the HIV and AIDS without openly and clearly teaching our people about their sexuality. Now I know that this will take us head on to a confrontation with our cultural norms in which sexual matters are not discussed openly and where they are it is between older women and younger women for instance. We must however understand that our society has changed dramatically from the days where this was possible with the 'vatete's'. The effects of urbanization and globalization have meant that many young girls do not have that opportunity. With both parents working it is a very different scenario now to when many of the older folks grew up. This means that much of what used to be solely the responsibility of the family circle is no longer happening. That vacuum that has been created must be filled by the faith based institutions. If we do not fill the gap, someone else will fill it usually with drastic consequences. We need to present to our communities a biblical exposition of human sexuality. As a minister of the gospel I find it very surprising that many clergymen have neglected to teach people about sexuality Gods way. The bible has much to say about human sexuality and we do a great disservice to our people by staying away from the subject of sex. God made sex and it is beautiful when practiced in the way God intended. We have taught and must continue to teach our people about the very heavy price tag that sex before marriage, and outside of marriage, carries such as disease, broken relationships, dysfunctional families, spousal abuse, unwanted pregnancies, abortion, baby dumping and of course HIV and AIDS. It may seem puritanical to some but sexual purity is for both the unmarried and the married and we must teach this. We must not be ashamed to declare this truth in the midst of a generation swayed by sexual perversion. The idea that men should have multiple partners as a sign of their manhood must be confronted head on. The practice of 'kugara nhaka' must be confronted head on. Despite the protestations of decadent so called liberal nations we must declare that homosexuality is an abomination and the practice of homosexuality has no place in our nation. These positions may be unpopular but in a war unpopular decisions may need to be taken. We must teach our people that the ability for one to control ones sexual urges is very possible. We are not animals that have sex whenever, wherever and with whoever they feel. As human beings we have the ability

to choose and have control. Failure to bring our people to this realization will render us powerless in this fight against HIV and AIDS.

- Hypocrisy in matters related to sexual behavior.

Closely linked to teaching about human sexuality must be for leaders in all sectors of the community to not only talk about safe sex but to practice it. The hypocrisy in matters related to sexual behavior is common place. We have people who teach about the dangers of having multiple sex partners and yet go right ahead and have those multiple partners themselves. Sadly even in the church this is so. We cannot win this war when parents, teachers, managers, politicians, pastors do not practice what they preach. Let us face the truth that we all know of church leaders, political leaders who have died of HIV and AIDS or are HIV positive. It is no secret that the majority of them got infected because of sexual promiscuity. We need to deal with this matter of behavioral change if we are going to slow down and eventually stop the spread of this murderous catastrophe.

- Gender in-equality.

The powerlessness of many African women is costing them dearly. The exploitation of young girls and impoverished women by men is another hurdle that needs to be overcome in this fight against HIV and AIDS. It is said that women account for 55% of the continent's HIV infections and teenage girls suffer five to six times the infection rate of boys. Women, because of their biological make up have a 33% faster rate of HIV infection than men. Barry Bloom, dean of the Harvard School of Public Health says that, "empowering women is critical to controlling the epidemic." On this same note Dr. Solomon Mutetwa of the University of Zimbabwe's department of Micro biology, said that, "we should develop strategies of empowering women economically, socially and legally so that they can refuse to be exploited and infected by men." In addition to advocating for more social clout for women, they also need contraceptives that they control directly.

- Promotion of safer sex.

At the risk of being declared a heretic and burnt at the stake, I must take the opportunity to discuss the matter of condom use as a church leader in the fight against HIV and AIDS. We must agree that if all people lacked was information, a good leaflet might end the epidemic. The trouble is that no one, rich or poor makes choices on the basis of information alone. The problem we face is not that we don't have information but we lack application. I have already made the case for behavioral change and what I am about to say is not a negation of what I have already stated. Safe sex to practice sexual purity before marriage and then for one man to have sexual relations with one partner for life. However we must be cognizant of the fact that the greater majority of the people we are trying to take this message to in the fight against HIV and AIDS are not in our churches. We must understand for example that if prostitution is your livelihood – or the sole source of intimacy in your mineworker's dormitory far away from home – you take the risk and learn to live with it. It is no good pontificating to these people on the virtues of celibacy; they are going to have sex. We need to help them to do whatever they can to protect themselves and this includes the use of condoms. Yes, I know that condoms are not 100% safe. I know that they have a failure rate,

but my argument is that even if condoms have a 10% failure rate they still help in 90% of the cases. Using nothing means a 100% opportunity for infection and as I stated earlier we must use all the means at our disposal to fight HIV and AIDS. There are other areas in which I would encourage use of condoms such as, when a person has tested positive and is in marital relationship. Even if the other partner is positive use of a condom prevents re-infection. Also when one of the partners has multiple partners we should encourage condom usage. Now, I do realize in adopting this attitude I may be breaking rank with many church leaders, as they feel that the use of condoms often leads to greater promiscuity. I can understand that but I think we should look at the whole issue objectively and see that there can be a justifiable case to be made for condom usage without compromising our values as Christians.

- Poverty.

You cannot tackle the issue of HIV and AIDS without addressing the issue of the lack of material resources and poverty. There can be no doubt of the link between poverty and the spread of HIV and AIDS. We in Zimbabwe and Africa are not any more promiscuous than people in Europe and North America, but the difference in infection rates is very clear and the availability of resources for treatment and care of HIV positive people is a definite factor. Poverty is one of the most pressing of all Africa's many depressing problems. Poverty has at least 4 serious manifestations which directly impact on the HIV and AIDS crisis. They are:

1. Hunger. One out of every three Africans does not get enough to eat. A study covering the period 1988-90 showed that 168 million Africans were the victims of chronic hunger. This cannot help in the fight against HIV and AIDS.
2. Income. Poverty means not having adequate income to meet basic needs and imprisons people in ignorance and superstition.
3. Disease. Poverty means disease. Africa is still plagued by numerous diseases, which are both curable and preventable. In Africa millions of people are still the victims of many infectious diseases such as malaria, river blindness, bilharzia, and respiratory infections.
4. The fourth manifestation or consequence of poverty is dehumanization. In the bible the parable of the rich man and Lazarus shows us that the poor man is no better than the dogs with whom he shares crumbs from the rich mans table. The church must be deeply concerned about the dehumanizing effect of poverty and ultimately HIV and AIDS.

- Testing.

I don't believe that we can get on top of this disease until we begin to see a very significant move towards getting our people to voluntarily submit to testing. There is no way we will win this war whilst the majority of Zimbabweans do not know their status. The Faith based Community once again must be at the forefront of this drive to urge people to be tested. Testing centers should be established on a massive scale and pastors should set the example by going for testing themselves and break the stigmatization of going to be tested. The example of the MPs from the House of Assembly must be applauded and duplicated all over the nation. I personally would not be against mandatory testing and neither would I be against making it illegal and a punishable offence for one person to deliberately infect another. In the church denomination that I give leadership to we have now made it mandatory for all couples getting married by our marriage officers to be tested. This also

means that all our marriage officers have to subject themselves to going for testing themselves. The results are to be known by the couples themselves but it is our way of getting people to deal with the whole issue of knowing their status. Another area that the knowledge of ones status would be helpful is in the area of mother to child transmission. Once a woman knows she is HIV positive my personal opinion is that we should discourage her from getting pregnant, but where that fails, then put in place strategies to curb the transmission of the virus to the child. Other countries have done this and we can too.

TREATMENT, CARE AND SUPPPORT

The HIV and AIDS crisis has presented the Faith Based community with a great opportunity to show genuine love to people who desperately need love and acceptance. It is sad to note that there still remain come people in the Faith Based community who continue to hold on to the myopic and bigoted position that HIV and AIDS is a punishment from God. What God may I ask is it that will doom a new born baby to a short, pain filled, hopeless life? Inflict a woman who has been faithful to her husband with the virus from a promiscuous husband? I' sorry but that is not the God that I know and that can be found in the bible. We must however highlight the tremendous work that has been done by the church in bringing health care to the people of Zimbabwe. The role that the church has played and continues to play in Zimbabwe in the delivery of health to our people is well documented. We applaud all the many churches who have invested heavily in bringing health care to our people in far flung places. However they need support. Both the government and the private sector must look at ways and means of making these efforts of the churches yield greater impact by the making available of resources and in the case of government enabling legislation that will assist churches in tapping into resources from their donors abroad

The magnitude of the crisis is such that no single church, mosque, synagogue has the resources too adequately respond to the multifaceted need that HIV infected people bring but we can do something and what we can do, that by the grace of God we must do. With the cost of anti retroviral drugs out of the reach of the majority of HIV and AIDS sufferers we must do more to prevent infection in the first place. One of the areas is in treating STD's that make people more susceptible to HIV. Studies have shown that by treating conditions such as Chlamydia and gonorrhea, with much cheaper, accessible antibiotics, we can cut new HIV infections by as much as 40%. We must make mention of the very positive recent moves to roll out ARV's by the Ministry of Health to vulnerable groups in our nation. With inflation running at 500% and an unemployment rate of over 70% it is clear that the majority of HIV and AIDS sufferers cannot afford the cost of ARV's that are now becoming available. We urge all sectors of the nation, the government, the private sector, the NGO's to make a concerted effort to do more to bring down the cost of ARV's and in some cases even offer them for free. It can be done if we have the collective will to do it. I cannot be persuaded to accept that, a nation that is able to boast the most modern of motor vehicles on its roads, the most recent of cell phones on the market being used, satellite dishes spring up like mushrooms on the rooftops of peoples homes, cannot make ARV's available to the vulnerable HIV and AIDS sufferers in our nation. What is needed is the collective will of all stakeholders and we will be able to put ARV's in the hands of all those who need them at an affordable price. The only hope for Africa though is a preventive vaccine and there does not seem to be much light at the end of the tunnel right now. So we need to manage the disease

as best we can. To this end we have and must continue to train and educate care givers in our churches. Set up support groups for people affected by and infected with HIV and AIDS. We can start income generating projects to both empower women and also give those infected an opportunity to fend for themselves.

STIGMA AND CONFIDENTIALITY

We need to see HIV and AIDS for what it is – a devastating epidemic, nothing more, nothing less. We must do all we can to break down the cloak of shame that currently envelopes the whole issue. People need to know that being HIV positive is not in and of itself a death sentence or that it is a sign that one has been promiscuous. How will this be done? By beginning to talk positively about the disease and encourage as many people as possible and in particular high profile people to come out talk about the disease. We can also allow HIV positive people to hold significant positions in the church to show people that there will not be discrimination based on a person's status. We also need to respect the confidentiality of those who come to the church for counseling but are not prepared to have their status disclosed.

No doubt we are faced with a daunting task but we can make a difference. The worst thing we can do is to throw our hands up in the air and say this is too huge a problem for us. First we must get real, admit the enormity of the problem, but then we must come up with a strategic plan with clear and specific objectives to deal with the problem. We must also develop partnerships with other people who are prepared to help us as we do not have the resources needed to fight this epidemic. Ultimately it is going to take courageous leadership, similar to that which was witnessed when Winston Churchill stood and lead the fight against the rampaging German advance. Nothing less than bold leaders who are prepared to take whatever blows come their way will be needed. As leaders in Faith Based communities we can do it and I pray that we will not be found wanting.

4.2.1.4 Zimbabwe's "National Plan of Action (NPA) on Orphans and Vulnerable Children (OVC)" by Mrs N Dhlembeu

Mrs Dlembeu started by giving an overview of the **extent of the problems of orphanhood** in Zimbabwe. She noted that 761 000 children were estimated to have lost one or both parents and that a projected 1.1 million children aged below 15 years of age will be orphaned due to HIV and AIDS by 2005.

Mrs N Dlembeu

Following is the full outline of her presentation

Local Responses

- Zimbabwe has well defined legislative and policy framework to support children. However, lack of resources prevents full implementation of key national policies, hence the need to mobilize and co-ordinate resources for full implementation of policies benefiting children.
- There are many efforts and interventions being undertaken in the country, showing that communities are responding to escalating numbers of OVC. Nonetheless, these activities lack in co-ordination thus resulting in fragmented impact.
- A lot of these programmes have links with government ministries, particularly Department of Social Services, as well as other NGOs and CBOs. These links need to be strengthened for positive co-ordination.
- There is wide scale lack of birth certificates among OVC and children in general that prevent them from accessing education, health services, inheritance, and other basic social benefits.

National Legislation Pertinent to Children

The following Acts of Parliament are already in place to protect children.

- Children Protection and Adoption Act.
- Guardianship of Minors Act
- Maintenance Act
- Education Act
- Citizenship Act
- Birth and Death Registration Act
- Legal Age of Majority Act
- Public Health Act
- Labour Relations Act
- National Social Security Act
- Sexual Offenses Act

National Policies

- Several supportive policies are in place:

- National Orphan Care Policy (1999)
- Provides a package of basic care and protection to orphans.
- Commitment to national and community support
- Commitment to allocation of resources for enhanced access to education and health services
- National Aids Policy (1999)
- Encourages multisectoral approach
- Contains guiding principles and strategies related to children affected by AIDS
- Includes component on care and support programs for OVC addressing child abuse, stigma and counseling
- Also: National Gender Policy and National Land Policy

UN Responses - UNGASS Goals 65,66 and 67

- By 2003, develop and by 2005 implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans, girls and boys infected and affected by HIV and AIDS, including providing appropriate counseling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;

Development of the NPA for OVC

- Social Services Action Committee of Cabinet
- Provision of support
- Establishment of the Working Party of Officials (see below for composition)
- National stakeholders Conference, June 9-12 2003

Working Party of Officials (WPO)

7 government line ministries (MoPSLSW,
MoHCW, MoJLPA, MoYGEC, MoFED, MoLGPWNH, MoESC)
1 repr. National AIDS Council
1 repr. UN system (UNICEF)
2 repr. Local NGOs/CBOs (CPS and FACT)
3 repr. International PVOs/NGOs (CRS, Futures, and SCN-Z)
2 repr. FBOs
1 repr. Zimbabwe Red Cross Society
2 repr. Donors (SIDA and USAID)
1 repr. National umbrella/ regional organization (NANGO)
1 repr. Private sector (ANGLO)

The National Plan - Vision, Goal and Objectives

Time Span: 3-5- years (phased approach)

Vision:

To reach out to all Orphans and other Vulnerable Children in Zimbabwe with basic services that will positively impact on their lives.

Goal:
By December 2005, to develop a national institutional capacity to identify all Orphans and other Vulnerable Children and to have reached out with service provision to at least 25% of OVC in Zimbabwe

Objectives
- The vision and goal will be achieved through the following objectives.
- Strengthen the existing coordination structures for OVC programmes and increase resource mobilization by December 2005;
- Increase child participation as appropriate in all issues that concern them from community to national level, considering their evolving capacities;
- Increase the percentage of children with birth certificates by at least 25% by December 2005;
- Increase new school enrolment of OVC by at least 25% by December 2005, while ensuring retention of OVC in primary and secondary schools;
- Increase access to food, health services and water and sanitation for all OVC by December 2005;
- Increase education on nutrition, health, and hygiene for all OVC by December 2005; and
- Reduce the number of children who live outside of a family environment by at least 25% by December 2005 (this includes children living without adult guidance, children living on the streets, and children in institutions).

Strategies
- Strengthen existing co-ordination structures by the provision of Secretariat at national, provincial and district levels
- Education and advocacy on the implementation of existing legislation and policies in the best interests of the child;
- Strengthening community based initiatives and social safety nets; and
- Strategies
- Strengthening the rights-based approach to programming, where the family, community, local authorities, civil society, and the state reaffirm their positions as duty bearers, and increase commitment to upholding children's rights.
- Mobilizing domestic and international resources: and
- Communicating with local stakeholders and other counterparts, regional and international.

Guiding Principles
- The recognition that children have the capacity, as well as the right, to participate in decisions that affect them;
- Gender equity, or equal attention paid to the roles of girls and boys;
- The recognition that children are resilient and have great capacity for self-reliance;

- Observance of non-discrimination in the provision of essential services to children;
- Building upon existing community structures, and paying attention to family ties and traditional capital;
- Effectively coordinating human, material, and financial resources at all levels will maximize local resources and minimize or avoid duplication of efforts; and
- Prevention of HIV and AIDS should be integrated in all programmes, strategies, and approaches.

4.2.1.5 "**HIV and AIDS: A Global Problem and Workplace Strategies in Zimbabwe**" by Titus Moetsabi

Mr Moetsabi started by giving a brief background of SMARTWORK, the organization for which he works.

The following is the full outline of Mr Moetsabi's presentation.

AED Overview-Mission
Founded in 1961, AED is an independent, nonprofit organization committed to solving critical social problems in the U.S. and throughout the world through education, social marketing, research, training, policy analysis and innovative program design and management. Major areas of focus include health, education, youth development, and the environment.
Employees: 1000+'; Countries Worked in: 164

Funding of AED Smartwork Zimbabwe
SMARTWORK is a project of the Academy for Educational Development, and is funded by the United States Department of Labor under Cooperative Agreement Number E-9-K-1-0074. In Zimbabwe, funding is also provided under grant number U62/CCU320180-01 from the United States Department of Health and Human Services, Centers for Disease Control and Prevention

Workplace Organisations and Partners of SMARTWORK
MINISTRY OF HEALTH, NAC, ZBCA, GOVERNMENT FOCAL PERSONS ON HIV and AIDS, ZIPM, ZNCC, EMCOZ, CZI, ZAN, ZAN MEMBERS, ILO, UNAIDS, UNDP, UNIFEM, UNPFA, Futures, PSI, ZAPP,SAFAIDS, GTZ, DED, DFID, SIDA, CIDA, MEDIA, INFORMAL SECTOR, ZCTU, ZFTU, FAITH BASED ORGANISATIONS, TRADITIONAL HEALERS, MINISTRY OF LABOR AND SOCIAL WELFARE etc

Why Should Business Bother (to work in HIV and AIDS in the Workplace)?
- Because it's humane. But also…
- You need your workforce

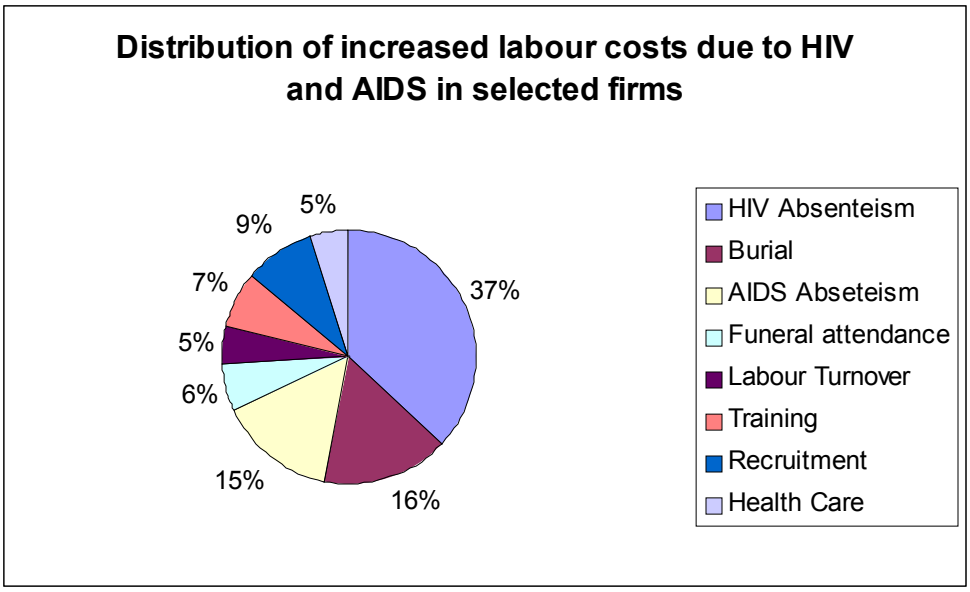
Statistics and background information on "Why Bother"
- Size of labor force in high-prevalence countries will be 10-30% smaller by 2020 from HIV and AIDS

- One Country in Southern Africa: 62% of manager deaths are from AIDS-related illnesses
- AIDS costs…
    - In One Company 6% profits lost due to HIV and AIDS related costs
- Who will buy your stuff?
    - 70% of households in some southern African countries have suffered labor losses because of AIDS-related sickness.
    - Fewer people and with less income
- To avoid bad decisions and poor publicity
- For yourself–as a manager and as a personal risk concern.
- Could that ever affect you?
    - An employee walks in and says I don't walk to work with Titus
- Huge impact on staff and dependants
- Workplace programmes are becoming "best practice"
- Morally and ethically important
- Economically make sense
- NGOs need workplace programmes to be credible

The Impact of HIV and AIDS on Workplaces

- **Increased costs due to:**
    - Absenteeism (due to direct and indirect illness)
    - Loss of skills
    - Staff turnover recruitment (ex. Advertising)
    - Training costs for new employees
    - Reduced productivity of new recruits
    - Rising medical expenses or insurance-related fees
    - Increased death benefits, burial/funeral costs
- **Socio-economic or labor effects too:**
    - Increasing disorganization
    - Labor disruptions
    - Weakened morale

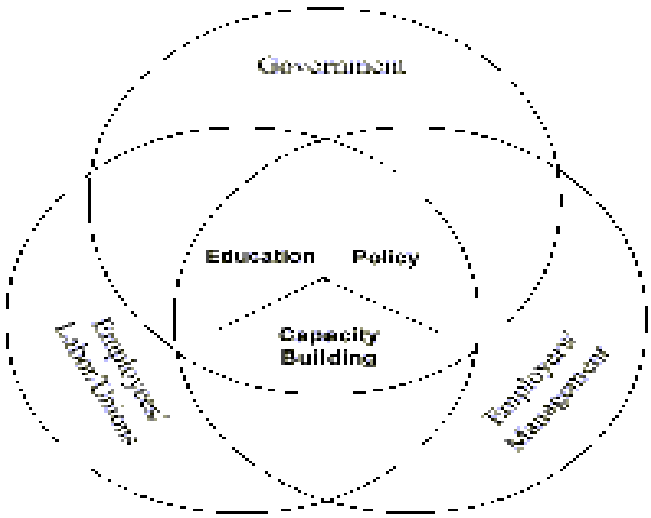
How HIV and AIDS Increases Employer Costs



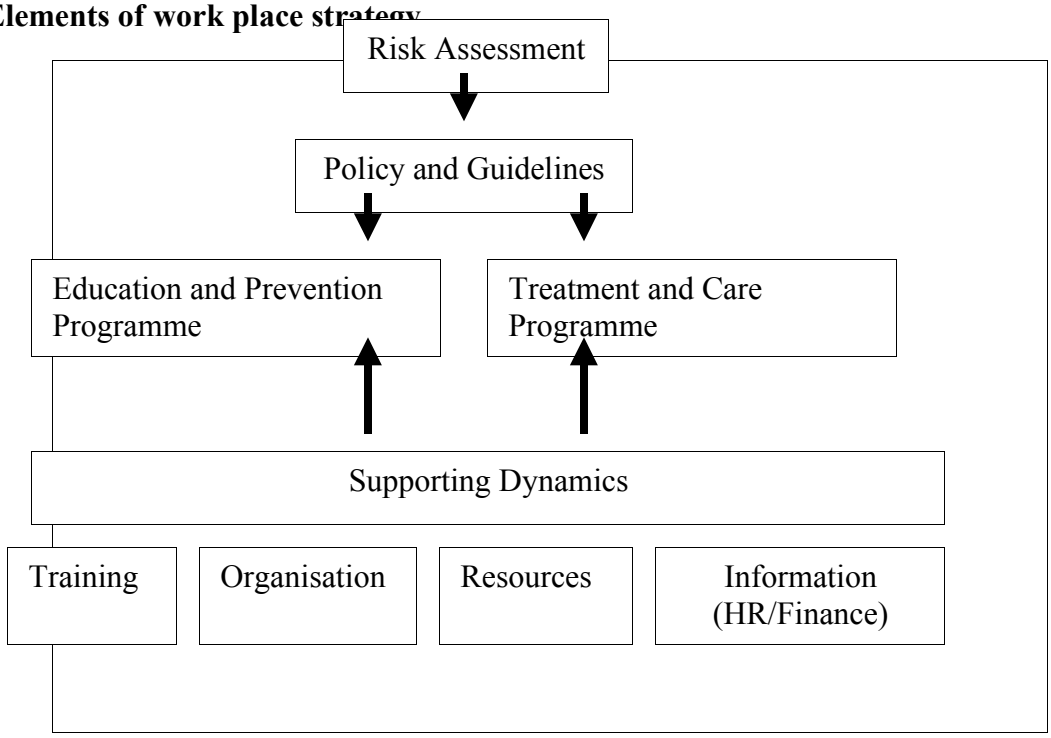
What Can Employers and Labor Leaders Do?

- Commit to joint action to prevent further spread of the epidemic
- Adopt and implement HIV and AIDS policies that protect workers' rights and employer interests
- Establish prevention education, care, and support programs consistent with worker needs and employer capacity and interests
- Put language into collective bargaining agreements to protect worker rights and specify access to HIV and AIDS services
- Allocate human and financial resources for HIV and AIDS prevention education, support, and care

A Tripartite Approach



Elements of work place strategy



Workplace HIV and AIDS Policy needs to cover…

Policy and guidelines	Including management and staff guidelines
Education	Internal and external education, First Aid guidelines
Non-discrimination	Non-discrimination, protection, treat as other illness, adjust roles
Confidentiality	Right to confidentiality, No obligation to inform, No compulsory HIV testing
Access to support	Access to VCT, PEP, ART, Free condoms (male and female), support networks

A Union Recognised Policy

- " Workplaces provide the key venue for initiating effective programmes of prevention and care relating to HIV and AIDS. Programmes to counter this deadly disease must involve workers, trade unions and employers in efforts to address the crisis through agreements and joint action." — General Secretary Bill Jordan, International Confederation of Free Trade Unions, World AIDS Day, 2001

Recommended Elements of a Workplace HIV and AIDS Policy

- Should be formulated around the principles of:
    - Non-discrimination
    - Equality
    - Confidentiality
    - Medical Accuracy
- People with HIV and AIDS are entitled to the same rights, benefits, and opportunities as people with other serious or life-threatening illnesses
- Employers should not require HIV screening as part of pre-employment or general workplace examinations
- Employers have a duty to protect the confidentiality of employees' medical information
- If fitness to work is impaired by HIV-related illness, reasonable alternative working arrangements should be made, to the mutual benefit of company and employee

Key Elements of a Workplace HIV and AIDS Program

- Having a widely communicated, properly implemented, equitable HIV and AIDS policy that counters stigma and discrimination
- Ongoing formal & informal education on HIV and AIDS for all staff, particularly via peer educators
- Availability of condoms to employees and their partners
- Diagnosis, treatment and management of Sexually Transmitted Infections (STI) for employees and their partners
- Where appropriate, voluntary, confidential HIV and AIDS testing and pre- and post-test counseling (VCT)
- Care and support services for employees and their families
- Treatment of opportunistic infections (OIs)
- Possibility of encouraging antiretroviral therapy (ARVs) where feasible

Are There Models of Success Out There?

Yes, though still surprisingly few, including:

- Standard Chartered Bank- Comprehensive program and ARVs for staff and spouses
- Hippo Valley Estates
- Cottco
- Dairiboard
- Unilever
- Dyno Nobbel

Sum-up

- Workplaces can make a huge difference in preventing and treating HIV and AIDS
- The financial impact of HIV and AIDS in the workplace makes workplace policy and programs necessary and cost-effective
- Working across sectors works best, Leadership from the top
- Dedicated resources, Staff involvement and surveys

- Involvement of People Living with HIV and AIDS in development and implementation
- Clear communications strategy

4.2.1.6 Gender Issues & HIV and AIDS- WASN's Experiences In Rural Settings By *Dr Manangazira*

Dr Manangazira began by giving some background information about how her organization, WASN, became involved in HIV and AIDS and how it began mainly by firefighting on behalf of women and girls.

The following is the full text of her presentation.

Background
- WASN is a women's organization
- Journey began in 1989 Society for Women & AIDS Conference in Africa
- need to look at HIV and AIDS as it relates to women and girls
    - fire-fighting in formative years
    - complaints of reaching urban women only
    - spread to other locations, many activities
    - Response to women's calls
    - programs in Masvingo, Gokwe, Mash. East
    - gender mainstreaming into WASN programs and other ASOs
    - little impact

An evaluation in 1997 showed that WASN was too wide and was spread too thin. It needed to concentrate efforts in one area.

Mission Statement
WASN is an organization that seeks to address the sexual and reproductive health needs of women and girls in the era of HIV and AIDS:
- Information
- Advocacy
- Women
- Youth

The Chikwaka Model Project
- HIV and AIDS threaten the lives of women and girls in Sub Saharan Africa
    - biological
    - socio-cultural
    - economic
- In Zimbabwe women and girls bear biggest brunt as affected or infected.
- Chikwaka is in Goromonzi District of Mashonaland Province, 50 Km east of Harare
    - high incidence of STIs, HIV, AIDS (Growth Point & Truckers)
    - WASN worked in three wards, Gutu, Dzvete & Mwanza

    - proximity to Harare
    - other developmental activities
- Baseline Findings:
    - Knowledge gap on sexual and reproductive health information
        - girls and women unable to manage relationships
        - girls and women subject to physical & sexual violence
        - high rates of STIs, teenage pregnancies
        - women could not negotiate for safe sex
        - women could not communicate with children on HIV and AIDS
        - women and girls generally lacked access to

Chikwaka Project Hypothesis

- Equipping girls and women with information and communication approaches on HIV and AIDS, sexual, reproductive health and rights would enable them to make informed decisions
    - leading to reduction of unplanned pregnancies, STIs & HIV, better management of sexual relationships,
    - open dialogue to create enabling environment

Purpose of the Chikwaka Model

- To provide information to women and girls on sexual and reproductive health & rights to deal with socio-economic problems related to HIV and AIDS at a personal level
- to provide support to women and girls through inclusion of community leaders, school system, health fraternity to create the environment
- to impart communication and assertiveness skills to women and girls so that they can be confident to make informed decisions and choices
- to make the women and girls aware of their sexual and reproductive health and rights
- to have documented purpose of sharing with other ASOs, NGOs lessons and processes

Components of the Model

- Entertainment and education
- Community mobilization (political, religious, traditional leadership)
- Integration of health system into program
- Creation of a supportive environment
- Linkages with organizations already working in Chikwaka
- The Reproductive Health Package

Methodology

- Clearance from Provincial Health Directorate, Local Govt., Regional Education Directorate, key community people
- Familiarization tour with Agritex,
- Secondary data review – Reproductive health components
- Training of WASN staff on Participatory Rural Communications Methodologies

- Questionnaire for individual interviews and guidelines for FGDs
- Pre-testing of questionnaire in Dzvete
- Representative sample selected

Data Collection
- Program used PRA to determine community perceptions, beliefs, myths, culture and knowledge about RH, sexuality and rights among women and girls
- Communication research to establish the women & girls' info and communication networks, channels, attributes, preferences, symbols and figurative language
    - to ensure relevant and appropriate info from a socio-cultural perspective
- Land use, social, village and resource maps
- Time line and trend lines
- Disease, water and food and activity patterns were discovered using seasonal calendars
- Wealth ranking, livelihood mapping, internal and external communication networks
- Semi structured interviews with elders to elicit the people's history and culture
- FGDs to investigate access to information from a gender perspective

PRCA & Baseline Findings
- Awareness of STIs and RH info and rights was low among women in Chikwaka
- Knowledge on methods that reduce STIs/HIV was extremely low indicating high risk behavior
- Many women were still bound by myths and misconceptions that tended to deter them using protection (women who carry condoms are loose)
- Women were at high risk of HIV infection as they could not negotiate safe sex, married women more so that unmarried women
- Level of formal education was low hence problems reading and understanding messages
- The study identified a good communication strategy in the community, traditional leaders being the most respected in the community
- Radios do play an important role in HIV and AIDS & RH info dissemination

Recommendations
- Appropriate materials to be availed to the community to enhance knowledge on sexual and RH
- To train community facilitators
- To involve men and boys in interventions on RH and rights programs
- To involve elderly women and traditional leaders in any RH programs as they are influential, trusted and respected.

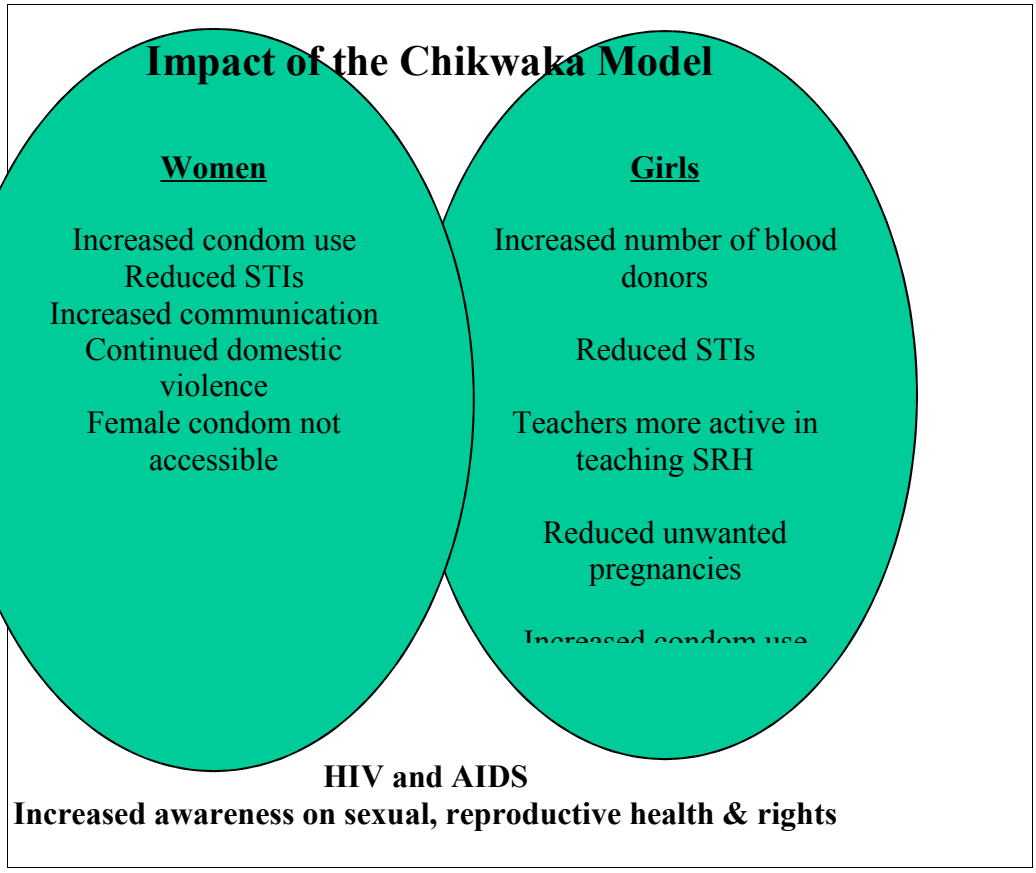
Outputs
- Communication strategy from the qualitative and quantitative findings
    - social mobilization
    - discussion and community dialogue
    - institutional training

- Media mix with traditional communication, theater, print materials
- Women's Reproductive Health Package (7 booklets)
- Girls Reproductive Health Package (6 booklets)

Evaluation of the Model

- Done by WASN Staff and a consultant – participatory approach
  - although project design focused on women and girls impact was on the whole community
  - women and girls are part of the community, they cannot be separated from people they live with

Impact of the model



Acknowledgements

- Many players deserve mention for support, advice and time:
- PMD Mash East, MOE, Police, Local Govt
- Chikwaka Community & Leadership, Women and Girls
- WASN Funding partners
- Our current and future implementing partners

4.2.2 Abstract Presentations

4.2.2.1 The Station Day Innovation: Data Collection Made Fun

Jennifer Lentfer, The STRIVE Project, Catholic Relief Services/Zimbabwe, and Justin Mucheri, Precious Somerai and Constance Chasi, Tsungirirai

Background

One of the most significant challenges of collecting data from children is finding a way to do it that is beneficial to both the child and the organization. Often times, and especially with children, data collection easily becomes extractive and can sometimes become exasperating for all parties. Tsungirirai, a CRS/STRIVE partner organization, has developed a remarkable innovation that not only makes it possible to regularly collect accurate data on children's health and psychosocial status, but also provides a useful tool for distributing material goods and disseminating information to children.

What is a Station Day?

Tsungirirai holds station days on a regular basis at a centralized location. All children participating in the implementation partner's interventions participate in the activity. At the entrance, each child receives a "ticket" that is used to verify the child's attendance and participation. Children then pass through various "stations" that vary with the type of information to be collected or given. Examples of stations include: height/weight measure, the "clinic" where a medical check up is performed, a "counselling room" where the child can discuss questions focusing on his or her home life (such as "What did you eat for dinner last night?" "Whom do you usually talk to if you have a problem?" etc.), an informational station in which they participate in a talk or discussion on topics ranging from personal hygiene to HIV and AIDS. Once a child has had all stations on their ticket checked, they can move to the final station, where they can play a game or receive a donated item such as soap or a school notebook.

Methods

Through a comprehensive operations research strategy, the STRIVE Project identifies proven models of care and support that have the greatest impact on the well being of children in Zimbabwe. The operations research process involves the collection and analysis of quantitative and qualitative data, before, during, and after implementation of project activities. The partners' monitoring and reporting systems provide most of the essential data for the operations research process, as well other research initiatives such as special studies. Data on interventions and specifically gathered from station days is compiled on a quarterly basis and is contained in STRIVE partner organizations' reports to CRS/STRIVE. The CRS/STRIVE OR Unit has also carried out direct observation and interviews regarding the station day innovation. The CRS/STRIVE OR Unit then generates reports showing lessons learned across partners and progress on project

indicators and operations research variables on the impact, cost- effectiveness, replicability, and quality of care that STRIVE interventions provide.

Results
Station Days have proven to be an exciting and extremely promising means of combining data collection with other activities for children. Most importantly, the data collected at station days has proven to be consistent, reliable, comparable, and much simpler to collect than with other methods. The response from children participating in station days has been overwhelmingly positive and station days have also included community members to assist in the activities, part of Tsungirirai's initiatives to sensitize communities on the importance of listening to children. Interactions between staff, community members and children also highlight concerns and problems of specific children so that follow-ups can be made.

Conclusions
NGOs and CBOs must make specific adjustments to conventional M&E and research methodologies and tools in order to adapt them to the specific ages, interests and situations of the children they serve. Most importantly, data collection activities must be interesting and fun for kids. Station days are a recent development in Tsungirirai's programming but initial indications are that station days are an extremely effective means of collecting data from children. Additional research and analysis is necessary to determine station days' replicability and to look for ways to improve, adapt, and expand the activity.

4.2.2.2 Challenges and Incentives for Adults When Considering Taking in Children Orphaned by AIDS

Nelia Matinhure and C. Chipere, Africare/Zimbabwe

Background
Africare is implementing a Community-Based Care, Protection and Empowerment for Children Affected by AIDS (COPE for CABA) in Mutasa District in Manicaland Province, designed to encourage and enable communities to share in the responsibility of caring for children affected by AIDS. The project provides education support, psychosocial support, and HIV prevention through 34 primary- and secondary- school based clubs, each consisting of 55 AIDS affected students and their caregivers. In July-2003, Africare carried out a baseline survey for this project with one of the objectives being to explore adoption barriers and incentives in the time of AIDS.

Methodology
A quantitative cross-sectional case control survey was carried out .Covering all 34 schools, the survey looked at samples of Club members from each school (cases); their classmates (controls) who were not Club members, matched to cases by gender and school grade and primary caregivers of children. 389 children and 372 caregivers were interviewed.

Results
The most important factors in an adoption decision are financial resources and degree of relatedness to the child, each cited by roughly one-third of caregivers. Fear and stigma surrounding AIDS persist but are not primary considerations for adoption. One-fourth of caregivers were willing to take in any orphaned child, even a stranger's, and larger proportions were willing to adopt any child from their own community, church, or home region.
Previous adopters were three times as likely as other caregivers to say they were willing to take in any child in need; clearly their experience with orphans had not soured them on adoption. Caregivers who had never adopted were more likely to say that the child's age, gender, and health (especially HIV status) mattered in an adoption decision. Insufficient food and money, enormous stress, and poor health are problems shared by both adopters and non-adopters, at comparably high levels. Caregivers' personal experience of adoption is generally positive, and most believe that adoptive caregivers gain in community respect.

Conclusions
Barriers to the adoption of children orphaned by AIDS are not primarily problems of attitude or culture but of economics and organization, and that effective incentives to adoption must reflect this reality. Adoptions occur where sense of obligation overlaps economic capacity. As a caregiver's economic means shrink, the circle of her priorities tightens. Funneling financial assistance to adoptive families in need and encouraging extra-familial adoption will require a supportive mechanism outside the family. An education and advocacy campaign can encourage extra-familial adoption by highlighting its successes and reducing misgivings about "AIDS orphans.

4.2.2.3 The Extent of Orphan hood and Vulnerability of Children in Two Districts of Zimbabwe

S S Munyati ,[1] B Chandiwana,[2] S J Rusakaniko,[3] P Chibatamoto [2], F Mupambirei, [2,4] S Mahati[1] , G Chitiyo,[2] J Mutsvangwa, [2,] W Mashange[1]

Ms S Munyati

Background: A 5- year intervention project on orphans and vulnerable children (OVC), their families and households was commissioned by WK Kellogg in Botswana, South

Africa and Zimbabwe, through the HSRC (SA). In Zimbabwe, as an initial step, an OVC population census was conducted in Bulilimamangwe and Chimanimani to document the extent of the problem.

Methods: Information collected from house to house, using a questionnaire. Orphans were children 18 years and below who had lost a mother, a father or both parents. Nine household indicators for vulnerability where assessed, i.e. " frequency of meals per day"; "households that some days go without food"; "children of school going age not going to school"; "inability to pay for medical fees if children are sick/ill"; "inadequate clothing for children"; "very ill person in household during the past month"; "inadequate uniforms for school going children"; "absence of caretakers"; and "absence of someone to discuss problems with".

"Vulnerability Score" defined using all the vulnerability indicators, adding up all individual indicator scores to come up with a Total Vulnerable Indicator Score (TVIS) and divided into 3 categories;

1. Less Vulnerable: - TVIS < 50% of the total score.
2. Moderately Vulnerable – TVIS between 50%-75% of the total score.
3. Highly Vulnerable - TVIS >75% of the total score.

Results: Prevalence of orphans was 25.9% (22 388/86 445) *(95% CI: 25.6% - 26.2%)* for Bulilimamangwe and 29.2% (16 217/55462) *(95%CI: 28.9% - 29.6%)* for Chimanimani district. The most common type of orphan was with father dead (16.7% and 18.2% for Bulilimamangwe and Chimanimani respectively).

Bulilimamangwe had higher level of "moderately vulnerable" (27.7%), and "highly vulnerable" households (2.4%), as compared to Chimanimani, (17.0% and 0.5%), respectively. A larger proportion of HH, 47.2%, in Bulilimamangwe, were having one meal a day compared to 10.2% in Chimanimani. Similarly, those HHs "going without food" (72.6% vs. 65.4%), "with children of school going age not attending school" (25% vs. 17.6%) and "not being able to pay medical bills" (45.5% vs. 35.4%) where reported more in Bulilimamangwe than Chimanimani. Proportion of children who did not have caretakers in both districts was 55.5% and 46.9%, and those not having someone to discuss their problems with, 29.7% and 36.6% for Bulilimamangwe and Chimanimani, respectively. "Child-headed" households where reported more in Bulilimamangwe (4.9%) than in Chimanimani (3.2%).

Conclusion: OVC Census was able to document the extent of the problem in the two sites as well as the types of orphans that are more prevalent. Use of the TVIS is a very plausible method of assessing "vulnerability" of HH and has potential to be adopted for future surveys. Results emphasize the importance of collecting baseline data for planning of interventions.

4.2.2.4 Girls speak their minds to protect their futures: A study to explore the sexual health needs of young women affected by AIDS in urban Zimbabwe

Elizabeth Jasi[1] and Priscah Makwati[1]
Co-authors: Netsai Mudziwapasi[2], Sostain Moyo[1], Abel Zimunya[2], Tomaida Banda[2], Isolde Birdthistle[3], Farirai Mutenherwa[5], Judith Glynn[3], Simon Gregson[4]

Ms E Jasi and Ms P Makwati

Background

In what UNICEF has recently called a "crisis of gargantuan proportions", 25 million children are expected to have lost one or both parents to AIDS by the end of this decade. In Zimbabwe, 21 percent of all children may be orphans in the year 2010, more than one million due to AIDS. It is expected that desperate conditions and the absence of adult protection leave orphaned children vulnerable to abuse and sexual exploitation, thereby increasing their vulnerability to HIV infection and perpetuating a cycle of orphanhood, poverty and risk. In a recent systematic review of research, it was found that few studies have investigated the relationship between orphanhood and HIV risk in adolescents.[i] There is a need to understand how orphanhood and other effects of AIDS may influence vulnerability to HIV so that sexual risks to affected adolescents can be mitigated.

Methods

The study objectives, methods and research instruments were developed collaboratively by staff of the Child Protection Society (CPS), peer counselors of the Zimbabwe AIDS Prevention Project (ZAPP), and researchers at the London School of Hygiene and Tropical Medicine and Imperial College of London. The initial phase consisted of anthropological research methods and was conducted by and with young women in Highfield and Chitungwiza. A series of 11 focus group discussions explored local perspectives on girls' vulnerability and measures to protect adolescents affected by AIDS. The groups include:

- 6 groups of adolescent girls, separated by age (13-15 and 16-19 year olds) and whether orphaned;
- 2 discussions conducted by and with young HIV-positive members of the ZAPP Batanai support groups;
- 3 groups of adult community members in Highfield.

Findings from the group discussions were synthesised and analysed through content analysis and participatory reflection sessions with the facilitators.

Results
Preliminary findings indicate that young women believe that adolescents orphaned or affected by HIV and AIDS are particularly susceptible to abuse, including verbal, physical and sexual abuse by relatives. Such abuse is often sanctioned by social structures, like pressure on young women to marry early; facilitated by traditional practices such as *chiramu* and *chigadza mapfihwa* and pressure to marry early; and at the hands of step parents.

Conclusions
The experience to date shows that young Zimbabwean women, including those living with HIV, can and should conduct scientific research as a tool to explore and voice their needs and ideas. Some of the demands voiced by young women include:

- It is time to break the taboos that silence parents – encourage them to discuss HIV and sexual health with their children
- Reduce pressures on young women to marry early: create job training and opportunities for young women and promote models of "sisters doing it for themselves"
- Find ways in urban contexts to influence cultural practices that are harmful to girls and young women.

4.2.2.5 Adult mortality and the economic sustainability of households in towns, estates and villages in AIDS-afflicted eastern Zimbabwe

Phyllis Mushati, Cleopas Zvidzai, James Lewis, Simon Gregson

Background: This study measures the impact of adult death on household income, expenditure, capital and survival in communities in eastern Zimbabwe subject to sustained crisis level mortality.

Methods: Data on household-level socio-economic effects of adult terminal illness and death were collected from primary caregivers for persons dying between 1998-2000 and 2001-2003 in a household census and cohort study conducted in small towns, commercial estates and rural villages in Manicaland.

Results: 268 adult deaths were identified. 78% of the deceased were the predominant income earners (75% plus) for their households. Fewer deceased women [OR, 0.39; 95% CI, 0.21-0.73] and people dying in village households [OR, 0.34; 95% CI, 0.17-0.70] were predominant income earners. More men (34%) than women (13%) had been in employment and 60% of each lost their job due to illness. Median expenditure on healthcare costs and funeral expenses were Z$2,000 (US$36) and Z$10,000 (US$180). Costs were highest in the towns and lowest on the estates. On average, 42% of healthcare costs were met by the sick person and his/her spouse, 41% by household members and

14% by non-resident family members. Most funeral expenses were met by household and family members. Asset sales to raise funds for healthcare (9%) and/or funeral expenditure (8%) were reported in rural households (14%). One-in-seven caregivers gave up a job to care for the sick. One tenth and one quarter of households dispersed and relocated following an adult death, respectively. Households in towns (43%) and estates (25%) were more likely to relocate than village households (17%) [OR, 2.45; 95% CI, 1.37-4.38]. Most households relocated to rural villages.

Conclusions: Heavy expenditure, losses of income and erosion of capital assets associated with adult deaths undermine the economic viability of households in eastern Zimbabwe. Households in subsistence farming areas bear the brunt of the epidemic but face deepening poverty.

4.2.2.6 SCALING UP THE NATIONS RESPONSE TOWARDS HIV and AIDS PROGRAMMES: PARTNERSHIP between UNAIDS and NATIONAL AIDS COUNCIL

UNAIDS Zimbabwe's experience

Victoria Ndlovu

Ms V Ndlovu

Statement Of The Purpose

To present modalities of how UNAIDS works through NAC community structures in fostering and enhancing community responses by utilizing the district as the focus of Implementation in six major areas of focus

Brief Description Of The Project

The project adopts priority strategies and interventions identified in the National Strategic Plan on HIV and AIDS and the National Aids
Policy. Districts are assisted in implementing community level interventions that

- Prevent transmission of HIV infection particularly among young girls and adolescent
- Care and support for the infected and affected youths
- Mitigate the impact of HIV and AIDS through microfinance and orphan support

- Strengthen the NAC institutional structures capacity to respond to the epidemic
- Advocate for greater involvement and commitment of political, religious and other opinion leaders in HIV and AIDS program

The emphasis in this project is that communities need to be empowered in order to respond to the HIV and AIDS crisis as a socio economic developmental problem. The leadership role towards HIV and AIDS in enhanced in various aspects.

The project is being implemented in

❖ Mash Central	Rushinga
❖ Midlands	Gokwe North
❖ Masvingo	Bikita
❖ Mash East	UMP
❖ Manicaland	Buhera
❖ Mat South	Bulilima
	Mangwe

The expected outcomes include

- Increased knowledge on HIV and AIDS and clear indicators of behaviour change among youths
- Greater understanding by religious leaders, political leaders on their role in fighting the epidemic in the districts
- Better planning of district and AIDS activities

Lessons Learnt

- Community empowerment towards managing and responding to the decentralised HIV and AIDS programmes
- Establishing Ward & Village Aids Action Committees
- Opening of Ward accounts
- Development of WAAC accounting and training manual
- Integrating recreation into Youth Friendly Centres
- Leadership training for youth leaders & youth taskforces in HIV and AIDS
- Best approaches in HIV and AIDS prevention strategies among youths

4.2.2.7 Impact of the Tsungirirai Orphan Programme on Child Outcomes – Norton, Mashonaland West Province, Zimbabwe, 2002

Christine Chakanyuka, G.Woelk, M. Tshimanga, D.Jones, W.Nyamayaro

Introduction: Zimbabwe has a steadily growing number of orphans as a result of the HIV and AIDS pandemic and the extended family is struggling to cope. Community-based models have been proposed and implemented, but until now little has been known about the impact of these programmes on child outcomes. This report evaluates the Tsungirirai Orphan Programme, a community-based initiative in Zimbabwe that provides food, educational, medical, and psychological support to orphans under its care.

Methods: We report on a retrospective cohort study of 231 orphans. For every assisted orphan, two non-assisted neighbourhood orphans were chosen; they were frequency matched for age and orphan status. The main outcomes (academic performance, psychological, nutritional and health status) were compared for the two groups.

Results: There was a significant, positive association between being in school and being assisted by Tsungirirai [RR = 0.07, 0.01-0.50, p< 0.01]. Adjusted for age, assisted orphans in the school-going age group (i.e., 7-18 years of age) had higher levels of academic performance than their non-assisted counterparts [ARR= 0.33, 0.18-0.59, p<0.01].

Assisted orphans also had fewer psychological symptoms than non-assisted
Orphans [ARR= 0.42, 0.27-0.64, p<0.01]. Health and nutritional status were similar for both groups.

Discussion: Overall, the Tsungirirai Orphan programme has had a positive impact on the academic achievements and psychological well-being of the orphans being served. Impact studies such as the one reported here should be done at the national level in Zimbabwe and other countries that have a substantial number of HIV and AIDS orphans in order to determine the most effective approach to caring for this vulnerable population.

4.3 Recommendations from breakout sessions

4.3.1 Recommendations on Orphans and Vulnerable Children

- The Department of Social Welfare should take a leading role in the development of a minimum standard package for OVC care in consultation with other organizations and line ministries involved in care of OVC. The Department of Social Welfare should take leading role to coordinate all organizations government, NGOs etc working with OVC.
- All government line Ministries should have a coordinated approach especially at District level to lessen duplicity
- Government to make efforts to improve on staffing in Dept of Social Welfare and have at least 3 officers per district
- DAAC structures should be strengthened to act as effective platforms for communication and sharing of information for the various OVC organisations, ASO etc working with OVC. They could also be used a platform to inform about results of researches conducted
- Social Services Action Committee should expedite the formalization of the National Action Plan and its adoption so that the roll- out of activities can be implemented without further delay
- Demystify psychosocial support. Organizations providing PSS to act together and identify forms of traditional PSS.
- Engage and consult children on their needs and what interventions they want

- Lessen the bureaucracy for children to access social services such as access to education, health and other services
- Universal free primary education should be re-introduced, and be funded properly.
- Through a meeting of various stakeholders, come up with strategies for communities to "own" the programmes so that they become more sustainable. Put in place programmes that can be sustained within the community by giving start-up capital for OVC and the caregivers.
- Programs should focus on family integration not institutional care. Already established institutions (orphanages) should open themselves to local communities and establish linkages and integrate into community. Could identify parents within these communities willing to foster children. These families should then be supported by Social Welfare if unable to do it on their own.
- Avoid separating children by mobilizing community on child fostering and dispelling cultural beliefs that prevent families from taking in children that are not their own.
- Encourage the traditional practices at community level that foster the care of the child. Mobilize and educate the community about child-headed households so that they take on these children as foster parents and avoid children having to live alone.
- Establishment of "half way houses could be another option as a temporary home for the children until a home is identified.
- A national Census of OVC similar to what has been done in 2 districts by the national Institute of Health Research (former Blair Research) should be conducted where uniform standard methods are used for data collection and meaningful comparisons can be made which can them be used or incorporated into the national Action Plan for OVC
- There is need to co-opt Media Representative and Private Sector in these OVC intervention programmes for publicity so that people are made aware of what is happening and also for resource mobilization purposes.
- The State should facilitate birth registration at clinics or allow the children to register through organizations that are working with the orphans. In many instances the village head can estimate the age of the child and this facilitates the registration of the orphans

4.3.2 Recommendations on Economic, legal and Institutional Support

- Any child who is born in hospital should have a birth certificate issued before that child is discharged from hospital. Zambia does the same and it works.
- For those children not born in hospital, the registration of births should be simplified and decentralised so that people such as ministers of religion and traditional leaders can be capacitated to issue birth certificates.
- Education on the issue of birth certificates should be intensified especially at grassroots level.

- There is need to come up with strategies to address the problems of those children who at present do not have birth certificates. They should be allowed to sit for public examinations, to avoid causing undue hardships.
- There should be compulsory partner notification as well as notification of all those who have a vested interest in the person's HIV status e.g. carers, marital and non-marital partners.
- Given the problems associated with proving infection in the case of willful transmission of HIV, the law should be amended so that the offence includes willfully putting someone at risk of infection, whether or not such exposure results in infection.
- There is need to put together a legal taskforce on HIV and AIDS, which will consider issues of ethics, and human rights in proposed law reform e.g. it will be tasked to consider issues of compulsory testing, compulsory notification etc.
- On the issue of compulsory testing, lessons can be drawn from the Botswana experience where routine testing of people visiting health centres is being carried out. A person is then given the option of knowing the outcome of his/her results.

4.3.3 Recommendations on Workplace Mitigation

- Statutory Instrument 202/98 should be completely revised since it has a number of gaps, which include gender gaps. Such revision should be done with the involvement of all stakeholders i.e. business, government, NGOs.
- Couples should not be separated because of work demands.
- There is need for every company to have an HIV/ AIDS policy. To this end, there should be in place guiding principles as to the minimum expected from a workplace programme.
- Companies should show their commitment to workplace programmes by adequately budgeting for them. In addition there is need for innovation in fundraising. Leadership commitment should be supported by budgetary allocations to workplace HIV and AIDS response at enterprise level.
- It was suggested that since so much money is being repatriated by Zimbabweans living abroad, if a percentage of that money was diverted towards HIV then it would boost the resources available to initiate HIV programmes.
- There is need for companies to put in place for their employees who have reached retirement age or who have had to go on retirement owing to ill health, better post retirement care/ social safety nets. This is because employees, who have been contributing to the national AIDS levy and medical aid, sometimes find themselves destitute after they leave work.
- There is need to come up with effective strategies to involve the informal sector in HIV and AIDS workplace programmes because the informal sector is increasingly becoming a major employer in Zimbabwe. In this regard, the suggestion was made to make the existence of HIV workplace programmes as a pre condition for engaging in a particular business in the informal sector.

- There is need for social security for the informal sector, i.e. medical insurance etc. It was suggested that lessons could be drawn from the Tanzania comprehensive social security programmes in the informal sector.
- Poverty and underdevelopment fuel the epidemic and any interventions should also address these issues. There is need generally for interventions to look at the underlying causes fuelling the epidemic and try to address those underlying causes.
- There is need for greater coordination of efforts and interventions by industry. It was noted that the Zimbabwe Business Council on HIV and AIDS, could play a central role in coordinating industry's efforts.
- There is need for incentives for companies with HIV and AIDS Workplace programmes, such as tax breaks. This will encourage companies to expend more resources on workplace programmes.
- For those companies that have workplace programmes, there is need for them to integrate nutrition into their programmes, not just for their employees, but also for the dependants of these employees.
- There is need for any workplace programmes e.g. training, to include spouses and partners of employees.
- A generic workplace policy should be developed to guide sectors and enterprises to develop their own workplace policies or policy frameworks or codes of conduct to guides their responses. This should be guided by the national policy, the statutory instrument, the ILO Code of practice on HIV and AIDS and the world of work and the SADC code on HIV and AIDS and employment.
- Workplace prevention programs should be comprehensive and guided by the policy principles and strategies. Components should include:
    - Prevention: VCT access, condom promotion, nutrition education, STI management, peer education, and access to referral facilities
    - Care .STI management, nutrition, home based care counseling and support, treatment and support
    - Mitigation strategies.
    - Media care, use of performing arts and IEC
- The Zimbabwe Business Coalition on AIDS (ZBCA) should work closely with other key stakeholders to execute its mandated roles including compilation of best practices and dissemination of information to the businesses to enhance their capacity to response, enhance partnerships, influence policy on workplace responses and support capacity building for program management.
- Businesses and workforce should come up with innovative health insurance schemes as security for those infected and affected by HIV and AIDS for long term sustainability of impact mitigation and access to ARVs.

CHAPTER 5
SUMMING UP AND THE WAY FORWARD
DAY 4

5.1 Summary of day's proceedings

Day 4 was the last day of the conference and was taken up mainly with summing up, agreeing on the main issues raised and the main recommendations of the conference. The issue of lack of coordination of the various players kept coming up throughout the conference and NAC was asked to lead discussion on this topic.

NAC reminded participants that it was established through the National AIDS Council Act Chapter 15:14 of 1999 to coordinate, facilitate, mobilize, support and monitor the decentralized national Multi-Sectoral response to HIV and AIDS in accordance with the Zimbabwe Strategic Framework for HIV and AIDS interventions (2000-2004) and to administer the National AIDS Trust Funds (NATF) and other donated resources. However, this has proved to be a difficult task and some of the challenges it has faced are:

- Difficulty in bringing different stakeholders to work together
- Limited multi-sector response framework experiences and lessons learnt
- Amount of resources that reach the targeted beneficiaries vs. the budgeted resources
- Accountability of the players to the community
- Low priority given to effective monitoring and evaluation

- Absence or ignorance of the national policies, guidelines and standards by he partners
- Competing and changing priorities.
- Overwhelming demands and needs to be met with limited resources

The following issues were raised from the NAC presentation:

- Some delegates observed that people attend DAAC meetings, but they do not seem to have a constituency to report back to, nor a forum for feedback. The challenge is to create an enabling environment for coordination.
- Delegates also observed that patients are not able to pay for care, i.e nursing care which is vital for the dignity of people living with HIV and AIDS. In such cases, NAC has to set aside a budget to pay or support people providing day-day care for people who are ill.
- The presenter advised that the cost of a simple HBC kit is about $300 000. NAC can and will provide this basic HBC kit. But there is need for community and family involvement when it comes to actual care. NAC cannot pay for nursing care.
- Another delegate wanted to know what mechanisms NAC has put in place to prosecute people who misappropriate NAC funds. The meeting was informed that there are mechanisms in place to monitor usage of funds and prosecute offenders.
- Delegates were also concerned that the money is not getting to the people in need fast enough. It was also observed that the economic base from which NAC is drawing its funding is shrinking. Delegates wanted to know what NAC is doing to mobilise resources from such sectors as the new farming sector and the informal sector. The meeting was informed that NAC is working to consider other sources of funding and the mechanisms to implement such mobilisation. In addition, it has funded government and other agencies to mainstream HIV and AIDS so that they have budgets for HIV and AIDS activities and programmes in their business.
- The question of meaningful involvement of implementers was raised, the delegates wanted to know whether NAC had for example consulted implementers when it coming up with its M&E tools. The delegates urged NAC to not only coordinate but also to bring implementers at local level together so that there is exchange of ideas.
- The meeting was informed that NAC discusses issues that come from the grassroots. There is need for NGOs and other local level implementers to meet at local level. An example of where this has happened effectively is Makoni District where local NGOs and all other actors meet monthly and a report is submitted to the DAC, and from there it goes up the NAC structures.
- The meeting was told that NAC has provision in its budget for income – generating projects for PLWA and that this is done through the local level NAC structures. This response was given in answer to a question posed by a delegate as to what was being done about empowering PLWHA in terms of making them self sustaining.
- NAC was asked whether it was possible for it to facilitate the fast track production of ARVs. The presenter advised the meeting that NAC currently has a

budget of about $7 billion for ARVs production/ procurement. However there are currently shortages of forex and these shortages are impacting on the programme.

(See 5.2.1 for the full presentation by NAC)

Mr Manenjiof NAC

Dr B Manyame, the chairperson of the Conference Organising Committee, presented a summary of the main issues that had been noted from the conference deliberations and a summary of the main recommendations noted from all the sessions. **(See 5.2.3 for the main issues and recommendations)**

The presentation of the main issues and recommendations was followed by a general discussion. The **following points and recommendations were raised about the conference main issues and recommendations:**

1. There is need to establish a website to post the recommendations coming out of the conference to enable further discussion beyond the conference- to enable even other countries to learn from our experiences.
2. The other option is to publish a newspaper supplement, perhaps twice a year, with updates on implementation of workshop recommendations.
3. There is need to set up a task force to follow up and monitor the implementation of the recommendation of this conference.
4. There is need to group recommendations into thematic areas.
5. There is need for recommendations to be time-bound.
6. There is need for a paradigm shift in the way we conceptualise human rights, to include such rights as the rights to health, the right to life etc.
7. There is need to ensure ARVs are not only accessible to people in positions of power but that they also reach out to the grassroots.
8. MOHCW should address the issue of brain drain from the health sector as it is resulting in undue hardship for people.
9. Nutrition should have been made a top priority- it should be part of the package of treatment and care. This should be available at all hospitals and clinics.
10. Conference has adopted a too top-down approach thus discouraging participation of grassroots people and PLWA.

11. The issue of population mobility and vulnerability was not adequately covered during the conference, there is need to come up with recommendations to tackle this issue.
12. There is need for openness about their status among HIV and AIDS activists, whether positive or negative, to encourage uptake of VCT among the general population.
13. Prison population has been neglected. We need to come up with recommendations for interventions in this sector.
14. Need to work with the informal sector as well as SMEs.

The conference ended with a closing ceremony at which the following organizations spoke: **EU, UN, ZBCA and PLWA and the Deputy Minister of Health, Angola(See 5.3 for all the remarks the various organizations)**

Dr David Parirenyatwa, the Minister of Health and Child Welfare then closed the conference with the following remarks:

Minister of Health and Child Welfare's Remarks

1. Expected the conference to come up with recommendations on testing which are specific. E.g should there be compulsory testing? Or should it be routine as in Botswana. Or should we retain VCT.
2. Need for conference to come up with recommendations on what behaviour change strategies the MOHCW should focus on.
3. Health financing is of concern to the Ministry. However it is not a MOHCW issue alone. The conference should have come up with recommendations on this issue.
4. There is need to distinguish between HIV and AIDS.
5. The MOHCW position on testing:
   -testing for behaviour change- VCT
   - testing for service delivery, for ART, other treatment and care
   - Routine testing for PMTCT.
   - Mandatory testing in rape and other sexual offences.

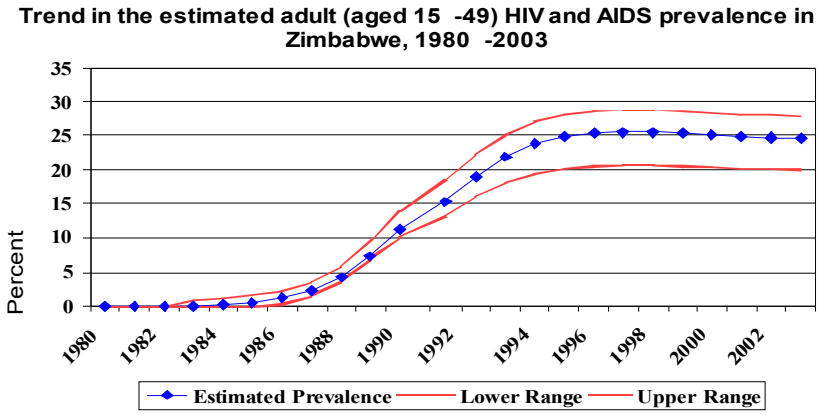
5.2Presentations of the day

5.2.1 Presentation by NAC on Coordination

5.2.2 Summary of the Key Issues and Major Recommendations of the Conference

5.2.2.1 Main achievements of HIV and AIDS Response So Far

The rise in HIV prevalence rates has reached a plateau
The conference noted that there is evidence that the emphasis on prevention in the HIV



and AIDS programme was now bearing fruit, as shown by the leveling off in the rise of the prevalence rates in sexually active adults (see graph below). The country now seems to have finally reached the plateau and should intensify efforts towards a decline in the prevalence rates.

All sectors involved in the response
The conference also noted that this has been achieved with the involvement of all sectors of Zimbabwean society, from government, the private sector, non-government organizations, bilateral and multi-lateral partners as well local communities and community-based organizations.

Expansion of VCT centres
Voluntary counseling and testing (VCT) facilities are being set up throughout the country, though it was noted that the rural areas are still under-served.

ART and PMTCT scaling up
Though the emphasis up until recently had been on prevention, it was noted that with the recent decline in the prices of anti-retroviral drugs (ARVs), a well thought-out anti-retroviral therapy (ART) implementation scaling up had started, again involving all sectors, so as to effectively cater to the needs of those already infected. PMTCT implementation has also expanded and is operational at district hospitals in 43 of Zimbabwe's 58 rural districts, as well as all the major referral hospitals.

OVC Policy
The conference noted that an overall policy on mitigating the effects of HIV and AIDS on orphans and other vulnerable children (OVC) had just been concluded and should assist in coordinating mitigation efforts in all sectors.

High level of commitment by all partners
Another of the main achievements of the national HIV and AIDS response has been the visible show of commitment from all partners, as evidenced by the:

- Establishment of HIV Policy in workplace, National AIDS Policy & other policies on Home Based Care, OVC etc.
- Creation of a Multi-sectoral National AIDS Council.
- Establishment of National AIDS Trust Fund which has so far cumulatively collected more than 26 billion ZW$.
- Establishment of District Response through VAACs, DAACs & PAACs.
- Declaration of AIDS as a National Emergency to improve access to AIDS drugs.
- Funds for ARVs in the Ministry of Health and Child Welfare budget since 2002.
- Establishment of community based ASOs.
- Focal persons for HIV and AIDS in all Govt department and some private sector organizations.
- Establishment of Business Council on AIDS.
- Stronger partnerships forums (CSAC, GF-CCM etc).

Details of these and other achievements can be found in the main body of the report.

5.2.2.2 Key Lessons Learnt

Coordination is essential
One of the key lessons observed was that though the response has involved all sectors, it has not been as coordinated as it should have been, at all levels. The need for better coordination was observed in all areas, from prevention to care to mitigation efforts, and that there is need for all organisation to be willing to work under one umbrella policy and programme and to buy into it based on their comparative advantages.

Emphasis on prevention is essential
Given the signs of plateauing in the rise of the HIV prevalence in sexually active adults, it was noted that prevention needs to remain the mainstay of response to turn the tide of the increase in new cases and lessen the burden on service delivery facilities in all sectors.

ART needs to be comprehensive and planned carefully
It was noted that though care for those with AIDS had started, it has not always been comprehensive and tended to focus on ARVs, rather the needs of the whole person. In particular, it was noted that better nutrition has been shown to be effective for enabling patients with HIV and AIDS to lead healthier and more productive lives and should form an integral part of the care package.

The nation could also learn from the experience in some countries in the region which show that unless ART scaling up is careful planed, it could result in periodic stops due to shortages of drugs and other essential materials.

Need for involving beneficiaries of programme such as youths, PLWAs and the disabled

Some specific segments of society eloquently spoke of the need to more meaningfully involve them in programmes that are targeted at them and which affect them, at all stages from planning to implementation an monitoring/evaluation. In particular youths, the disabled and people living with HIV and AIDS (PLWA) felt that though efforts have been made to address their needs, they were not always involved in formulating them so as to make them more relevant.

Information dissemination/sharing is essential

It was also observed from though there is a huge amount of information, it has not been well disseminated or shared with relevant others who could benefit from it. This included, the need for better dissemination/sharing of information such as guidelines, policy documents, studies and evaluations

Need for regular updates in policies related to HIV and AIDS

It was also noted that policies related to HIV and AIDS need to be updated regularly to keep them relevant to a changing environment.

5.2.2.3 Areas needing improvement

Based on the lessons learnt, the following main areas were identified as needing improvement:

- Better coordination in all activities and all levels, since this has been identified as one of the main weaknesses of the response effort so far
- More openness to fight stigma and discrimination associated with AIDS
- Intensification of the prevention efforts, so as to reduce new infections and eventually the prevalence rates in the population.
- Speeding up and expanding access to ART, while making it more comprehensive to include other aspects such as nutrition care.
- Paying more attention to improving access of services to women and children
- Greater involvement of youths
- Involvement of PLWA
- Improving the human resource capacity, both in terms of skills and numbers
- Increasing the uptake of counseling and testing services, particularly in under-served rural areas.
- Resources for OVCs (incl. children in institutions)
- Resource mobilisation for scaling up ART, for example

5.2.2.4 Overall Summary of Recommendations from All Sessions

N.B: Please see Chapter 6 for more detailed recommendations of the conference on the three main themes of Prevention, Care and Mitigation.

The following is a summary of recommendations, which should be considered in conjunction with the thematic recommendations from each conference session.

1. Improve coordination in all activities and all levels
2. Build on and intensify prevention efforts to start the reduction of the number of new cases
3. Improve access to ART by
   i. Reaching more clients
   ii. Ensuring uninterrupted drug supply
   iii. Reducing the cost by working with local drug manufacturers to make the RVs more affordable
   iv Removing duty on imported raw materials for ARVs
   v. Being more comprehensive and including other care aspects such as nutrition and traditional remedies which have been shown to be effective
4. Improve access of services to women and children
5. Involve youths in programmes targeted at them
6. Involve PLWA in all aspects of the response
7. Improve human resource capacity through
   a. Training and skills development in all aspects of the response e.g during ART scaling up
   b. More innovative human resource retention schemes
8. Increase uptake of counseling and testing, particularly in rural areas
9. Improve resources for OVCs (incl. children in institutions)
10. Intensify resource mobilisation such as for ART scaling up
11. Regularly update policies related to HIV and AIDS
12. Ensure needs of the disabled of all types (deaf, blind, etc) are taken into account when drawing up interventions
13. Improve the dissemination/sharing of information such as guidelines, policy documents, studies and evaluations

6... Improve services to migrant populations and refugees

5.2.1 Closing Speeches and Remarks

5.3.1 Remarks at Closing Ceremony by Dr. Jose Van Dunem, Deputy Minister of Health, Angola.

Dr Van Dunem

The Hon Minister of Health and Child Welfare, Dr. David Parirenyatwa, dear members of high table, dear ambassadors, members of NGOs, partners and common fight against AIDS. I would like once more to begin by thanking you very much to the government and people of Zimbabwe through the Minister of Health Dr. Parirenyatwa for the hospitality of this country. I join also my thanks for the opportunity to see to participate to be a witness of the commitment of all people of Zimbabwe Minister of Health and the leadership NGOs Civil Society people living with AIDS all joined trying to push analysing the conquest and the mistakes committed in the past in frank participative dialogue in order to achieve as quickly as possible the wish to get Zimbabwe free of AIDS. Unfortunately the trends show that the trend of epidemic has changed now its not growing. It's good; it reflects that your work is good. And this is a good lesson for us. We are in a different stage, as I could say in my form of communication we have had 30 years of war and more than 70% of infrastructure has been destroyed. We did not have enough time to train our professionals, our staff. Even the NGOs don't have yet the performance. I have had the opportunity to see here but this is our momentum and we must live our momentum but we are obliged to learn from others who have in the past lived these moments we are living now in order to speed up through the same goal that shall free our country from HIV and AIDS. But I don't agree with my friend David, when he said that this is a good document "Guidelines to manage the dietary situation with people living with AIDS". This is not a document, this is a hotel, it's an enormous hotel they are giving us not only you but also us because in my country it's a weak point they are facing to improve the dynamic in the fight against AIDS. And the respect to choose our nutrition because there are a lot of documents and books talking about nutrition but they are preoccupied talking about other diets but not our diets, mealie-meal, the number of calories, it has, the enormous number of calories in butternuts. Thank you very much David, it's wonderful tool you are giving us. I would like once more to thank you very much and I repeat once again "your fight is our fight." The success of SADC passes through Zimbabwe. Thank you all for what you are doing in the fight against AIDS in the whole continent and sub region. Thank you.

5.3.2 Remarks at Closing Ceremony by Mr Lovemore Kadenge, Zimbabwe Business Council on HIV and AIDS.

Mr L Kadenge

Thank you very much Mr. Chairman. I have been attending this meeting since Tuesday and I thought one of the resolutions if resolutions were read would have been. What I observed during the four days was the interventions by the private sector and industry in the workplace are fragmented. There is need for greater coordination of effort and intervention by industry in this regard. And I would want to say that the Zimbabwe Business Council on HIV and AIDS (ZBCA) was launched in September last year and 13 companies actually came together and formalised the wish of the business community to form a coalition of business partners with a common goal in the fight against HIV and AIDS thus how the ZBCA was born So these four days have been a revelation to me and I could see that from the concerns raised in the various workshops in the various breakouts rooms where I was especially workplaces that there is a gap, there is so much happening that we can't wait any longer. And maybe for the purpose of this I just want to say the vision of ZBCA that our main vision was to act on the impact of HIV and AIDS in the workplace and in the community at large and to implement measures to prevent, control, mitigate and stop the spread and to alleviate the suffering of the afflicted families. When we went through the three days where we were looking at mitigation and others we looked at the strategic objectives of ZBCA briefly and I will end just now was to identify and actively undertake community related projects that have an impact on the reduction of HIV and AIDS in Zimbabwe to partner with other stakeholders both locally and internationally to strengthen the capacity in the fight against HIV and AIDS and to be the voice of the business and to influence policy in HIV and AIDS in Zimbabwe. Develop, implement and sustain best practices in workplace programs on HIV and AIDS and finally to develop strategies, and programmes to reduce infection rates in the workplace. And you find that in other countries the actual workplace coalitions of business long back but for us it's better let than never just as we heard that the first infection was detected in 1985 but of course it has taken us 20 years to have a workshop but it's commendable that already different people are doing different roles and I think the main thing is as the ZBCA we want to coordinate a business to come together and take advantage of different experts medical experts we have here, the donors, civic societies and also work very actively with government to share in the problem of how we can eradicate or at least cut costs as it is. And I feel that it's not just a social issue or a moral issue, HIV is a business issue it's really a cost itself. And for this I know people will say what have you been doing but this is my fifth week in the office and we just recently established an office at one of our companies, Unilever, that's the host company so for those members, currently

we have 13 members, so for those who are in the business sector who would like to join us because we would want to share the various experiences which I also noted over the past three days that different companies have their own policies. But I think the idea is to have a coordinated way, we heard from the President and I think the minister as well said we have over 300 institutions working on the issues of HIV and AIDS. I don't think it's possible for government to be dealing with 300 different people, so I feel that the issue of ZBCA we can coordinate the business sector and come together. Finally Mr. Chairman the ZBCA would like to commit itself to work very closely with the government and for that we have committed ourselves to support the CR-ROM for what has been happening at the conference the ZBCA supported the production the CD-ROM to the tune of $50m and one of our major companies as well Cottco I think have given a donation of $50 million. We will try to work very closely with the donor community with government but I think the participation of various partners is very crucial when you come to a donor, you should have your own ideas of what you need to be implemented rather than for you to listen because I could hear from different people complaining that so many donors come in but I think in our communities wherever we are as leaders we must get together and come up with their views and then we use the various experts who work together so I wish to thank all of us especially the business community in particular have been very excited to come to this conference. I see quite a number of our members were also here and exhibited at this conference. I hope it will not be just the first one, we will have a number of this conference every year so that we review but as someone said we must have a better mechanism or reviewing this things but the most important thing is to act so that at least we just don't have to come back again to a workshop but review what we would have done. Once again thank you very much.

5.3.3 Remarks at Closing Ceremony by Ms Francesca Mosca, European Union

Ms F Mosca

Hon Minister, Dr. Xaba, Members of the Diplomatic Corps, Distinguished Guests, Ladies and Gentlemen. I am really very happy to have the possibility for some deep remarks at the end of this exciting week. I am impressed by all the activities going on in the country and all the efforts you are all contributing in the fight against HIV and AIDS. I would like to congratulate the Ministry of Health, National AIDS Council (NAC) and the College of Public Health Physicians taking the initiative to this conference only half a year ago. The energy and commitment that government and partners has shown over the last six months to make this conference a reality is an excellent example of how to achieve progress when we all work together and the national leadership sharing the same vision and I am glad that the EU could also play its small part in making it happen. I would like to express my thanks to all the people that worked so hard to make this conference a reality and if you

allow I just want to single out one person who has been very instrumental on our behalf. Thank you very much Patricia Darikwa. This conference has put HIV and AIDS in the forefront of the country's priorities and raising awareness is the first condition for being successful in this fight. This is not enough of course, we all have to do more we in the international community, have to realise and act to the suffering and avoidable death. The national leadership has to be in front fighting the epidemic and as we have seen this week, we need everyday to see the leaders of the community to talk about AIDS and thereby reduce the stigma. We mothers need to get our children to understand how important it is not to get in risk of getting the virus. We have this week seen examples of how we can reach the persons and families infected and affected by HIV. I think this conference has been very instrumental to give all of us a common understanding of all the issues relating to the fight against HIV and AIDS. I believe we have gathered the relevant materials for a national plan and we now have to prepare for the most important issues we want to deal with in the next 1 or 2 years. This is not an easy task since there are so many priorities. One area is to increase the continuous awareness to HIV and AIDS among the general population particularly young people. Prevention, prevention, prevention were the words said by the Minister of Health of South Africa and I think they are totally right. We have to reduce the individual risk of sexual transmission by making persons having an informed choice and have the services needed available. Another important area is to make sure access and quality of care, treatment and support for people living with HIV and AIDS are increased. But also of great importance is the often challenge. How can we make sure these children without parents get the psycho-social support they need to become responsible adults in our future society. We need to show these children human respect and make sure they get to school and they are looked after. The response to HIV epidemic needs collaboration, coordination and harmonisation among all stakeholders. We have to think different and to be together to be successful in the fight against AIDS and you will notice I am always saying 'we' because we donors are very much part of it and it's not just a fight of one government or each government of the planet, it's a joint fight. But we must certainly not forget keeping and supporting the basic systems to make sure all the people of Zimbabwe urban and rural HIV infected and person without the virus continue to have access to basic health care and primary education. I hope the experience from this conference has shown the way forward to improve coordination and harmonisation of activities in the national response to the HIV epidemic. The European Commission would like participating in such harmonisation and partnership efforts. A strong national leadership is required to succeed in coordination of the many partners like us. The European Commission, the United Nations, Bilateral donors, private sector, NAC, and all the other ministries. HE the President of Zimbabwe has during this week shown his great commitment to this fight against HIV and AIDS, which he has put, in the forefront of the country's challenges and s priorities. We hope this will be adequately reflected in the international budget for next year and next years to come. The fight against HIV and AIDS is not a short-term event and it is only with long term commitment from all of us that we can beat the pandemic. Strong collaboration efforts and positive spirit are needed we have over the last week seen it possible and I am sure we are on the right path in our fight against HIV and AIDS. Thank you.

5.3.4 Remarks at Closing Ceremony by Mr Sostain Moyo, PLWHA

Mr Moyo

Thank you very much I recognise the presence of the Hon. Minister of Health & Child Welfare and all the invited guests and distinguished delegates among ourselves. I am going to speak on behalf of the social movement group Zimbabwean Activists against AIDS. We just wanted to register some of the demands that we have, now we are coming to the close of the conference. We demand good practice for public health NGOs, FBOs, Faith Based Organisations responding to HIV and AIDS. As a way of a background Zimbabwean Activists are a social movement comprised of individuals, organisations dedicated to mobilise communities, political leaders and all sectors of society to ensure access to HIV and AIDS related treatment as a fundamental in the comprehensive care for people living with HIV and AIDS in Africa or Zimbabwe. Our general objective to draw up a social movement to strategise to ensure rapid scale up of anti-retroviral therapy in Zimbabwe and understand that all people in the world including Zimbabwe are vulnerable to HIV infection and know that HIV positive people in Africa or Zimbabwe particularly women and vulnerable groups experience greater challenges that must be addressed urgently. In our view good practice will include fostering partnership no one organisation or institution can respond to HIV and AIDS in isolation given the diversity and complexity of needs that it creates. The pandemic demands mobilisation, collaboration at community level, national level and international level. Governments and social movements or civic society and private public sector all have a vital role to play. Fostering partnership we need to ensure that we compliment each others' strategies and actively collaborate while respecting each others' independence and acknowledging differences, transparencies, critical thinking, learning and sharing are essential elements of successful partnership. How meaningful involvement of people living with HIV and AIDS and those affected communities is fostered depend on clearly defining the role and its special associated responsibilities. Assessing what a particular role requires the capacity of individual to fulfill the role and the provision of the necessary support including financial support to enable meaningful involvement. Ensuring organisational policies and practice provide timely access to information to enable participation, preparation, input before programmatic and policy decisions are made and workplace policies and practices that creates an environment which support involvement of people living with HIV and AIDS and affected communities. How to make treatment programme work in Zimbabwe I think we all realise that the target for WHO, MOH treatment initiative are targeting at treating 3 million people by 2005. I think we all realise that we are in the middle of 2004 meaning to say 2005 is just by the corner so we need to

accelerate the process by ensuring transparency, accountability inclusiveness in execution of treatment related policies and programmes building capacity of key stakeholders communities which are media, people living with HIV, care providers and etc with the skills and knowledge on issues of HIV and AIDS related treatment and monitoring of the implementation of programmes. Mobilising and sensitisation of local NGOs, Community based organisation Faith based organisation, human rights community, Care providers and other stakeholders towards a strategic action plan for strengthening the quality of HIV and AIDS treatment policy drafting and implementation process building partnership between formal and informal outlets in community based organisations. Enhancing national exchange of information and experience between HIV and AIDS workers and organisations the private sector, community groups, people living with HIV and AIDS, the media in Zimbabwe on issues of access to treatment and community participation is a key element in ensuring acceptability to treatment making treatment part of the social fabric rather than a hidden enterprise can ensure long term adherence of treatment. I thank you.

5.3.5 Remarks at Closing Ceremony by Mr Victor Angelo, UN Resident Representative

Mr V Angelo

Honorable Minister of Health and Child Welfare, Distinguished delegates, Colleagues, Ladies and gentlemen.

On behalf of the UN Country Team, I would like to commend the Ministry of Health and Child Welfare, NAC and the Organising Committee for their efforts to convene the first ever National Conference on HIV and AIDS in Zimbabwe. I congratulate you for a very successful initiative.

It is remarkable that you have brought together a wide range of stakeholders, including Government, international partners, civil servants, as well as community based 153rganizations, Ward AIDS Action Committee members, religious 153rganizations and NGOs to participate in this conference. It gives them a rare opportunity to take stock of the HIV prevention, care and mitigation programs in Zimbabwe.

Over the past four days, excellent and well researched papers have been presented by various experts. Besides this, there has been an extensive sharing of experiences and

knowledge among participants. The challenge for all of us is to turn the lessons learnt, and the gaps and opportunities identified, into action to eradicate the HIV and Aids epidemic once and forever. By doing so we save lives and enhance the well-being and prosperity of individuals, family members and communities across Zimbabwe, today and in the future.

On the behalf of my colleagues in the United Nations, I would like to offer the organizers of this conference assistance in compiling and documenting the findings so that they are preserved for future reference and use. Furthermore, as the existing national strategic framework on HIV and AIDS 2000-2004 expires by the end of this year, we are committed to provide all the support we can in close collaboration with government, NGOs and all other stakeholders in the elaboration of a new instrument for the coming years. The outcomes of this conference are indeed fertile seeds to bear the new framework.

I would also like to mention how impressed the members of our UN family have been by the fact the President of the Republic of Zimbabwe, as well as the Honorable Minister of Health and Child Welfare and his SADC counterpart, have all made reference to ”the 3 ones principle” for coordination of HIV programmes, something that is also close to our heart. At this stage, I take the opportunity to pledge our full support to NAC, the recognized HIV and AIDS coordinating body in Zimbabwe, for the efforts it is making to establish a unified monitoring and evaluation framework throughout the country. It would be useful for that framework to take into account the needs of young people and people living with HIV and Aids.

One of the most important messages from this conference, in my view, is that together each can achieve more. To this end, partnerships are crucial for the future, that include mobilization of funds to achieve our shared vision.

Ladies and gentlemen, we thank each and everyone who has made this first ever national conference on HIV and AIDS the great success it has been. I wish you a safe return to your respective homes, hoping that you will carry and spread this conference’s crucial messages.
I thank you

Chapter 6
Issues and Recommendations from the Breakout Sessions By Themes

6.1 Key Issues and Recommendations on "Care and Treatment"

6.1.1 Key issues in Anti-retroviral Therapy (ART) and Opportunistic Infection (OI) Treatment

- Zimbabwe developed the National AIDS Policy and the National Strategic Framework for the National Response in 1999. Guided by this policy, government has embarked on an ART programme that is in line with WHO's goal to treat 3 million people by 2005. Clinical Guidelines and Training Manuals have been mobilized from local and international partners.
- However, laboratory capacity in terms of resources and equipment needs to be improved.
- It was felt that access to VCT services is limited access and needs to be expanded, particularly to growth points and other rural service centers.
- Delegates pointed out that while distribution of anti-retrovirals is inadequate especially at grassroots level, pediatric HIV and AIDS managements and treatment is lacking for most of the time, raising the need for attachments for clinical experience at centers where ARVs are being offered.
- The need for government coordinate all OI and ART initiatives at all levels, with continued participation and collaboration by NGOs, bi-lateral and multi-national organizations was stressed.
- Public awareness and patient literacy needs to be improved and increased with special consideration on the needs of women and children who are especially vulnerable
- Delegates were concerned that with the scaling up efforts now gathering momentum, suppliers might run out of drugs. Related to the question of availability was the issue of affordability.
- Delegates noted the fact that locally produced drugs appeared to be more expensive than some imported ones, probably because of customs duty on imported raw materials for locally produced ARVs. Government was therefore urged to take appropriate measures to ensure that raw materials for the production of ARVs are exempted from import duties as well ensuring the availability of foreign currency for the procurement of these supplies.
- Manufacturers were urged to also prioritise the production of paedriatic formulations of ARVs.
- There was discussion on the question of whether or not to charge for ARVs , with panelists agreeing that some cost recovery charge is necessary for those who can afford, while ensuring that the disadvantaged are not neglected.
- The need for all doctors to undergo training for HIV and AIDS management was debated, with representatives from ZIMA urging that this be done urgently.
- The call was made to make all this information available in Braille, sign language and other appropriate mediums of communication to reach people with disabilities.

6.1.1.2 **Recommendations on ART**

- Government should coordinate OIs and ART Treatment initiatives at all levels
- VCT services should be expanded down to growth points.
- ART should be decentralised down to district level, maintaining quality of care and good follow up in the process of scaling up
- Documentation needs to be strengthened for improved monitoring and evaluation
- Government should mobilize and include communities in planning and implementation of ARV initiatives. Public awareness should be increased. Patient literacy should be improved
- Treatment guidelines should be distributed equally throughout the nation using existing distribution networks for all sectors of health, including traditional healers and AIDS service organisations.
- There should be greater coordination between public and private sectors,
- Laboratories should be adequately equipped to fully support ART scaling up.

Government should remove import duties for raw materials for the production of ARVs, while prioritising foreign currency allocations to the manufacturers.

6.1.2.1 Key Issues in Nutrition, Treatment and Care

- Since good nutrition has the capacity to prolong life and improve quality of life and minimize the effects and impact of HIV and AIDS, the challenge is how to mainstream nutrition, integrate it into the HIV and AIDS.
- Nutrition Guidelines are necessary and these guidelines must recognize the multi-sectoral dimension of nutrition so as to harness all stakeholders in this regard.(**N.B:** the National Nutrition Guidelines were launched by the Minister of Health and Child Welfare on the last day of the conference and are available form the Ministry of Health and Child Welfare – NNU)
- Concern was expressed on developing policies when there are no people on the ground to implement them. Staff retention and recruitment are therefore essential to raise the capacity to implement.
- It was felt that the issue of children and nutrition had been neglected, particularly children from 2 years onwards. There is a large incidence of malnutrition in this group after mothers stop breastfeeding. Guidelines are necessary for mothers at this stage.
- The nutritional habits of health professionals may seem to contradict nutritional messages in rural communities, particularly with the emphasis on locally available foods (and professionals seem to want processed “Western” foods). There is need good role models.
- The need to restore belief in indigenous foods was stressed. Traditional foods must come to the fore.
- There need to integrate nutrition into all research was raised. How can people produce cheap nutrition?
- It was felt that the issue of micronutrients has been neglected.

- Poor handling of food throughout Zimbabwe was also raised as an issue which needs to be addressed.
- Industry was felt to be lagging behind in issues of HIV and AIDS.

6.1.2.2 Recommendations on Nutrition

- Government should consider a policy to improve the nutritional status of the whole country from kindergarten children to schools and workplaces to ensure that good nutrition is available to boost immunity.
- Nutrition must be mainstreamed and become an integral part of the HIV and AIDS agenda.
- Nutrition must be provided as part of a holistic strategy under HIV care and support.
- The printing of a manual on nutrition is recommended. This manual must be taken to the grassroots communities in a form that is accessible.
- A conference on nutrition and HIV and AIDS should follow as part of a development strategy

6.1.3.1 Key Issues in Home Based Care

- It was stressed that the National Home-Based Care Policy and the HBC standard produced by the MOHCW should guide all HBC initiatives in the country.
- However it was noted that a number of organizations are conducting HBC programmes, including training of caregivers, using their own standards and manuals and that this has led to disjointed efforts and differential impact. For instance, some organizations will offer incentives while others will not. This has led to some programmes being more 'popular' than others.
    - It was also noted that volunteer work in HBC is often done by women, in addition to their many other responsibilities, though they are not paid for it. The need for guidance and standards on this and other issues was therefore underscored.
- The role of traditional healers in HBC has not been properly defined or integrated even though they are involved.
- It was observed that some health service providers are not following the requirements of the patient discharge guidelines. The MOHCW was urged to make HBC standards widely available to ensure their utilization by the different providers.
- It was noted that while substantial financial and other resources had been expended on HBC activities countrywide, more funding is required owing o the magnitude of the problem.

6.1.3.2 Recommendations on Home Based Care

- Government should coordinate HBC initiatives at all levels.
- There should be a clear definition or roles and responsibilities for NAC, NGOs, Hospitals, and government structures.

- The Ministry of Health should appoint a National Home-based Care Coordinator. The District Nursing Officer could be mandated to coordinate at district level.
- Training for HBC should be standardized using the MOHCW standards. The training should be a package that includes topics on nutrition, drugs, ethics, communication etc. There is need to monitor the quality of such training offered.
- Training guidelines at all levels of HBC interventions should be standardised, including that for medical personnel, traditional healers, and especially for primary care givers.
- The HBC policy needs to be updated and used as the framework for all HBC activities.
- There is need to implement and revive the discharge plan, involving HBC programmes where the patients will be assisted.
- The MOHCW should standardize incentives given to HBC volunteers to ensure that they remain motivated and not exploited.
- Government should mobilize and include communities in planning and implementation of HBC initiatives. Part of the National AIDS Trust Fund could be used to scale up activities needed for an expanded HBC programme.
- OVC services should be expanded to all OVC, including those in care homes.

6.2 Key Issues on "Prevention"

6.2.1.1 Issues on Prevention of Mother to Child Transmission of HIV (PMTCT)

- Though PMTCT programmes have been initiated by the Ministry and client registration into the programme has been done at 43 out of a total of 58 district hospitals, it was however, noted that while there is large participation by women in PMTCT health centers, where training and other programmes are based is not male friendly.
- There is a shortage of programmes targeting men and this is hindering prevention efforts since men are significant in the spread of the disease. This was evidenced by the fact that only 4% of male partners were counseled in 2003. There is therefore a need for programmes to include men in prevention work.
- Delegates also expressed concern that while it is commendable that the Ministry has a strategic framework for expansion of PMTCT, the programme seems to concentrate on children under 18 months of age. It was stressed that there is need for follow-up not just of the children, but also of the mothers even beyond this age.

6.2.1.2 Recommendations Prevention of Mother to Child Transmission of HIV (PMTCT)

Short-term recommendations:

- Infant feeding and HIV guidelines should be revised, taking into account all research and practical considerations
- Accelerate training for all Family and Child Health service providers in six-day training course in infant feeding counseling (utilizing infant feeding and HIV guidelines)
- Expand training and role of Primary Care Counselors (PCC) to include infant feeding and HIV, and general nutrition issues (minimum six days training)
- Develop an IEC strategy and best practice on involving men in Family and Child Health care at all levels, including in health institutions
- Consider introducing a revised child health card (including PMTCT "alert" in the at risk box, and integrated follow up care of HIV exposed infants) – to be accompanied by training for health workers and assessment of impact
- Ensure Traditional Midwives and Ambuyas are trained/sensitised in PMTCT issues
- Develop/revise training materials to ensure integration with all FCH programmes, in particular family planning
- Urgently develop system for tracking and follow up of PMTCT mothers and infants
- MOH/CW to contact Boheringer-Ingelheim for national donation of pre-packaged single dose NVP for infant

Longer term recommendations

- Advocate for expansion of cadres allowed to perform HIV rapid testing, e.g. PCC, microscopists, laboratory assistants
- Form a working group to develop protocols for early infant diagnosis of HIV infection
- Address issue of maternal resistance to single dose nevaripine regimen;
- Ultimately advocacy and resource mobilization for ART for those pregnant women, mothers, partners and children requiring treatment using PMTCT as an 'entry point' (family centred care/"MTCT Plus")

6.2.2.1 Issues on Youth Programmes

- Questions were raised about the role of the youth in HIV and AIDS prevention programmes. Youth representatives noted that there is need to be innovative and involve the youth themselves in the formulation of youth programmes and build the capacity of the youth to run these programmes. Examples of successful national youth programmes were cited from countries such as Zambia and Kenya, which start from the grassroots and go up to national level.
- Youth delegates felt that issues of concern to them had not been adequately covered during the conference e.g issues of youth and sexuality and empowerment programmes.

- Organizations need to set up youth friendly centers, to enable the youth to access information.
- It was suggested that there is need to convene a conference targeted at the youth where all issues concerning the youth would be addressed fully.
- The need for good adult role models for the youth was noted. On the other hand, there was also need for the youth to behave responsibly.

6.2.2.2 Youth Programmes Recommendations

- There is need for baseline information on youths (suggested to expand the Young Adult Survey)
- There is need for the scaling up and out of the stand alone Youth Friendly Centres (NB: not Corners). The centres should have sporting activities and income generating projects. The content of IEC materials should have the input of young people.
- The next AIDS conference should have a Young People Conference / Activities around HIV and AIDS running parallel to the main conference.
- There is need to disseminate information on the National Youth Policy – how it is being implemented. The Ministry of Youth, Gender and Employment Creation needs to take the lead role in this activity. Tied to this is the need to understand the role of the National Youth Council.
- There is need to sensitise all traditional authorities, including the parents, to ensure that all children are encouraged to take part in programmes which are for young people.
- There is need to use existing structures such as the Junior Councils and Parliament to mobilize and provide the lead for youth programming.
- There is need for funding security for the youth programmes.

6.2.3.1 Issues on *Workplace Programmes*

- It was noted that Statutory Instrument 202/98 needs to be amended. The delegates emphasized the need for involvement of all stakeholders for example business, government and non-governmental organizations.
- Delegates expressed concern at the problems of employees who after having served at a company for years and contributed to medical aid, sometimes find themselves destitute after they leave work. The need for post retirement care and social safety nets was therefore stressed.
- The informal sector was singled out as needing particular attention in HIV and AIDS prevention work, especially in view of the fact that the informal sector is increasingly becoming a major employer in Zimbabwe. Among the suggestions made was to learn from the Tanzania experience where a comprehensive social security programme is in place for the informal sector.
- Delegates also stressed the need for incentives for companies operating workplace programmes, as well as to coordination of the effort of industry. In this regard it was suggested that the Zimbabwe Business Council on HIV and AIDS could play a central role in coordinating the industry's effort.

6.2.3.2 Workplace Programmes Recommendations

- Because Statutory Instrument 202/98 has a number of gaps, which include, gender gaps, there is need therefore for its complete revision. Such revision should be done with the involvement of all stakeholders i.e. business, government, NGOs.
- Couples should not be separated because of work demands.
- There is need for every company to have an HIV/ AIDS policy. To this end, there should be in place guiding principles as to the minimum expected from a workplace programme.
- Companies should show their commitment to workplace programmes by adequately budgeting for them. In addition there is need for innovation in fundraising. In this regard the suggestion was made that since so much money is being repatriated by Zimbabweans abroad, if a percentage of that money was diverted towards HIV then it would boost the resources available to initiate HIV programmes.
- There is need for companies to put in place for their employees who have reached retirement age or who have had to go on retirement owing to ill health, better post retirement care/ social safety nets. This is because employees, who have been contributing to the national AIDS levy and medical aid, sometimes find themselves destitute after they leave work.
- There is need to come up with effective strategies to involve the informal sector in HIV and AIDS workplace programmes because the informal sector is increasingly becoming a major employer in Zimbabwe. In this regard, suggestion was made to make the existence of HIV workplace programmes as a pre condition for engaging in business with a particular business in the informal sector.
- There is need for social security for the informal sector, i.e. medical insurance etc. In this regard the suggestion was made that Tanzania has comprehensive social security programmes in place for the informal sector and lessons should be drawn from the Tanzania experience.
- There is need generally for interventions to look at the underlying causes fuelling the epidemic and try to address those underlying causes. Poverty and underdevelopment fuel the epidemic and any interventions should also address these issues.
- Because interventions by the private sector and industry in the workplace are fragmented, there is need for greater coordination of effort and interventions by industry. The Zimbabwe Business Council on HIV and AIDS, could play a central role in coordinating industry's efforts.
- There is need for incentives for companies with HIV and AIDS Workplace programmes. This can be in the form of tax breaks to encourage companies to expend more resources on workplace programmes.
- For those companies that have workplace programmes, there is need for them to have nutrition being integral to their programmes, not just for their employees, but also for the dependants of these employees.
- There is need for any workplace programme, e.g. training, to include spouses and partners of employees.

6.3 Key Issues and Recommendations on "Mitigation"

6.3.1.1 Issues on Orphans and Vulnerable Children

- Delegates noted that the OVC referral system is not clear and is uncoordinated. Various line ministries deal with OVC, for example, Education, Gender, Health and each has different rules for the children that they assist and this causes confusion and lack of coordination.
- It was noted that though presently there is a lot of research being conducted, it is not being coordinated and is not reaching the people that can operationalise it.
- The gap in both research and interventions for children with disabilities was also noted.
- The ethics of conducting research on children was also considered.
- Delegates considered the need to examine whether OVC interventions were empowering those who assist vulnerable groups, as opposed to just giving orphans handouts. The need to strike a balance between the two was stressed.
- Finally the delegates pointed out that while mobile birth registration teams are going round in the villages, this has not worked for some orphans who have lost both parents and have no access to their birth records and remaining relatives have no idea of the dates of birth of these children. A solution has to be found for this problem.

6.3.1.2 Recommendations on Orphans and Vulnerable Children

- The Department of Social Welfare should take a leading role in the development of a minimum standard package for OVC care in consultation with other organizations and line ministries involved in care of OVC. The Department of Social Welfare should take leading role to coordinate all organizations government, NGOs etc working with OVC.
- All government line Ministries should have a coordinated approach especially at District level to lessen duplicity
- Government to make efforts to improve on staffing in Dept of Social Welfare and have at least 3 officers per district
- DAAC structures should be strengthened to act as effective platforms for communication and sharing of information for the various OVC organisations, ASO etc working with OVC. They could also be used a platform to inform about results of researches conducted
- Social Services Action Committee should expedite the formalization of the National Action Plan and its adoption so that the roll- out of activities can be implemented without further delay
- Demystify psychosocial support. Organizations providing PSS to act together and identify forms of traditional PSS.
- Engage and consult children on their needs and what interventions they want

- Lessen the bureaucracy for children to access social services such as access to education, health and other services
- Universal free primary education should be re-introduced, and be funded properly.
- Through a meeting of various stakeholders, come up with strategies for communities to "own" the programmes so that they become more sustainable. Put in place programmes that can be sustained within the community by giving start-up capital for OVC and the caregivers.
- Programs should focus on family integration not institutional care. Already established institutions (orphanages) should open themselves to local communities and establish linkages and integrate into community. Could identify parents within these communities willing to foster children. These families should then be supported by Social Welfare if unable to do it on their own.
- Avoid separating children by mobilizing community on child fostering and dispelling cultural beliefs that prevent families from taking in children that are not their own.
- Encourage the traditional practices at community level that foster the care of the child. Mobilize and educate the community about child-headed households so that they take on these children as foster parents and avoid children having to live alone.
- Establishment of "half way houses could be another option as a temporary home for the children until a home is identified.
- A national Census of OVC similar to what has been done in 2 districts by the national Institute of Health Research (former Blair Research) should be conducted where uniform standard methods are used for data collection and meaningful comparisons can be made which can them be used or incorporated into the national Action Plan for OVC
- There is need to co-opt Media Representative and Private Sector in these OVC intervention programmes for publicity so that people are made aware of what is happening and also for resource mobilization purposes.
- The State should facilitate birth registration at clinics or allow the children to register through organizations that are working with the orphans. In many instances the village head can estimate the age of the child and this facilitates the registration of the orphans

6.3.2.1 Issues on Economic, Legal, and Institutional support

- Delegates expressed concern at the difficulties faced by people in trying to obtain birth certificates for their children. The problem is even worse for children who are orphans. The delegates urged government to amend the laws so that the process is decentralized. They specifically recommended that nurses be empowered to issue birth certificates so that each child has a birth certificate before they leave hospital. In addition, they recommended that religious leaders and chiefs should also be empowered to issue marriage certificates. The delegates concluded by recommending that strategies should be put in place to assist children who do not presently hold certificates and that they should not be hindered from taking part in public examinations, for example.

- The point was made that the law has to be amended in order that every person who has a vested interest in knowing another person's HIV and AIDS status is advised of that persons HIV and AIDS status. These people would include caregivers as well as marital and non-marital partners.
- The question of compulsory testing generated much debate. Besides the issue of capacity, the delegates were concerned that this move would have ethical implications. It was suggested that a middle ground might be found in the Botswana experience where routine testing is conducted on people visiting health centers. A person is then given the option of knowing the result of the test. It was decided that a legal taskforce on HIV and AIDS should be established which would consider issues of ethics and human rights in any proposed law reform and advise NAC accordingly.
- It was noted that it was proving difficult enforce the law on willful transmission of HIV and AIDS and that perhaps willfully exposing someone to the risk of HIV infection should also be criminalised. In the latter case the offence would be exposing someone, whether or not such exposure actually resulted in infection.
- Delegates noted there is need for government to put in place mechanisms to ensure that there is exemption from import duty on raw materials and other necessary equipment for the production of ARVs. In the same vein, government was also urged to put in place incentives in the form of tax breaks for companies conducting HIV and AIDS programmes in the workplace.
- The need for Government to make post exposure prophylaxis available to victims of rape and other sexual abuse, as a right, was noted. This is due to the high HIV and AIDS prevalence rate in Zimbabwe and the increasing incidence of rape and other forms of sexual abuse. Delegates noted and agreed that persons accused of rape should be compulsorily tested.
- It was observed that government and other stakeholders need to initiate education and awareness raising campaigns around laws that are already in place as well as proposed reform so that people are aware of their rights.

6.3.2.2 **Recommendations on Economic, Legal and Institutional Support**

- Any child who is born in hospital should have a birth certificate issued before that child is discharged from hospital. Zambia does the same and it works.
- For those children not born in hospital, the registration of births should be simplified and decentralised so that people such as ministers of religion and traditional leaders can be capacitated to issue birth certificates.
- Education on the issue of birth certificates should be intensified especially at grassroots level.
- There is need to come up with strategies to address the problems of those children who at present do not have birth certificates. They should be allowed to sit for public examinations, to avoid causing undue hardships.

- There should be compulsory partner notification as well as notification of all those who have a vested interest in the person's HIV status e.g. carers, marital and non-marital partners.
- Given the problems associated with proving infection in the case of willful transmission of HIV, the law should be amended so that the offence includes willfully putting someone at risk of infection, whether or not such exposure results in infection.
- There is need to put together a legal taskforce on HIV and AIDS, which will consider issues of ethics, and human rights in proposed law reform e.g. it will be tasked to consider issues of compulsory testing, compulsory notification etc.
- On the issue of compulsory testing, lessons can be drawn from the Botswana experience where routine testing of people visiting health centres is being carried out. A person is then given the option of knowing the outcome of his/her results.

6.3.3.1 Issues on Work Place Mitigation

- It was noted that Statutory Instrument 202/98 needs to be amended. The delegates emphasized the need for involvement of all stakeholders for example i.e. business, government and NGOs.
- Delegates expressed concern at problems of employees who having served a company for years and after contributing to medical and sometimes find themselves destitute after they leave work. The need for post retirement care and social safety nets are therefore stressed.
- The informal sector was singled out as needing particular attention in HIV and AIDS prevention work, especially in view of the fact that the informal sector is increasingly becoming a major employer in Zimbabwe. Among suggestions made was to learn from the Tanzania experience where a comprehensive social security programmes in place for the informal sector.
- Delegates also stressed the need for incentives, such as tax breaks, for companies operating workplace HIV and AIDS programmes as well as coordination of the effort of industry in this regard. It was noted that the Zimbabwe Business Council on HIV and AIDS could play a central role in coordinating industry's effort.

6.3.3.2 Recommendations on Workplace Mitigation

- Statutory Instrument 202/98 should be completely revised since it has a number of gaps, which include gender gaps. Such revision should be done with the involvement of all stakeholders i.e. business, government, NGOs.
- Couples should not be separated because of work demands.
- There is need for every company to have an HIV/ AIDS policy. To this end, there should be in place guiding principles as to the minimum expected from a workplace programme.
- Companies should show their commitment to workplace programmes by adequately budgeting for them. In addition there is need for innovation in

fundraising. Leadership commitment should be supported by budgetary allocations to workplace HIV and AIDS response at enterprise level.

- It was suggested that since so much money is being repatriated by Zimbabweans living abroad, if a percentage of that money was diverted towards HIV then it would boost the resources available to initiate HIV programmes.
- There is need for companies to put in place for their employees who have reached retirement age or who have had to go on retirement owing to ill health, better post retirement care/ social safety nets. This is because employees, who have been contributing to the national AIDS levy and medical aid, sometimes find themselves destitute after they leave work.
- There is need to come up with effective strategies to involve the informal sector in HIV and AIDS workplace programmes because the informal sector is increasingly becoming a major employer in Zimbabwe. In this regard, the suggestion was made to make the existence of HIV workplace programmes as a pre condition for engaging in a particular business in the informal sector.
- There is need for social security for the informal sector, i.e. medical insurance etc. It was suggested that lessons could be drawn from the Tanzania comprehensive social security programmes in the informal sector.
- Poverty and underdevelopment fuel the epidemic and any interventions should also address these issues. There is need generally for interventions to look at the underlying causes fuelling the epidemic and try to address those underlying causes.
- There is need for greater coordination of efforts and interventions by industry. It was noted that the Zimbabwe Business Council on HIV and AIDS, could play a central role in coordinating industry's efforts.
- There is need for incentives for companies with HIV and AIDS Workplace programmes, such as tax breaks. This will encourage companies to expend more resources on workplace programmes.
- For those companies that have workplace programmes, there is need for them to integrate nutrition into their programmes, not just for their employees, but also for the dependants of these employees.
- There is need for any workplace programmes e.g. training, to include spouses and partners of employees.
- A generic workplace policy should be developed to guide sectors and enterprises to develop their own workplace policies or policy frameworks or codes of conduct to guides their responses. This should be guided by the national policy, the statutory instrument, the ILO Code of practice on HIV and AIDS and the world of work and the SADC code on HIV and AIDS and employment.
- Workplace prevention programs should be comprehensive and guided by the policy principles and strategies. Components should include:
    - Prevention: VCT access, condom promotion, nutrition education, STI management, peer education, and access to referral facilities
    - Care .STI management, nutrition, home based care counseling and support, treatment and support
    - Mitigation strategies.
    - Media care, use of performing arts and IEC

- The Zimbabwe Business Coalition on AIDS (ZBCA) should work closely with other key stakeholders to execute its mandated roles including compilation of best practices and dissemination of information to the businesses to enhance their capacity to response, enhance partnerships, influence policy on workplace responses and support capacity building for program management.
- Businesses and workforce should come up with innovative health insurance schemes as security for those infected and affected by HIV and AIDS for long term sustainability of impact mitigation and access to ARVs.

Annex 1
Agenda of the Conference

	Proposed Agenda Zimbabwe National HIV and AIDS Conference of 15- 18 June 2004 :							
(Day 0) **Monday** 14 June						▪ **Registration Opens** ▪ **Social/Networking Event in Evening**		
	8.30-9.15am **(8.30 – 10:30am on Day 2)**	**9.30 – 11am** (10:30.- 11am- on Day 2)	**11-11.30am** (11-12:30 on Day 1)	**11.30 – 1pm** (12:30-1:30 on Day1)	**1-2.30pm** (1:30-3pm on Day 1)	**2.30 – 4pm** (3-4pm on Day 1)	**4 – 4.30pm**	**4.30pm – 5.30pm**
Day 1 : Tuesday, 15 June 2004 **Theme: Prevention**	Invited Speakers on key topics in Prevention 1. **Experience with National PMTCT program** 2. **Youth experience with prevention** 3. **Workplace Prevention Experience** (20 mins each) **Poster themes** (10 mins)	**Oral abstract presentations I** (programs or research) **Oral abstract presentations II** (programs or research) (Two sessions in parallel)	T E A	**Panel Discussion on Prevention Experiences** (invited panelists to discuss different aspects of Prevention, also addressing coordinated health systems/ multisectoral approaches) Panelists to include: 1. PLWA 2. Youth 3. Media Representative 4. MOHCW provincial/district representative 5. Workplace prevention programme 6. NGO/CBO representative	**LUNCH** **Posters**	**Group Discussions and recommendations for future** (Rapporteur/ Priorites for Prevention) **Group 1** : PMTCT **Group 2** : Youth targeted programmes **Group 3** : Workplace Programmes	**Tea**	▪ Presentation of Recommendations from group discussions **Plenary Session**
Day 2 : Wed 16 June 2004 **Theme: Care**	**Opening Ceremony** • Introduction of Dignitaries : PS of MOHCW – Dr E Xaba • Welcome Remarks - Hon. Minister of HCW – Dr D Parirenyatwa • Remarks by Chairperson of OC – Dr B Manyame • Youth Experiences with HIV and AIDS • Experience of PLWA • Opening Address by His Excellency, The President, Cde R G Mugabe • Key note address – Dr K Kaunda • "The Story So Far	**Oral Abstract presentations III** (Programs or research) **Oral Abstract presentations IV** (programs or research) (Two sessions in parallel)	**Tea**	**Invited Speakers on key topics in Care** 1. Nutrition and other aspects of care for HIV and AIDS 2. ART Scaling up Programme 3. Traditional Medic	**LUNCH** **Posters**	**Panel Discussion** (invited panelists to discuss different aspects of CARE, also addressing coordinated health systems/ multisectoral approaches Panelists to include: 1. Nutritionist 2. Pharmaceutical Industry Association Representative 3. ART carer at hospital/site level 4. Neighbouring country rep. (Botswana) 5. PLWA 6. Traditional healer	**Tea**	**Group Discussions and recommendations for future** (Rappateur/ Priorites for Care) **Group1** : Nutrition and other aspects of care **Group 2** : ART scaling up **Group 3** : Home-based Care

Day 3 : Thursday 17 June 2004 **Theme: Mitigation**	▪ Presentation of Recommendations from previous day's group discussions ▪ **Plenary Session**	**Oral Abstract presentations V** (programs or research) **Oral Abstract presentations VI** (programs or research) (Two sessions in parallel)	**Tea**	**Invited Speakers on key topics in Mitigation** 1. National OVC plan (Orphans and Vulnerable Children) 2. Workplace strategies 3. Gender issues, esp. in rural areas (3 speakers, 20 mins each) **Poster themes** (10 mins)	**LUNCH** **Posters**	**Panel Discussion** (invited panelists to discuss different aspects of MITIGATION, also addressing coordinated health systems/ multisectoral approaches Panelists to include: 1. Young person to talk about OVC 2. PLWA 3. NGO 4. Business Council 5. Legal Person 6.	**Tea**	**Group Discussions and recommendations for future** (Rappateur/ Priorites for Mitigation) **Group 1 :** Orphans and Vulnerable Children care **Group 2** : Legal Aspects of HIV and AIDS **Group 3** : Workplace mitigation
Day 4 : Friday 15 June 2004 **The Way Forward**	▪ Presentation of Recommendations from previous day's group discussions ▪ **Plenary Session** Multi-sectoral coordination to enhance the response	**CONCLUSION** Development of final Recommendations	**Tea**	**Closing Ceremony** Remarks by sponsors: a) UNDP Rep. b) UNICEF Rep. c) Donor Rep. : EU etc d) Business Council on AIDs e) etc Vote of Thanks - Participant Closing Address - TBA	**LUNCH**			

Annex 2
List of Members of the Organising Committee (OC)

Members of the Organising Committee		
Name	**Organisation**	
Dr Boniface Manyame	Zimbabwe College of Public Health Physicians	Chairman of OC
Ms Victoria James	HIVOS	Vice-Chair of OC
Mr Raymond Yekeye	NAC	(Co-chairman of the Board)
Dr Owen Mugurungi	AIDS and TB Unit, MOHCW	(Co-Chairman of the Board)
Dr Christine Chakanyuka	AIDS and TB Unit, MOHCW	
Dr Agnes Mahomva	AIDS and TB Unit, MOHCW	
Mr Albert Manenji	NAC	
Ms Madeline Dube	NAC	
Dr Panganayi Dhliwayo	International Union Against Lung and TB Diseases	
Dr Shannon Hader	Zim CDC	
Ms Hege Waagan	UNAIDS	
Dr Jabulani Nyemwa	JSI/Deliver	
Mr Samuel Tsoka	MOHCW	
Dr Mufuta Tshimanga	Medical School, University of Zimbabwe	
Dr Jack Forbes	Elizabeth Glaser Paediatric Foundation	
Ms Vuyelwa T.S. Chitimbire	ZACH	
Ms Patricia Darikwa	EU HSSP	
Ms Lisbeth Kallestrup	EU	
Mr Lovemore Kadenge	Zimbabwe Business Council on AIDS (ZBCA)	

Annex 3
List of Members of the Conference Organising Board

Members of the Conference Organising Board		
Name	**Organisation**	
Dr Boniface Manyame	Zimbabwe College of Public Health Physicians	Chairman of Org Comm.
Ms Victoria James	HIVOS	Vice-Chair of Org Comm.
Mr Raymond Yekeye	NAC	(Co-chairman of the Board)
Dr Owen Mugurungi	AIDS and TB Unit, MOHCW	(Co-Chairman of the Board)
Dr Christine Chakanyuka	AIDS and TB Unit, MOHCW	
Dr Agnes Mahomva	AIDS and TB Unit, MOHCW	
Mr Albert Manenji	NAC	
Ms Medeline Dube	NAC	
Dr Panganayi Dhliwayo	International Union Against Lung and TB Diseases	
Dr Shannon Hader	Zim CDC	
Ms Hege Waagan	UNAIDS	
Dr Jabulani Nyemwa	JSI/Deliver	
Mr Samuel Tsoka	MOHCW	
Dr Mufuta Tshimanga	Medical School, University of Zimbabwe	
Dr Jack Forbes	Elizabeth Glaser Paediatric Foundation	
Ms Vuyelwa T.S. Chitimbire	ZACH	
Ms Patricia Darikwa	EU HSSP	
Ms Lisbeth Kallestrup	EU	
Mr Lovemore Kadenge	Zimbabwe Business Council on AIDS (ZBCA)	
J. Kirk Felsman	CRS/STRIVE	
Peter Kiff	ZVITAMBO	
S. Mahombere	Zimbabwe Youth council	
Sithokozile Maposa	Advance Africa	
B. SENZANJE	UNICEF	
C Mutiti	Harare City Health	
Vuyelwa T S Chitimbire	ZACH	
Darlington Muzeza	Zimbabwe Youth Council	
Virginia Bourassa	CDC	
Bright Mpofu	MOHCW	
Peter Iliff	Zvitambo	
Lovemore Kadenge	ZBCA	

Members of the Conference Organising Board		
M. Mehlomakulu	UNICEF	
Florence Gwazemba	ZNNP+	
Sithokozile Maposa	Advance Africa	
Premila Bartlett	Advance Africa	
Judith Chinamaringa	UNICEF	
Kumbirai Chatora	PSI	
Jack Forbes	EGPAF	
Witmore B Mujaji	UZ	
Sibusisiwe Zembe	Min of Labour & S W	
Sara Page	SAfAIDS	
Nicholas Midzi	National Institute for Health Research	
S Midzi	MOHCW	
M A Chemhuru	MOHCW	
A Mavise	MOESC (Min of Education)	
I C Bowora	MOESC(Min of Education)	
O I Mbengeranwa	Harare City Health	
S Mungofa	Harare City Health	
M Sandasi	WASN	
L Hungwe	ZAPSO	
H Zimudzi	NAC	
P Halpert	USAID	
A Boner	PSI	
T T Kufa	MSF Spain	

Annex 4

Income and Expenditure Statement for the Conference

N.B:

1. The following is a tentative summary of the income raised for the conference and the amounts spent (expenditure) on the conference.
2. Though not all bills have come in yet , it is expected that the conference will remain with a surplus.

Commitments by Sponsors **(Income Raised)**
(Funds already received or already in pipeline awaiting to be received)

Income committed by sponsors		
1.0	European Commission	386,662,950
2.0	National Aids Council	400,000,000
3.0	JSI/UK/DFID	97,982,600
4.0	Crown Agents	15,000,000
5.0	WHO **(fund not not yet received)**	
6.0	UNICEF	205,671,600
7.0	PSI/DFID	94,707,500
8.0	IOM	26,750,000
9.0	VARICHEM	20,000,000
10.0	First Banking Corporation	500,000
11.0	Cottco	50,000,000
12.0	UNFPA	5,350,000
13.0	UNDP **(funds not not yet received)**	
14.0	Buchmann Medical Care Services	22,949,675
15.0	Coca Cola	1,000,000
16.0	BP Shell	6,497,500
17.0	Zimbank	
18.0	ZBCA **(funds not not yet received)**	2,330,000
19.0	CAPS	29,029,450
20.0	Renaissance Merchant Bank Limited	5,000,000
21.0	Exhibition	5,256,000
22.0	Subscriptions	18,400,000
Grand total income		**1,393,087,275**

Committed Expenditure

		Cost commit-ment
Payments		
2.0	Venue	
2.1	Sheraton	230,600,000
2.2	HICC + VIP lounge	106,963,459
2.3	Press room and rapporteurs	650,000
3.0	Hotel accommodation for Dignitaries	7,360,079
4.0	Transport to and from venue	5,562,000
5.0	Social Event	71,515,484
6.0	Video documentation	29,955,000
7.0	Conference packages	7,317,985
8.0	Guest Speakers	2,986,148
9.0	Audit	4,600,000
10.0	Security	0
11.0	Conference CD Rom	50,000,000
12.0	Facilitators fees	6,500,000
13.0	Event Management Firm	415,692,400
14.0	Transport for SADC Ministers	5,000,000
15.0	Accommodation for SADC Ministries	0
16.0	Performance Groups	10,497,500
17.0	Dinner for Ministers	0
18.0	Market Place	52,661,391
19.0	Private Sector/Minister Breakfast	4,330,000
20.0	Journalist Seminar	1,431,600
21.0	Abstract Book	26,731,540
22.0	Bags and gifts for dignitaries	8,425,814
23.0	Administration fee 5 %	14,625,501
24.0	Contingency	0
Total committed expenditure		**1,063,405,902**
Total committed sponsorship (income)		**1,393,087,275**
Balance between income and expenditure		**329,681,373**

ANNEX 5
List of Sponsors

Cash

EU	Z$415 000 000
NAC	Z$400 000 000
UNICEF	Z$208 000 000
JSI/DFID	Z$98 000 000
PSI/DFID	Z$95 000 000
WHO	Z$52 000 000
Cotco	Z$50 000 000
CAPS	Z$24 000 000
IOM	Z$27 000 000
Buchman	Z$21 000 000
VARICHEM	Z$20 000 000
Crown Agents	Z$15 000 000
UNFPA	Z$5 000 000
Renaissance Bank	Z$5 000 000
First bank	Z$500 000

Donations in Kind

UNAIDS	Sponsored all sub-national NAC delegates
Coca Cola	30 cases minerals; 10 cases squashes
BP Shell	100 t-shirts
ZimBank	600 ball point pens
UNDP	US$10 000
Stanbic Bank	Z$5 000 000
ZBCA	Z$50 000 000
Participants' organizations	All participants were sponsored by their own organizations for accommodation and meals

Pledges (Funds not yet received by the time of writing the report)

UNDP	US$10 000
Stanbic Bank	Z$5 000 000
ZBCA	Z$50 000 000

Annex 6
List of Participants

ORGANISATION	NAME	ADDRESS	TELEPHONE No	E-MAIL ADDRESS
NGOs, Advocacy Grps ad Legal bodies				
Island Hospice + Berevement Service	Mrs Ruth A Mazarura	5 Lezard Ave Milton Park Harare	04-701674-7	island@africaonline.co.zw
National Association of Non-Governmental Organizations (NANGO)	Mrs Judith Chaumba	19 Selous Ave 1st Floor Mass Media House Harare	04-708761	juchaumba@yahoo.com
National Association of Non-Governmental Organizations (NANGO)	Mr D Chivi	19 Selous Ave 1st Floor Mass Media House Harare	04-708761	
National Association of Societies for the Care of the Handicapped (NASCHO)	Miss Lucina Mangwanda	90A McChlery Avenue Eastlea Harare	04-776683	nascoh@zol.co.zw
SANASO	Ms Farai Mugweni	6 Dunkirk Dr, Alex Park, Hre	04-745748	farai@africaonline.co.zw
Zimbabwe Association of Church-related Hospitals (ZACH)	Mrs Vuyelwa Chitimbire *	160 Baines Avenue, Harare	04-790597	chitimbire@zach.org.zw
Zimbabwe Association of Church-related Hospitals (ZACH)	Mr Angelbert Mbengwa	160 Baines Avenue, Harare	04-790597	mbengwa@zach.org.zw
Zimbabwe Aids Network	Sheilla Dotoro	154 Samora Machel Avenue, Hre.	04-775320	sdotoro@zan.co.zw
Zimbabwe Aids Network	Ms Kate Mhambi-Musimwa *	154 Samora Machel Avenue, Hre.	04-775320	kmhambi@zan.co.zw
	9			
OTHER LEVELS OF REPRESETATION				
ZAN Provincial	Mr Orbert Manyeza (Hre)	154 Samora Machel Avenue, Hre	04-775520	omanyeza@zan.co.zw
ZAN Provincial	Mr Philemon Handinahama (Mash. East)	154 Samora Machel Avenue, Hre	04-775520	
ZAN Provincial	Mrs Cathrine Madondo (Byo/Mat. North)	Scripture Union 125 Robert Mugabe Rd 13th Avenue, Famona, Bulawayo	04-775520	zan-madondo@zol.co.zw

ZAN Provincial	Mr Jonathan Muchuchu (Manicaland)	Mutare Main Post Office 1st Fl Office No 5, Robert Mugabe Road, Mutare	04-775520	zan-muchuchu@zol.co.zw
ZAN Provincial	Mrs Tariro Kutadza (Mash. Cent/Mash. West)	ZESA Office No. 17, Stand 31A, Appleby St Old ZESA, Bindura	04-775520	zan-tkutadza@zol.co.zw
ZAN Provincial	Mr Henry Muusha (Mat. South)	ZNFPC, Stand 381/51 Jahunda, Gwanda	04-775520	zan-muusha@zol.co.zw
ZAN Provincial	Zendakwaye Zendakwaye (Masvingo/Midlands)	154 Samora Machel Avenue, Hre.	04-775520	zan-zendakwaye@zol.co.zw
	7			
ZACH PROVINCIAL				
ZACH Provincial	Mrs Johanne Gibson	Howard Hospital Box 190 Howard	0758-2433	howardhospital@africaonline.co.zw
ZACH Provincial	Dr TimCavanagh	St Theresa Hospital P.Bag 7015 Mvuma	0308-373	domhama@mweb.co.zw
ZACH Provincial	Dr Neelah Naha	Chikombedzi Hospital P.Bag 7075 Chiredzi	014-396	
ZACH Provincial	Mr Titelo Nare	St Lukes Hospital P Bag R 5314 Bulawayo	0898-349	
ZACH Provincial	Ms Susan Tawodzera	Murambinda Hospital P.O. Box 20 Murambinda	021-2573/4	murambi.hosp@healthnet.zw
ZACH Provincial	Mrs Esnath Chiyeke	St Paul's Hospital P Bag 667 East Harare	078-2253	
ZACH Provincial	Dr Jono Mbangani *	Chidamoyo Hospital P.O. Box 330 Karoi	064-7200	
ZACH Provincial	Dr Dawn G. Howse	Tshelanyemba Hospital P.O. Tshelanyemba Via Maphisa	082-416	tshelanyemba.hosp@healthnet.zw
	8			
FBOs				
Masiye Camp (Salvation Army)	Pastor Willard Ndlovu	98a Fife Street Bulawayo	09-880834, 023 247852	wndlovu@byo.masiye.com
UDACIZA Union of the Development of Apostolic Churches of Zimbabwe	Mr Xavier Chitanda	P.O. Box 230 Chitungwiza	04-791946	

YMCA Young Men's Christian Association	Mr Isidor Mazipetele	21 1st Ave Mabelreign Harare	04310096, 011 741078	imazipetele@yahoo.com
Scripture Union	Dr Leonard Makoni	23 Selous Avenue, Harare	04-252442	shalom@mango.zw
Christian Care	Mrs Ellen Jaka	120 Baines Avenue Harare	04-728016, 011 200135	ejaka@ccare.co.zw
(ZAOGA) Zimbabwe Assemblies of God Africa	Rev Janet Dhlakama	13A Powell Rd. Waterfalls, Harare	04-621591	
The Apostles Church	Pastor N. Moyo			
Dominican Convent	Sr Patricia Walsh	P O Box CY1562 Causeway Harare	04- 701725	pwalsh@ecoweb.co.zw
	8			
NATIONAL NGOs				
Zimbabwe Red Croass Society	Mrs Emma Kundishora	98 Cameron Street Red Cross House, Harare	04-775416/8	zrcs@ecoweb.co.zw
Association of Women's Clubs	Miss Martha Pitima	3 Craneleigh rd, Hatfield, Hre	04-571903, 091252519	awc@mango.zw
Jekesa Pfungwa/Vulinqondo	Miss Grace Kuvengurwa	44 Logan Road Hatfield Harare	04-570846	jekesa@africaonline.co.zw
Farm Community Trust of Zimbabwe	Mr Taurayi Malunga	45 Glengary Road Highlands Harare	04-300290	tmalunga@fctz.org.zw
Farm Orphan Support Trust	Mrs Lynn Walker	1 Adylinn Rd Marlbrough Harare	04-309869	fostharare@mango.zw
Zimbabwe Women's Resource Ctr and Network (ZWRCN)	Mrs Nomthandazo Jones	288 C Herbert Chitepo Avenue Harare	04-737435	njones@zwrcn.org.zw
Women and AIDS Support Network (WASN)	Ms Gladys Chiwome	13 Walter Hill Avenue Eastlea Harare	04-332882	zapso@mweb.co.zw
Networking & Support for HIV and AIDS Trust	Miss Angeline Chiwetani	Suite 501 5th Fl Equity Hse Cnr Jason Moyo/Rezende Street Harare	04-732966	achiwetani@yahoo.com
Zimbabwe AIDS Prevention Support Organization(ZAPSO)	Dr. Gerard Kadzirange	4 Aberdeen Road Avondale, Harare	04-749849	gkadzirange@zappuz.co.zw
Zimbabwe Albino Association	Janet Mudzviti	149 Samora machel Avenue Harare	04-724744	zimas@ecoweb.co.zw
Action Aid International	Mr Sheperd Murahwi	P O Box CY 2451 Causeway Harare	04- 788122	sherperdm@aafrica.org.zw
Action Aid International	Mr Ian Mashingaidze	P O Box CY 2451 Causeway Harare	04- 788122	ianm@aafrica.org.zw
	12			
NGOs LOCAL SUB-NATIONAL				

Zimbabwe Women Against HIV and AIDS	Mrs Beatrice Karimanzira	P.O. Box GD 373 Greendale Harare	04-746908, 091 243975	zwaapv@mweb.co.zw
Hope Humana People to People	Mr Washington Matshe	Stand 68/69 First Street Appleby Bindura	071-6833, 023 416819	hopezim@comone.co.zw
Matabeleland AIDS Council (MAC)	Mr Danmore Sithole	97A J. Tongogara Street Bulawayo	09-62370	danmore@telconet.co.zw
Revival of Hope	Mrs. Nosihle Ndlovu	c/o ZAN Scripture Union 125 Robert Mugabe Rd 13th Avenue Famona Bulawayo	091 346373	
Carelite Counsellors	Mrs Flora Rusinga	P.O. Box 123 Hwange	081-23101-6, 011417179	florarusinga@yahoo.com
Lubancho House	Ms Magdalen Nehwati	P.O. Box 376 Hwange	081- 22760, 091 914537	lubhouse@comeone.co.zw
MASO	Mrs Veronica Nhemachena	P.O. Box 880 Gweru	054-21029, 091 324098	maso@adtech.co.zw
Bethany Project	Mrs Rangarirayi L Mhindu	Private Bag 683 Zvishavane	051-2186	
Mash East AIDS Network Macheke Clinic	Mr Nicholas Dzwete	P.O. Box 133 Macheke	0798-266	
Seke Rural Home-based Care	Mrs Veronica Kanyongo-Ngwerume *	P.O. Box SK160 Seke	023 411699	sekeruralhbc@yahoo.com
Batsirai Group	Mr Daniel Gapare	125 Midway Chinhoyi	067-24115	batsirai@mweb.com
Tsungirirai Group	Mr Elliot Chabhongora	P.O. Box 107 Norton	062-2080	tsungi@mweb.co.zw
Umzingwane AIDS Network	Mrs Lucia Malemane	457 Habane T/Ship Esigodini Bulawayo	088-472	umzingan@mweb.co.zw
Insiza Godhliwayo AIDS Council	Mr Wakhumuzi	P.O. Box 140 Filabusi	017-424	
FACT Masvingo	Ms Theresa Tsitsi Chimusoro	P.O. Box 1626 Masvingo	039-65677	factnet@mweb.co.zw
FACT Masvingo	Mr Tanonoka Whande	P.O. Box 1626 Masvingo	039-65677	factnet@mweb.co.zw
Rural Unit For Development Organization (RUDO)	Mrs S Hamadziripi	P O Box 1329 Masvingo	039-62374	mahohoma@mweb.co.zw
FACT Mutare	Mr C Ngarivhume	P.O. Box 970 Mutare	020-63564	jeph@zol.co.zw
ZAPSO	Muchaneta Zhangazha	Box CY1417 Causeway Haraare		
	19			
NGOs - COMMUNITY BASED ORGANISATIONS				

Chiedza Home of Hope	Mrs Susan Ndongwe	3659 61st Crescent Glenview 3 Harare	04-692983	chiedzah@africaonline.co.zw
Together As One Highfield Legal Advise Centre	Mr Washington Masenda	P.O. Box HD 369 Highfield	04-661819, 091 329137	washmas@yahoo.co.uk
Nhimbe Trust	Mr Joshua Nyapimbi	P.O. Box 509 Bulawayo	09-886104	nhimbetrust@comone.co.zw
Isibi Sabo Mthwakazi Trust	Mr Bekezela Dube	P.O. Box RY94 Rayton Bulawayo		isibisabomthwakazi@classicmail.co.za
Uzumba Orphan trust	Mr F Chimombe	P.O. Box 379, Mrewa	091 369965	uzumba@hotmail.com
Hope AIDS Orphan Support Service (HOSS)	Mr Sherperd Chawira	P.O. Box 203 Beatrice	065-517	
Mufudzi Wakanaka HBC	Pastor Staben Maenda	P.O. Box 150 Mubaira Mhondoro	065-3014	
Kariba AIDS Network	Miss Ellen Vengere	P.O. Box 95 Kariba	061-2382/3	
Soul's Comfort Trust	Miss Vimbai Bhiri	P.O. Box 264 Gwanda	084-20834	costainmpala@yahoo.com
Sikhethimpile Centre	Mr Meck Sibanda	P.O. Box 119 Maphisa, Kezi	082-446	sikheth@mweb.co.zw
Batsiranai Buhera South	Mr. Francis Tembo *	P.O. Box 150 Birchenough Bridge	0248-2324	batsiranai@zol.co.zw
ZNNP+	Miss Tendai B. Chimusoro	Masvingo	039-62229	tbchimusoro@yahoo.co.uk
Batanai HIV and AIDS Support Group	Mr Peter Marimi	P.O. Box 1707 Masvingo	091 405790	pmarimi@hotmail.com
SEVACA (Sengwe Vamanani Caring Association)	Mrs Tsitsi Machisi	P.O. Box 510 Chiredzi	011 408906	
Silveira House	Ms Thokozani Mugwetsi	P.O. Box 545 Harare	04-491856	silveir@admin.co.zw
Hwange Urban Arts Assembly	Mr Petros Ndhlovu	P.O. Box 92 Hwange	081-2271/2	
GWAPA Gweru Women AIDS Prevention Association	Ms Petty Govathson	P.O. Box 2474 Gweru	054-27500	gweru-aids-prevention@yahoo.co.uk
Eden Home Health Centre	Mr Martin Moyo	P.O. Box 985 Gokwe	023 421142	
Murambinda Home Based Care Programme	Mr Steven Mushambi	Box 16 Murambinda	021-2264	
	19			
INTERNATIONAL NGOs				
Africare Zimbabwe	Miss Nelia Matinhure *	22 Carlise Drive Alexandra Park Harare	04-745859	nmatinhure@africare.co.zw
Catholic Relief Services (CRS)	Dr J. Kirk Felsman *	103 Livingstone Ave Harare	091 286793	kfelsman@crszim.org.zw
John Snow International (UK)	Mrs Judith Sherman *	Standards Assoc. Bldg Northridge Park Borrowdale Harare	04-850265	jsherman@jsiuk.co.zw

John Snow International (UK)	K Zvobgo	Standards Assoc. Bldg Northridge Park Borrowdale Harare	04-850265	
Plan International	Mrs Alima Musa	7 Lezard Road Milton Park Harare	04-791601	Alima.Musa@plan-international.org
SAFAIDS	Mrs Lois Lunga	17 Beveridge Rd Avondale Harare	04-336193/4	lois@safaids.org.zw
CESVI	Mrs Emilia Venetsanou	29 Northwood Rise Mount Pleasant	091 913673	cesvivenetsanou@zol.co.zw
Futures Group	Mrs Sarah Musungwa	1 Adylin Rd CFU Building Marlborough Harare	04-309855-9	smusungwa@fgzapa.org.zw
John Snow Incorporated/DELIVER	Mr David Alt	1 Adylin Rd CFU Building Marlborough Harare	04-309829	dalt@zol.co.zw
John Snow Incorporated/DELIVER	P Shumba	1 Adylin Rd CFU Building Marlborough Harare	04-309829	
PACT	Mrs Bernadette Sobuthana	29 Lawson Avenue Milton Park Harare	04-794620	bernadetteso@pact.org.zw
COSV	Dr Maria Extremania *	10 Devilliers Rd Alexndra Park Harare	04-744975	cosvzimb@zd.co.zw
Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)	Dr. Maurice Adams *	33 Lawson Milton Park Harare	04-723375	maurice@ppedaids.org
Medicins San Sronteries (MSF)	Dr Tendesayi Kufa	50 Harvey Brown Road Milton Park Harare	04-720918	msf-harare@barcelona.msf.org
Population Services International (PSI)	Dr Karin Hatzold	30 The Chase Emerald Hill Haare	04-334631	khatzold@psi-zim.co.zw
Southern African AIDS Trust (SAT)	Mrs Hester Musandu	P.O. Box 390 KOPJE Harare	04-781123-9	hestermusandu@satregional.org
	16			
LEGAL/ADVOCACY BODIES (11)				
Legal Resources Foundation (LRF)	Jacqueline Mupanhanga	5th Fl Blue Bridge Eastgate Harare	04-251170/4	lrfhre@mweb.co.zw
Child Protection Society	Mrs Doreen Mukwena	Cnr H. Chitepo/Snowdon Rd Belvedere Harare	091 283389	advocacy@mweb.co.zw
ZAHA Life Project	Mr Tapiwa Kujinga *	P.O. Box 838 Mutare		
Women in Law Southern Africa (WILSA)	Miss Slyvia Chirawu	2nd Floor Zambia House Kwame Nkrumah Avenue Harare	04-771959	schirawu@yahoo.com

Musasa Project	Sheila Mahere	64 Selous Ave Cnr 7th Street Harare		
PATAM	Mr Wilson Johwa	C/o The Centre 24 Van Praagh Ave Milton Park Harare	091 316152	wilsonjohwa@yahoo.com
Zimbabwe Women Lawyers'Association (ZWALA)	Ms Joyce Sivereyi	17 Fife Ave Harare	04-706676	joyce@zwala.co.zw
PADARE	Mr Regis Mtutu	The Ecumenical Centre, 83 Central Avenue Harare	04-799047	padare@mweb.co.zw
Women's Action Group (WAG)	Mrs Ednah Masiyiwa	11 Lincoln Rd Avondale Harare	04-339161	wag@wag.org.zw
GALZ	Miss Clara Kena	35 Calenbrander Rd Milton Park Harare	04-741736	gender@galz.co.zw
	10			
PLWHAS (10)				
The Centre	Miss Marvelous Muchenje	24 Van Praagh Ave Milton Park Harare	04-732966	centre2@africaonline.co.zw
Public Personalities Against AIDS	Mrs Tendayi Westerhof *	2nd Fl Thomson House 130 Harare Street Harare	04-780200	ppaat@mweb.co.zw
ZNNP+	Mrs Florence Gwazemba	28 Divine Rd Milton Park Harare	04-741824	znnp@znnp.co.zw
Wandzanai support Group	Mrs Sherry Chitenga	1272 Red Cross Crescent Chikange Karoi		
Difereni Support Group	Miss Loice Machete	Tongwe Sec. School P. Bag 5722 Beitbridge	086-2290	
FASO Support Group	Mr Tonderai Chiduku	363 Area 13 Dangamvura, Mutare	020-66309	
	6			
GOVERNMENT				
Parliament of Zimbabwe	Hon L Mupukuta	c/o The Clerk of Parliament Harare		
Parliament of Zimbabwe	Hon J Sansole	c/o The Clerk of Parliament Harare		
Parliament of Zimbabwe	Mr Gibson Munyoro	c/o The Clerk of Parliament Harare	011 871796	
Parliament of Zimbabwe	Nomalanga Khumalo	14887 Nkumulane	04- 700181	
Parliament of Zimbabwe	Mr Bethel Makwembere	c/o The Clerk of Parliament Harare	04- 700181	

Parliament of Zimbabwe	Mr Blessing Chebundo	c/o The Clerk of Parliament Harare	04- 700181	chebundo@yahoo.com
Parliament of Zimbabwe	Mr Isaac Mackenzie	c/o The Clerk of Parliament Harare	04- 700181	
Parliament of Zimbabwe	Miss Aillet Mukono	c/o The Clerk of Parliament Harare	04- 700181	
Parliament of Zimbabwe	Mr Lovemore Mupukuta	c/o The Clerk of Parliament Harare	011 764374	
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President's Office	Ms Florence Nhekairo	P Bag 7700 Causeway Harare	04- 797271	
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Public Service Commission	Tendai R W Bare	Box CY 440 Causeway Harare	04-250238	
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Public Service Commission	Mrs Clara Nondo	Box CY 440 Causeway Harare	04-700883	
Public Service Commission	Dr Job Whabira	Box CY 440 Causeway Harare	04-700881	
Public Service Commission	Mrs Precious Mudonhi	Box CY 440 Causeway Harare	04-700881	
Public Service Commission	Mr Rodgers Sisimayi	Box CY 440 Causeway Harare	04-700881	
Public Service Commission	Mr L Duve	Box CY 440 Causeway Harare	04-700881	
Public Service Commission	Mrs S Mutasa	Box CY 440 Causeway Harare	04-700881	
Public Service Commission	Dr Sylvia Utete-Masango	Box CY 440 Causeway Harare	04-700881	
Public Service Commission	Mrs Norah Machekano	Box CY 440 Causeway Harare	04-700881	
Public Service Commission	Mr Clive Manjengwa	Box CY 440 Causeway Harare	04-700881	
Public Service Commission	Mrs Nyasha Bore	Box CY 440 Causeway Harare	04-700881	
Public Service Commission	Mr Matondo	Box CY 440 Causeway Harare	04-700881	
Public Service Commission	Mr Dennis Chifamba	Box CY 440 Causeway Harare	04-700881	
Public Service Commission	Mr Nelson Zvidzai	Box CY 440 Causeway Harare	04-700881	
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Ministry of Health	Mr F D Bastillo	2nd Floor Mukwati Building MOHCW Harare		
Ministry of Health	Mr J Tshabalala	2nd Floor Mukwati Building MOHCW Harare		
Ministry of Health	Mr J Masamvu	2nd Floor Mukwati Building MOHCW Harare		
Ministry of Health	Mr M T Nyandoro	2nd Floor Mukwati Building MOHCW Harare		
Ministry of Health	Mrs R Madzima	3rd Floor Kaguvi Building MOHCW Harare		
Ministry of Health	Dr Sikosana	2nd Floor Mukwati Building MOHCW Harare		
Ministry of Health	Mr I W Chikiyi	2nd Floor Mukwati Building MOHCW Harare		
Ministry of Health	Dr Pazvakavambwa	2nd Floor Mukwati Building MOHCW Harare		
Ministry of Health	Dr Madziwa	2nd Floor Mukwati Building MOHCW Harare		
Ministry of Health	Mr Nathan Tinarwo	2nd Floor Mukwati Building MOHCW Harare	04-798537	
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Ministry of Health	F K Zingoni	2nd Floor Mukwati Building MOHCW Harare		
Ministry of Health	C P Muganiwa	2nd Floor Mukwati Building MOHCW Harare		
Ministry of Health	Dr S Chiriva	2nd Floor Mukwati Building MOHCW Harare		
Ministry of Health	Mr V K Nyamandi	2nd Floor Mukwati Building MOHCW Harare		
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Ministry of Health - AIDS & TB Programme	Miss Getrude Ncube	P O Box CY 1122 Causeway Harare	04 - 726803	nacp@telco.co.zw
Ministry of Health	Mrs Chiweshe	P O Box CY 1122 Causeway Harare	04 -798537	
Ministry of Health	Ms Sheila Chidyausiku	P O Box CY 1122 Causeway Harare	04- 790513	
Ministry of Health	Miss Cynthia Chasokela	P O Box CY 1122 Causeway Harare	011 723 367	wallace@ecoweb.co.zw
Ministry of Health - Cuban Medical Brigade	Dr J G Caperillo	P O Box 1478 Avondale Harare	091 245 248	
Ministry of Health - Cuban Medical Brigade	Dr C Gverrapena	P O Box 1478 Avondale Harare	091 245 248	
Ministry of Health - Cuban Medical Brigade	Dr H Alvarez Martinez	P O Box 1478 Avondale Harare	091 245 248	
Ministry of Health - Cuban Medical Brigade	Dr B R Esqvivel Benitez	P O Box 1478 Avondale Harare	091 245 248	
Ministry of Health - Cuban Medical Cooperation	Dr F D Bustillo	P O Box 1478 Avondale Harare	091 245 248	
Ministry of Health	Mr D Meriwether			
Ministry of Health	N Mujuru			
Ministry of Health	Mrs I Moyo			
Ministry of Health-Harare Hospital	T Nyahodza	P O Box ST890 Southerton Harare		
Ministry of Health-Harare Hospital	Dr Chimhini	P O Box ST890 Southerton Harare		
Ministry of Health-Harare Hospital	Dr Milton Chemhuru	P O Box ST890 Southerton Harare	011 738789	
8 Ministries (2 HQ level 2 Provincial/District level)				
Ministry of Labour and Social Welfare HQ	Mrs Sibusisiwe Zembe	P Bag 7707 Causeway Harare	04-250193	szembe@zarnet.ac.zw
Ministry of Labour and Social Welfare HQ	Mr Nathan Nkomo	P Bag 7707 Causeway Harare	04-252368	
Ministry of Labour & Social Welfare P/D	Mr Jefferson Tsuro	P Bag 7505 Chinhoyi	067-23815	jfmhanda@yahoo.com
Ministry of Labour & Social Welfare P/D	Mr S G Mhishi	P Bag 7707 Causeway Harare	04-250193	
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Ministry of Youth and Gender P/D	Miss C. Matizha	P Bag 7735 Causeway harare	04-708373	
Ministry of Youth and Gender P/D	Miss E Chitambira	P Bag 7735 Causeway harare	04-708373	
Ministry of Education HQ	M F Choga	Box CY 121 Causeway harare		
Ministry of Education P/D	Mr A Mavise	Box CY 121 Causeway harare		
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Ministry of Higher and Tertiary Education H/Q	Mr Munorwa Masaka	Box UA 275 Union Avenue Harare	04-796441	Masakam@mhet.ac.zw
Ministry of Higher and Tertiary EducationP/D	Mr Fanuel Manyinyire	Belvedere Tech Teachers' College Box BE100 Belvedere Harare	04-778180, 023 514423	fmanyinyire@yahoo.co.uk
Ministry of Higher and Tertiary EducationP/D	Mrs Agnes Dube	Box 1700 Harare	011 769776	
Ministry of Agriculture HQ	Mr Ian Madume (ARDA)	P Bag 7701 Causeway Harare	04-700095-8	ian@arda.co.zw
Ministry of Finance HQ	Mr Mupuriri			
Ministry of Finance P/D	Mr Nemaruru			
Ministry of Information HQ	The Permanent Secretary	Box CY 1276 Causeway Harare		
Ministry of Local Government and Housing HQ	Ms Rose Rudo Sanyamandwe	Cnr Herbert Chitepo/Leopold Takawira Harare	04-793700	
Ministry of Local Government and Housing HQ	Mr Bigy Narira	Cnr Herbert Chitepo/Leopold Takawira Harare	04-793700	narirab@webmail.co.za
Ministry of Local Government and Housing P/D	Mr Tendai G. H. Pangeti	Cnr Herbert Chitepo/Leopold Takawira Harare	04-708646	
Ministry of Local Government and Housing P/D	Miss T. L. Manjengwa	Cnr Herbert Chitepo/Leopold Takawira Harare	04-792201	
Ministry of Foreign Affairs	Mr Mortazavi	Box CY 4240 Causeway Harare		
Ministry of Foreign Affairs	Mr A Sangi	Box CY 4240 Causeway Harare		
Ministry of Foreign Affairs	Mr Tadeous T Chifamba	Box CY 4240 Causeway Harare		
Ministry of Foreign Affairs	Mr Joey Bimha	Box CY 4240 Causeway Harare	04- 750965	
Ministry of Foreign Affairs	Mrs Pavelyn Musaka	Box CY 4240 Causeway Harare	04- 704139	
Ministry of Foreign Affairs	Mrs Caroline Matipira	Box CY 4240 Causeway Harare	04- 794681	
Ministry of Transport and Communication	Dr Virgi Masunda	Box CY BW 1657Borrowdale Harare	04-786053	masunda@yahoo.com

Ministry of Justice	Mr S M Goneso			
Department of Natural Resources	Mrs Mutsa Chasi	DNR Makombe Bldn Block 1	04- 705671	zpn143@mweb.co.zw
Department of Social Service	Mr Togarepi A Chinake	P Bag CY429 Causeway Harare	04-703711	
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Matabeleland South Province	PMD Dr. Jabulani Ndlovu	P. Bag A 5225 Bulawayo	09-68346	jndlovu@healthnet.zw
Matabeleland Norht Province	PMD Dr. Gibson Mhlanga	P.O. Box 4441 Bulawayo	09-77919	gmhlanga@healthnet.org.zw
Mashonaland Central Province	PMD Dr. Biggie Mabaera	P.O. Box 96 Bindura	071-6764	mabaera@africaonline.co.zw
Mashonaland West Province	PMD Dr. Wenceslas Nyamayaro	P.O. Box 139 Chinhoyi	067-23211	wenceslas2001@yahoo.co.uk
Mashonaland East Province	Dr B Madzima	P.O. Box 10 Marondera		
Midlands Province	Dr. S. Chihanga *	P.O. Box 206 Gweru	054-21394-7	
Manicaland Province	PMD Dr. Robert Mudyiradima	P.O. Box 33 Mutare	020-60624	rmudyaradima@healthnet.zw
Masvingo Province	PMD Dr. Tapuwa Magure *	P.O. Box 147 Masvingo	039-65745	tmagure@yahoo.com
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Director Health Services Department City of Harare	Dr. L. Mbengeranwa	P.O. Box 596 Harare		
Director Health Services Department Bulawayo City	Dr. Zanele E. Hwalima	P.O. Box 1946 Bulawayo	09-71405	adph@healthnet.zw
Director Health Services Department Chitungwiza	Dr. Simoyi	P.O. Box CZA 70 Chitungwiza		
District Hospitals (2 per Province) 20				
District Hospital - Zvishavane	Ms T. Mhlanga District Nursing Officer	Zvishavane	054-21394-7	
District Hospital - Mvuma	Dr Tsododo District Medical Officer	Mvuma	054-21394-7	
District Hospital - Midlands	Ms M. Maketo Provincial Nursing Officer	Midlands	054-21394-7	
District Hospital - Midlands	Ms A. Makotore A/STI/HIV and AIDS Coordinator	Midlands	054-21394-7	

District Hospital - Banket	Mrs Stella Zengwa	Banket Hospital Box 28 Banket	066-3177	
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District Hospital - Harare Central Hospital	Dr Samuel Lutalo	Harare Central Hospital P O Box CY 2538 Causeway Harare	04-707111	slutalo@healthnet.zw
District Hospital - Harare Central Hospital	Dr Iskra Glavintcheva	Harare Central Hospital P O Box CY 2538 Causeway Harare	04-621100	iglavintcheva@healthnet.zw
District Hospital - Parirenyatwa Hospital	Dr. Martin Odwee	Ministry of Health Parirenyatwa Hospital	04-701556	odwee@africaonline.co.zw
District Hospital - Masvingo	Miss Judith Chitando	7124 Kopje Street Masvingo	039- 62463	
District Hospital - Chinhoyi	Miss Clemenciana Bakasa *	PMD Mash West Box 139 Chinhoyi	067-23211	cbakasa2001@yahoo.com
District Hospital - Mpilo Hospital	Dr. Mark Dixon *	Mpilo Hospital Bulawayo	011 424336	hilarychigu@yahoo.com
District Hospital - Mpilo Hospital	Dr. Hilary Chigu	Mpilo Hospital Bulawayo	09-61632	mdixon@netconnect.co.zw
District Hospital	Dr. Lindiwe Mlilo	Mpilo Cenral Box 2096 Bulawayo	09-212011	
District Hospital - Chegutu	Dr. Stella Chiriva	Chegutu Hospital Box 468	053-3303	chegutuhosp@healthnet.zw
District Hospital - Chinhoyi	Miss Egnes F. Makwavarara	748 Spreckley Close Chinhoyi	067-24429	emakwavarara@yahoo.ca
District Hospitals - Chinhoyi	Clifford T. Mafusire	Chinhoyi Provincial Hospital Box 17 Chinhoyi	067-22395	ctmafusire@hotmail.com
District Hospital - A/PHEO Manicaland	Mr Makoni	A/PHEO Manicaland Box 323 Mutare	020-60624	
District Hospital - A/PNO Manicaland	Mrs Chikukwa	A/PNO Manicaland Box 323 Mutare	020-60624	
District Hospital - DNO Manicaland	MMr K Mudozhi	DNO Chipinge Box 323 Mutare	020-60624	
District Hospital - DNO	Mrs A Vinga	DNO Makoni Box 323 Mutare	020-60624	
District Hospital - Mash East	Mrs Masangwi			
District Hospital - Midlands	PNO Mrs Thokozani Ngwere	P O Box 206 Gweru	054- 21394	
District Hospital - Midlands	Dr Simon Chinhanga	P O Box 206 Gweru	054 - 21227	simonc@mweb.co.zw
Metropolitan Clinic	Dr Malusi P Ndiweni	P O Box MP1365 Mount Pleasant	04- 723639	

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Zimbabwe Airforce HQ	Miss Nyaradzai Chiwara	P. Bag CY 7721 Harare	04-795143	
Zimbabwe Airforce H/Q	Dr. Maureen Chiweshe	P Bag CY 7721	04-795143	
Ministry of Defence HQ	Colonel (Dr) Gwinji (Director General Health Serv	Privatge Bag 7713 Causeway Harare	04-251570/3	
Ministry of Defence HQ	Brig Douglas Nyikayaramba	Privatge Bag 7713 Causeway Harare	04-251570/3	
Zimbabwe Prison Service HQ	Dr. Munyaradzi Madhombiro	P Bag 7718 Causeway Harare	04-710097	zps@gta.co.zw
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Zimbabwe Prison Service P/D	Mr Sirbet Makuzha	P Bag 7718 Causeway Harare	04-710097	zps@gta.co.zw
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Zimbabwe Republic Police	Mr F Mhishi	Box CY34 Causeway Harare	04-796426	
Zimbabwe Republic Police	Mr Charles Mhondoro	Box CY154 Causeway Harare	04- 777777	
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PRIVATE SECTOR (30) (1 EACH)				
Employers Confederation of Zimbabwe (EMCOZ)	Mr Ezreck Hweru	4 Central Avenue 2nd Floor Chamber of Mines Building, Harare	04-739647	
Zimbabwe Congress of Trade Unions (ZCTU)	Mr George N. Wilson	3rd Floor Travlos House, Jason Moyo/Rezende Str Harare	04-772723	nashowilson@yahoo.com
Zimbabwe Business Council on AIDS (ZBCA)	Mr Lovemore Kadenge *	c/o UniLever 2 Stirling Road Harare	04-753700	kudzai.kwenda@unileaver.com
Iron and Steel Workers Union (ZISCO)	Mr Moses Kavhenga	c/o Zisco Steel, P. Bag 8 Torwood Kwekwe	055-69799	
	4			
PRIVATE COMPANIES				
Astra Holdings –Harare	Mrs Elizabeth Mazetese	36 Bermingham Road Southerton Harare	04-754612	mazhetesee@farmec.co.zw
Dyno Nobel (Pvt) Ltd	Mr Simeon Pikirai Chakamba	P.O. Box 194 Kwekwe	055-23361	cfato@dynozim.co.zw
Hippo Valley Estates	Dr. Richard Davy *	P.O. Box 1 Chiredzi	031-2712	

Triangle Limited	Dr. Sheckie Mashange	P. Bag 801 Triangle	033-6387	
AED Smartwork Zimbabwe	Mr Titus Moetsabi	32 Cumberland Drive Eastlea Harare		
Circle Cement	Mr Wilson Kado	Circle Cement Manresa Works Arcturus Rd, Harare	04-491028-34	
Windmill	A Masendeke	Box WGT 560 Westgate Harare		
Interfresh	Mr Trust Mabaya	Cnr Boshoff Drive/Shepperton Road Graniteside Harare	04-758520/30	trustm@interfresh.co.zw
First Banking Corporation	Miss Netsai Chihuri	76 Samora Machel Avenue Harare	04-774946	netsaichi@yahoo.co.zw
Old Mutual	Dr. Audrey Chivaura	100 The Chase West Emerald Hill Harare	04-308400	audrey@oldmutual.co.zw
British American Tobacco Limited	The Chief Executive	1 Manchester Road Southerton Harare		
Cotton Company of Zimbabwe	Mr M Rooyen	1 Lytton Road Workington Harare		
Anglo American Corporation	Mr Charles Makina	Charter House 70 Sdamora Machel Avenue Harare	091 233682	cmakina@aacs.co.zw
Dairibord Zimbabwe Limited	Mrs D Mvududu-Bope	9th Floor Intermarket Life Towers Cnr Sam Nujoma/Jason Moyo Harare	04-790801	chindoveb@daribord.co.zw
Varichem Phamaceticals	Mr Hercules T. Maguma *	194 Gleneagles Road Willowvale Harare	04-667763-5	expeder@mweb.co.zw
National Foods (Pvt) Ltd	Mrs M Sanyanga			
Barclays Bank	Mrs Beauty Maringani			
Crown Agents Zimbabwe (Pvt) Ltd	Mr Thomas Wushe	P O Box 4200 Harare	04-850265	thomasw@zw.crownagents.com
Crown Agents Zimbabwe (Pvt) Ltd	Mr Richard Deh	P O Box 4200 Harare	04-850265	cazim@zw.crownagents.com
Zimasco	Dr Everton Maisiri	P O Box 124 Shurugwi	011 413371	maisiri@zimasco.co.zw
Nestle Zimbabwe	Mr Almot B. Mushavi	Box 1668 Harare	04-702393	almot.mushavi@zw.nestle.com
	21			
MEDIA (5)				
Media For Development Trust	Miss Lavinia Mushamba	19 Van Praagh Ave Milton Park Harare	04-701323	sales@mfd.co.zw
	1			

HEALTH-RELATED PROFESSIONAL ASSOCIATIONS (7)				
Zimbabwe Medical Association (ZIMA)	Dr Billy Rigava	ZIMA House 172 Baines Ave Harare	04-612254	rigava@telco.zw
Zimbabwe Nurses Association (ZINA)	Miss Abigail Kurangwa	47 Livingstone Ave Harare	04-700479	
Laboratory Services	Dr. Obadiah Moyo	Hematology Department B Floor Corridor Parirenyatwa Hospital	04-701382	abamoyo@hotmail.com
Zimbabwe Dental Association	Prof Midion Mapfumo Chidzonga	143 Fife Avenue Harare	04-795964	mmchidzo@utande.co.zw
Medical & Dental Practitioners Council	Dr Gordon Bango	Box 2817 Causeway Harare	09-72996	
	5			
RESEARCH INSTITUTIONS (20)				
National Institute of Health Research (former Blair Research)	Mrs R Zinyama	Cnr Josiah Tongogara Avenue and Mazoe Street Harare	04-253975-8	tkduri@yahoo.co.uk
Biomedical Research and Training Institute (BRTI)	DR. Simon Gregson *	17 Beveridge Road Avondale Harare	04-303294	Saigregson@aol.com
National Assosiation of Medical Aid Societies (NAMAS)	Mrs Florence Kazhanje	No 6 King George Court King George Road Avondale Harare	04-70903803	fkazhnje@aacs.co.zw
National Blood Transfusion Service Zimbabwe	Mr Billy Sombi	Mazowe St. North, Avondale, Harare	04-707801-4	
National Blood transfusion Service	Mr James Chitsva	Central Hospital Grounds Khumalo Bulawayo	011 600 614	jchitsva@blodbank.co.zw
Medicines Control Authority of Zimbabwe	Ms Gugu N. Mahlangu	106 Baines Avenue Harare	04-736981-5	gnmahlangu@yahoo.com
Medicines Control Authority of Zimbabwe	Mrs Pricilla P. Nyamabayo	106 Baines Avenue Harare	04-736981-5	mcaz@africaonline.co.zw
Poverty Reduction Forum	Mrs Judith Kaulem	c/o University of Zimbabwe Room 19 and 20, First Floor, Institute of Development Studies Mount Pleasant Harare	04-307907	kaulem@prf.org.zw

Poverty Reduction Forum	Mr Daniel Matimba	c/o University of Zimbabwe Room 19 and 20, First Floor, Institute of Development Studies Mount Pleasant Harare	04-307907	research@prf.org.zw
National Pharmceutical Company	Mr Charles Mwaramba *	Lobengula Road Southerton Harare		
UZ College of Health Sciences	Dr. Gabriel Chirimumimba	University of Zimbabwe, Mount Pleasant Harare	04-791631	gabrielc@medsch.uz.ac.zw
UZ College of Health Sciences	Mr Witmore B. Mujaji	P O Box A178 Avondale Harare	04-791631	wbmujaji@medsch.ac.zw
UZ College of Health Sciences	Mrs Esnath J Sibenge	P O Box A178 Avondale Harare	04-791631	nursing@medsch.uz.ac.zw
UZ College of Health Sciences	Mrs Grace Nkhoma	P O Box A178 Avondale Harare	04-791631	Nkhoma@yahoo.co.uk
UZ College of Health Sciences	Mrs Beauty Gasura	P O Box A178 Avondale Harare	04-791631	nursing@medsch.uz.ac.zw
UZ College of Health Sciences	Mrs Mathilda Zvinavashe	P O Box A178 Avondale Harare	04-791631	zvinava@yahoo.com
UZ College of Health Sciences	Ms Margo B Mapanga	P O Box A178 Avondale Harare	04-791631	nursing@medsch.uz.ac.zw
UZ College of Health Sciences	Mr Andrew Madondo	P O Box A178 Avondale Harare	04-791631	andymadondo@yahoo.com
UZ College of Health Sciences	Mr Washington Mhare	P O Box A178 Avondale Harare	04-791631	wellasboy@yahoo.co.uk
UZ College of Health Sciences	Mrs Rudo Nyamakura	P O Box A178 Avondale Harare	04-791631	rnyamakura@yahoo.co.uk
UZ College of Health Sciences	Mrs Gladys Saburi	P O Box A178 Avondale Harare	04-791631	glsab@yahoo.com
UZ College of Health Sciences	Dr Clara Haruzivishe	P O Box A178 Avondale Harare	04-791631	claraharuzivishe@yahoo.co.uk
UZ College of Health Sciences	Ms Rose Ndlovu	P O Box A178 Avondale Harare	04-791631	ndlovurj@ecoweb.co.zw
UZ College of Health Sciences	Dr Kudakwashe G Mapanga	P O Box A178 Avondale Harare	04-791631	nursing@medsch.uz.ac.zw
UZ (Med. School)	Dr Lynn Zijenah *	College of Health Sciences Mazoe Street Harare	04-791631	lzijenah@health.zw
UZ (Med. School)	Dr E G C Muchaneta-Kubora	College of Health Sciences Mazoe Street Harare		
UZ /CERTC	Dr Jonathan Matenga	CERTC Dept UZ Medical School Parirenyatwa Hospital Mazoe Street Harare	04-791995	jonmatenga99@hotmail.com
UZ/CERTC-HAQOC	Dr. Chiratidzo Ndlovu	CERTC Dept UZ Medical School Parirenyatwa Hospital Mazoe Street Harare		natpac@healthnet,zw

UZ-UCSF Project	Mrs Mavis Kahwemba *	15 Phillips Avenue Belgravia Harare	04-704890	Kahwemba@uz-ucsf.co.zw
Zimbabwe National Family Planning Council	Mr Godfrey Tinarwo	Headquarters Highfield Road Spilhaus Clinic Harare	04-621909	znfpc@ecoweb.co.zw
Bindura University of Science	Mrs C.S. Katsinde	P. Bag 1020 Bindura	071-7531	
Africa University	Mr Maxwell V. Madzikanga	P.O. Box 1320 Mutare	020-60075	madzikangam@africau.ac.zw
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MULTILATERALS (16)				
AFRICAN CAPACITY BUILDING FOUNDATION (ACBF)	Mrs Grace Banya	7th and 15th Floor Intermarket Life Towers Cnr Jason Moyo Avenue/Sam Nujoma Str Harare	04-700208	g.banya@acbf-pact.org
FOOD AND AGRICULTURE ORGANISATION (FAO)	Dr Kaori Izumi	6th Fl Old Mutual Centre Cnr Jason Moyo Ave/3rd Street Harare	04-700724	fao-safr-registry@fao.org
INTERNATIONAL LABOUR ORGANISATION (ILO)	The Director	101 Nkwame Nkrumah Ave Harare		
UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP)	MissNomasomi Mpofu	7/8/9 Takura House 67-69 Kwame Nkrumah Ave Harare	04-792681	nomasomi.mpofu@undp.org
UNITED NATIONS EDUCATIONAL SCIENTIFIC AND CULTURAL ORGANISATION (UNESCO)	Mr Arno Willems	8 Kenilworth Road Newlands Harare	04-776775	a.willems@unesco.org
UNITED NATIONS DEVELOPMENT FUND FOR WOMEN (UNIFEM)	Ms Nomcebo Manzini	7th Floor Takura House 67-69 Kwame Nkrumah Avenue Harare	04-795972	nomcebo.manzin@undp.org
UNITED NATIONS DEVELOPMENT FUND FOR WOMEN (UNIFEM)	Mrs Memory Zonde	7th Floor Takura House 67-69 Kwame Nkrumah Avenue Harare	04- 792681	memory.zonde@undp.org
WORLD FOOD PROGAMME (WFP)	Mrs Mumtaz Osman	15 Natal Road Belgravia Harare	04-25247	mumtaz.sman@wfp.org
UNAIDS	Mrs Daisy Nyamukapa	Office of UN Resident Coordinator 6th Floor Takura House 67-69 Kwame Nkrumah Avenue Harare	04- 792681	daisy.nyamukapa@undp.org

UNITED NATIONS POPULATION FUND (UNFPA)	Mr Bruce Campbell	5th Floor Construction House 110 Leopold Takawira Street Harare	04-792681	campbell@unfpa.org
UNITED NATIONS POPULATION FUND (UNFPA)	Mr S. Chisungo	5th Floor Construction House 110 Leopold Takawira Street Harare	04-792681	
WORLD HEALTH ORGANISATION	Dr. Evarist Njelesni	Parirenyatwa Hospital Annex Bldg Mazowe Street Harare	04-253724	njelesanie@whoafr.org
WORLD HEALTH ORGANISATION	Dr. Batsirai Makunike	Parirenyatwa Hospital Annex Bldg Mazowe Street Harare		
UNITED NATIONS CHILDRENS FUND (UNICEF)	Dr Juan Ortiz	No 6 Fairbridge Ave Belgravia Harare	04-730093	harare@unicef.org
UNITED NATIONS CHILDRENS FUND (UNICEF)	Miss Nicolette Moodie	No 6 Fairbridge Ave Belgravia Harare	04-703941	nmode@unicef.org
	15			
BILATERALS				
Centres for Disease Control and Prevention (CDC)	Dr Shannon Hader *	2nd Floor 38 Samora Machel Ave, Harare	04-796032	haders@zimcdc.co.zw
Centres for Disease Control and Prevention (CDC)	Mrs Grace Osewe *	2nd Floor 38 Samora Machel Ave, Harare	04-796032	oseweg@zimcdc.co.zw
Centres for Disease Control and Prevention (CDC)	Dr Charity Alfredo *	2nd Floor 38 Samora Machel Ave, Harare	04-796032	alfredoc@zimcdc.co.zw
Centres for Disease Control and Prevention (CDC)	Ms Virginia Bourassa *	2nd Floor 38 Samora Machel Ave, Harare	04-796032	bourassav@zimcdc.co.zw
Canadian International Development Agency (CIDA)	Mr Sam London	45 Fife Avenue Harare	04-706781	psuzimbzbwe@acdi-cidapsu.co.zw
DFID	Mr Desmond Whyms	c/o British High Commission 7th Floor Corner House, crn Samora Machel Ave/Leopold Takawira St. Harare	04-774719	d-whyms@dfid.gov.uk
DFID	Miss Wendy Kawanzaruwa	c/o British High Commission 7th Floor Corner House, crn Samora Machel Ave/Leopold Takawira St. Harare	04-774719	w-kawanzaruwa@dfid.gv.uk

European Commission Humanitarian Aid Office (ECHO)	Mrs Regina Gapa	10TH Floor Construction House 110 Leopold Takawira Str Harare	04-707120	regina.gapa@cec.eu.nt
Delegation of European Union (EU)	Dr. Marc Bruycker	6th Floor Construction House 110 Leopold Takawira Str Harare	04-701912	marc.de-bruycker@cec.eu.int
Delegation of European Union (EU)	Dr Lisbeth Kallestrop	6th Floor Construction House 110 Leopold Takawira Str Harare	091 252502	lisbeth.kallestrup@cec.eu.int
Delegation of European Union (EU)	Mr Calisto Chihera	6th Floor Construction House 110 Leopold Takawira Str Harare	04-701912	calisto.chihera@cec.eu.int
German Technical Cooperation (GTZ)	Miss Theresa Ndikudze	No 1 Orange Grove	04-496723	gtz-hsr@mweb.co.zw
Japan International Cooperation Agency (JICA)	Mr James Nyahunde	8th Floor, International Life Towers, 77 Jason Moyo St. Harare	04-252500	jnyahunde@jicazim.co.zw
Swedish Development Cooperation (SIDA)	Ms Hazel Chinake	7th Floor, Pegasus House, 52 Samora Machel Avenue Harare		
Swedish Development Cooperation (SIDA)	Ms Joanna Plaluberg	7th Floor, Pegasus House, 52 Samora Machel Avenue Harare		
United States Agency for International Development (USAID)	Mr Peter Halpert	No 1 Pascoe Avenue Harare	04-252401	phalpert@usaid.gov
United States Agency for International Development (USAID)	Mrs Tonya Himelfarb	No 1 Pascoe Avenue Harare	04-252401	thimelfarb@usaid.gov
United States Agency for International Development (USAID)	Mrs Mercia Davids	No 1 Pascoe Avenue Harare	04-252401	mdavids@usaid.gov
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TRADITIONAL MEDICAL PRACTIONERS (10)				
TMPAZ	Dr Duri	University of Zimbabwe Mount Pleasant Harare		
ZINATHA	Dr. Chavunduka	Suite 202 Red Cross 98 Cameron Street Harare		

ZINATHA (Provincial)	Mr. Albert Mashoko	164 Herbert Chitepo St. Mutare		
ZINATHA (Provincial)	Mr Fanuel Hapanyengwi Nyashanu	House No 8-9 Mandava Zvishavanea		
ZINATHA (Provincial)	Miss Martha Katsande	4144 Chikudyu Crescent New Tafara Harare		
ZINATHA (Provincial)	Mr. Amon Ndlovu	16 Munondo St. Mufakose		
ZINATHA - Matabeleland Province	Miss Pricilla Chikono	7537/29 Tshalabalala, Bulawayo		
	7			
NAC	**National**			
National Aids Council (NAC) - National	Mrs D. Chirimuuta	No 98/100 Central Ave, Harare	04-796981	hzimudzi@nac.co.zw
National Aids Council (NAC) - National	Mr. Oscar M. Nyamayaro	No 98/100 Central Ave, Harare	04-796981	
National Aids Council (NAC) - National	Mr J. Sithole	No 98/100 Central Ave, Harare	04-796981	
National Aids Council (NAC) - National	Mr L. Maboreke	No 98/100 Central Ave, Harare	04-796981	
National Aids Council (NAC) - National	Mr A. Mpofu	No 98/100 Central Ave, Harare	04-796981	
National Aids Council (NAC) - National	Ms Madellina Dube *	No 98/100 Central Ave, Harare	04-796981	
National Aids Council (NAC) - National	Ms Vimbai Mdege*	No 98/100 Central Ave, Harare	04-796981	
National Aids Council (NAC) - National	Mr Mmafuso	No 98/100 Central Ave, Harare	04-796981	
National Aids Council (NAC)	Mrs B. Dube	No 98/100 Central Ave, Harare	04-796981	
NAC PROVINCIAL	**Nac Provincial**			
National Aids Council (NAC) - Harare Province	Miss B. Chigodo	PAC/PO		
National Aids Council (NAC) - Midlands	Mr Emmanuel M. Rubayah	PAC		
National Aids Council (NAC) - Matabeleland S	Mr Sinokuthemba Xaba	A/PAC		
National Aids Council (NAC) - Bulawayo Province	Mr Dingani Ncube	A/PAC		

National Aids Council (NAC) - Masvingo Province	Mr Raymond Yekeye	PAC		
National Aids Council (NAC) - Manicaland	Mr Martin Chizunza	PAC		
National Aids Council (NAC) - Mashonaland West	Mr Agrippa Zizhou	PAC		
National Aids Council (NAC) - Mashonaland West	Mr Lameck Mauhy	PAAC Chairperson		
National Aids Council (NAC) - Mashonaland C	Mr Andrew Timbe	PAC		
National Aids Council (NAC) - Matabeleland N	Mrs Rosemary Kona	A/PAC		
National Aids Council (NAC) - Mashonaland East	Mr Johnson Taruvinga	PAC		
NAC DISTRICT	**NAC DISTRICT**			
National Aids Council (NAC) - Epworth District	Mrs B. R. Luwaca	DAC		
National Aids Council (NAC) - Chitungwiza District	Mrs R. Tongoona	DAC		
National Aids Council (NAC) - Northern District	Mrs P. Samuriwo	DAAC Chairperson		
National Aids Council (NAC) - Midlands - NAC	Mr Peter Dube	DAC		
National Aids Council (NAC) - Tongogaara District	Mr Nkosana Muzeza	DAAC		
National Aids Council (NAC) - Matobo District	Mr Wilfred Ngwenya	DAAC		
National Aids Council (NAC) - Beitbridge District	Mr. Siyafa Moyo	DAAC		
National Aids Council (NAC) - Umzingwane District	Mr Alfren Ncube	DAAC-ARTIST		
National Aids Council (NAC) - Bulawayo - NAC	Ms M. Soko	DAC		
National Aids Council (NAC) - Luveve District	Mrs L. Nyathi	DAAC Chairperson		
National Aids Council (NAC) - Byo Tertiary College District	Mr A. Sithole	DAAC		
National Aids Council (NAC) - Mavingo Urban District	Mr Levison Nzvura	DAC		
National Aids Council (NAC) - Chivi District	Mr K. Marambire	DAAC		
National Aids Council (NAC) - Chipinge District	Mr James Gabaza	DAAC		
National Aids Council (NAC) - Makoni District	Mr Edward Pise	DAAC		

National Aids Council (NAC) - Makoni District	Mr Jaspa D. Nyarota	DAAC		
National Aids Council (NAC) - Kariba-Nyaminyami District	Mr Jacob Ngwenyama	DAC		
National Aids Council (NAC) - Kadoma District	Dr Nyika Gundu	DAAC		
National Aids Council (NAC) - Rushinga District	Mr Christian Mambo	DAAC		
National Aids Council (NAC) - Bindura District	Mrs Stella Muchapondwa	DAAC Chairperson		
National Aids Council (NAC) - Binga District	Mr Shadreck Mudimba	DAC		
National Aids Council (NAC) - Nkayi	Mr Medium Moyo	DAC		
National Aids Council (NAC) - Ruwa District	Mr Idine Magonga	DAC		
National Aids Council (NAC) - UMP District	Mr Sanyika	DAAC Chairpernon		
NAC Ward	**NAC WARD**			
National Aids Council (NAC) - Holycross Ward	Mr Jacob Gambiza	WAAC		
National Aids Council (NAC) - ZNNP+ Ward	Ms Constance Mohammed	WAAC		
National Aids Council (NAC) - Byo Tertiary College Ward	Ms B. Ndlovu	WAAC/PLWHA		
National Aids Council (NAC) - Byo Tertiary College Ward	Mrs S. Sabawu	WAAC/HBC GIVER		
National Aids Council (NAC) - UDACIZA Ward	Mr Nuywere Mangwiro	WAAC		
National Aids Council (NAC) - ZNNP+ Ward	Mrs Pauline Makute	WAAC		
National Aids Council (NAC) - Ward 15 Manicaland	Mrs Gladys Muzimba	WAAC		
National Aids Council (NAC) - Chinhoyi District	Miss Yananisa Zhou	WAAC/ZNNP+		
National Aids Council (NAC) - Murombedzi, Zvimba Ward	Ms Agatha R. Mutumburi	WAAC/HBC GIVER		
National Aids Council (NAC) - Bindura Ward	Mr Davison Gatsi	WAAC Chairperson		
National Aids Council (NAC) - Mvurwi Ward	Miss Ruth Mutape	WAAC Supervisor		
National Aids Council (NAC) - Nkayi Ward	Mrs Rebecca Masango	WAAC/Comm. Based Initiative		
National Aids Council (NAC) - Mrewa Ward	Mr. D.Mashonganyika	WAAC/PLWHA		
National Aids Council (NAC) - Ruwa Ward	Ms Tamari Timuri	WWAC/PLWHA		
National Aids Council (NAC) - Ward 12 Mrewa	Mr Jona Sewera	WAAC Chairperson		

NAC Various	**NAC Various**			
National Aids Council (NAC) - PLWHA	Ms E. Munyoro	Harare Province		
National Aids Council (NAC) - Elderly representative	Mrs E. Toriro	Harare Province		
National Aids Council (NAC) - Youth	Mr Luke Nyamazi	Harare Province		
National Aids Council (NAC) - Child MP	Mr Shepherd Nkomo	Matableleland South		
National Aids Council (NAC) - PLWHA	Mr Mavis Moyo	Matableleand South		
National Aids Council (NAC) - HBC GIVER	Mrs Lwazi Ngwenya	Matabeleland South		
National Aids Council (NAC) - Southern Afric Federation of Disabled	Ms A. Malinga	Bulawayo Province		
National Aids Council (NAC) - PLWGH	Mrs E. Zezeto	Masvingo Province		
National Aids Council (NAC) - Child Headed Family	Ms Felistas Dick	Masvingo Province		
National Aids Council (NAC) - CHBC	Mr C. Watipedza	Masvingo Province		
National Aids Council (NAC) - School AIDS Club	Mr Danson Ezrah	Masvingo Province		
National Aids Council (NAC) - Councellor	Mrs Audrey Hativagone	Mahonaland West		
National Aids Council (NAC) - CHBC	Mr Innocent Fuyane	Matabeleland North		
National Aids Council (NAC) - Herbalist-Moronga Project	Mrs Sophia Mweembe	Matableland North		
National Aids Council (NAC) - PLWA	Mrs Laizer Limangwe	Matableland North		
National Aids Council (NAC)	Mr Rumano			
National Aids Council (NAC)	Mr Ganje			
National Aids Council (NAC)	Mrs M Sanyaga			
National Aids Council (NAC)	T B Chimusoro			
National Aids Council (NAC)	Mrs Mandaba	100 Central Avenue Harare		
National Aids Council (NAC)	Dr B Sibanda			
National Aids Council (NAC)	Rev F Gono	100 Central Avenue Harare		
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SPEAKERS				
SPEAKER - Ministry of Health and Child Welfare				
SPEAKER	Dr Makurira	Masvingo		

SPEAKER	Mr Chipepera	Midlands Gweru		
SPEAKER - World Health Organisation (WHO)	Dr Robert Makombe, WHO (Harare)	Harare		
SPEAKER - DART	Dr Pascoe *	Harare		
SPEAKER - Luissa Guidotti	Dr Pesaresi *	Mutoko		
SPEAKER - SHAPE				
SPEAKER - Tsungirirai				
SPEAKER				
SPEAKER - ZINATHA	Mr Gwindi	Harare		
SPEAKER - Dept of Social Welfare				
SPEAKER - AID Smartwork				
SPEAKER - WASN				
SPEAKER	Dr Julia Hurwitz			
SPEAKER				
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PANEL FACILITATORS				
PANEL FACILITATOR - DART				
PANEL FACILITATOR - Dept of Social Welfare	Mrs Dhlembeu	Harare		
PANEL FACILITATOR - Save the Children Norway				
	3			
BREAKOUT SESSION FACILITATORS				
FACILITATOR -Nutrition Coucil	Mrs J Tagwireyi	Harare		
FACILITATOR - Midland Provincial Nutritionist	Mr P Chipepera	Gweru		
FACILITATOR	Dr Bwakura	Harare		
FACILITATOR - HOSPAZ				
FACILITATOR - Zimbabwe Red Cross Society	Mrs Muteiwa	Harare		
FACILITATOR - Elizabeth Glazer Foundation	Dr Anna Miller	Harare		
FACILITATOR - HAQOCI				
FACILITATOR - UNICEF				
FACILITATOR - ILO				
FACILITATOR - Delta Corporation				
FACILITATOR - HIVOS				
FACILITATOR - ZWALA				
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CHAIRPERSONS FOR ORAL ABSTRACTS				
CHAIR FOR ORAL ABSTRACT - MOHCW	Dr Tshimanga	Harare		
CHAIR FOR ORAL ABSTRACT - MOHCW				
CHAIR FOR ORAL ABSTRACT - City Health Hre				
CHAIR FOR ORAL ABSTRACT - Kapnek Trust	Dr Greg Powell	Harare		
CHAIR FOR ORAL ABSTRACT				
CHAIR FOR ORAL ABSTRACT - Hre Hospital				
	6			
PANELLISTS				
PANELLIST - The Centre				
PANELLIST - ZAPP				
PANELLIST - UNAIDS	Dr Dehne	Harare		
PANELLIST - Food & Nutrition Council				
PANELLIST - DART				
PANELLIST - The Centre				
PANELLIST - ZUJ				
PANELLIST - YOCIC				
PANELLIST - Uzumba Orphan Trust	Rev Chitiyo	Murewa		
PANELLIST - Rio Tinto	Mr Siapi	Kadoma		
PANELLIST - WAG	Miss Kureya	Harare		
	11			
AUDIENCE PARTICIPANTS				
AUDIENCE PARTICIPANT - GFTAM	Mr Mkweli	Harare		
AUDIENCE PARTICIPANT	Dr Bwakura	Harare		
AUDIENCE PARTICIPANT - Ministry of Education	Mr Bowora *	Harare		
AUDIENCE PARTICIPANTS - ZAPSO	Mrs Hungwe	Harare		
AUDIENCE PARTICIPANT - MOHCW	Mr Tsoka	Harare		
AUDIENCE PARTICIPANT - UNICEF	Ms Clara Dube	Harare		
AUDIENCE PARTICIPANT - Bezekela HBC				

AUDIENCE PARTICIPANT - Dept of Social Welfare	Mr Chinake	Harare		
AUDIENCE PARTICIPANT	Rev Manhanga	Bulawayo		
AUDIENCE PARTICIPANT - ZINATHA	Mr Gwindi	Harare		
AUDIENCE PARTICIPANT - HOSPAZ	Ms Lindi Choga	Harare		
AUDIENCE PARTICIPANT - NAC	J. Banda	Harare		
	12			
M.C's				
MASTER OF CEREMONY - JCI Deliver				
MASTER OF CEREMONY - WHO	Dr P. Makunike	Harare		
BOARD MEMBER - ZVITAMBO	Mr. Peter Iliff *			
	3			
OC				
CHAIRMAN ORGANISING COMMITTEE				
OC MEMBER - NAC	Mr. Manenji	Harare		
OC MEMBER - NAC	Mr. Zimudzi	Harare		
	3			
Scientific Committee				
SCIENT COMMITTEE - ELIZABETH GLAZER				
SCIENT COMMITTEE - MOHCW				
SCIENT COMMITTEE - UNICEF				
	3			
Resource Mobilization Committee				
Resource Mobilization - UNAIDS				
Resource Mobilization - MOHCW/EU				
	2			
ORAL ABSTRACTS				
ORAL PRESENTER - ZAPP	G. Kadzirange	Harare		
ORAL PRESENTER - MSF-Spain	Feli Ibanel	Harare		
ORAL PRESENTER - ZACH	E. Sithole	Harare		
ORAL PRESENTER - Africare Zimbabwe	C. Chipere	Harare		
ORAL PRESENTER - Chidamoyo Hospital	M. Mereki	Karoi		

ORAL PRESENTER - UZ Clinical EPID	G. Mawera	Harare		
ORAL PRESENTER - School and Colleges Perm.	W. Mugove	Harare		
ORAL PRESENTER - ZAPP	S. Moyo	Harare		
ORAL PRESENTER - JSI (UK)	L. Magwere	Harare		
ORAL PRESENTER - Kapnek Trust	F. Tarvireyi	Harare		
ORAL PRESENTER - Jesuit AIDS Project	N. Clement	Harare		
ORAL PRESENTER - David Whitehead Textiles	E. Katerere	Harare		
ORAL PRESENTER - UZ COMM MED	S. Matinhure	Harare		
ORAL PRESENTER - UZ Dept of Nursing	S. Chadenga	Harare		
ORAL PRESENTER - NRZ	B. Homela	Bulawayo		
ORAL PRESENTER - CRS STRIVE	J. Lentfer	Harare		
ORAL PRESENTER - Nat Institute of Research	S. Munyati	Harare		
ORAL PRESENTER - UNICEF	R. Pouwels	Harare		
ORAL PRESENTER - UNICEF/ZAPP	E. Jasi	Harare		
ORAL PRESENTER - BRTI	P. Mushati	Harare		
ORAL PRESENTER - UNAIDS	V. Ndlovu	Harare		
ORAL PRESENTER - UZ-UCSF	L. Sibanda	Harare		
ORAL PRESENTER - UZ Dept of Rel Studies	L. Togarasei	Harare		
ORAL PRESENTER - WAG	J. Mandangu	Harare		
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Poster Presenters				
Zimbabwe Red Cross Society	Muteiwa J		775416/18, 091 915 070	zrcs@harare.iafrica.com
Ruvimbo (Bindura Rehabilitation Network)	Muropa A		071-6666, 6555 ext 2039	
MOHCW	Mujuru N		023 287 339	nokumujuru@yahoo.co.uk
UZ Dept of Dentistry	Marimo C		791631-9 ext 2157, 091 397 180	clemmcmm@yahoo.co.uk
NUST, Applied Maths Dept.	Musekwa S		09-282842 ext 2349, 091 308 784	sdmusekwa@nust.ac.zw

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MSF			011 617 981, 720918, fax 794982	msfe-harare@barcelona.msf.org
MSF (Spain)	Ravinetto R			raffaella.ravinetto@barcelona.msf.org
UZ Clinical epidemiology resource and training centre dept	Hakim J		791631, 091 240 250	jhakim@samara.co.zw
UZ Clinical epidemiology resource and training centre dept	Haruzivishe C		791631, 091 240 250	
UZ Clinical epidemiology resource and training centre dept	Gwanzura L		791631, 091 240 250	lgwanzura@medsch.uz.ac.zw
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CDC Zimbabwe	Taylor A		796040	ATaylor2@cdc.gov
Mildmay International	Mavetera T		662308, 662312	tichmav@mweb.co.zw
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UZ - DART	Mahachi R		091 410 069	rachel@uz.crc.zw
MSF/Mpilo	Mukwevho E			msfe-bulawayo@barcelona.msf.org
UZ Comm Med	Machakwa Z			
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The STRIVE Project, CRS Zimbabwe	Jemison K		736740, 736715	kjemison@crszim.org.zw, kylejem@yahoo.com
Zimbabwe Open University	Majoni C		071-7484, 7107	cmajoni2002@yahoo.com, cleophaschidakwa@yahoo.com

NAC, District AIDS Coordinator, Rushinga, Mash Central	Mambo C		023 261 633, 011 863 970,	
Child Protection Society	Mukwena D		708829, 710024	advocacy@mweb.co.zw
Rural unity for Development Organization	Muza W		039-63906, 62374	rudo1@mweb.co.zw, mahohoma@mweb.co.zw
Matabeleland AIDS Council	Ncube L		09-62370, 61540, 091 321 973	linda.mac@telconet.co.zw, lynlynzw@yahoo.com
BRTI	Nyamukapa C		303294, 333364	Sajgregson@aol.com
Nhimbe Trust	Nyapimbi j			nhimbetrust@comone.co.zw
Tjinyunyi Babili Trust	Sibanda A		019-3381, 019-2337	bulirdp@mweb.co.zw
The STRIVE Project, CRS Zimbabwe	Tinarwo L		736740, 736715	kjemison@crszim.org.zw, kylejem@yahoo.com
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DOMCCP-STRIVE	Vudzijena A		025-3572, 091 922 859, 011 422 366	strive@comone.co.zw
Youth for a Child in Christ	Chirwa L		09-880834, 091 395 955	loveness@byo.masiye.com, yocic@byo.masiye.com
Zimbabwe Women's resource Centre and Network	Jones N		737435	njones@zwrcn.org.zw
New Dawn Children's Care trust	Mlambo A		690147	postmaster@newdawn.freehosting.net
BRTI	Chitiyo G		303294/7, 091 331 139	gchitiyo@vet.uz.ac.zw
GALZ	Tholanah M		741736, 740614	health@galz.co.zw
UZ-UCSF	Sibanda L		704890, 704920	lsibanda@uz-ucsf.co.zw
REPSSI	Moyo M		09-289462	kluckow@netconnect.co.zw
CAMFED Zimbabwe	Muzengi F		252389	cama@zwrcn.org.zw, cama2@zwrcn.org.zw
Kapnek Charitable Trust	Mutume R		792152/3, 091 351 622	rmut@ctazim.co.zw
Chipawo	Harimedi L		300925, 309887, 309730	chipawocmc@mango.zw
MPH Community trust	Gwekwerere N		881448, 023 294 389	rainbho@yahoo.com

United Methodist Church	Mwandira K		751508/9, Fax 791105	umczim@africaonline.co.zw
Batsirai group	Tisibele A		67-22398 / 24115	batsirai@mweb.co.zw, batsirai@mango.zw, nscchn@africaonline.co.zw
Catholic Youth Association	Mugoni S		059-2291, 2994	s_mugoni@yahoo.com
St. Alberts Mission Hospital	Tarira E		087-2238/2359	etarira@healthnet.zw
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BRTI	Dauya E		303294, 011 422 247	ethel.dauya@vet.uz.ac.zw
Bindura University of Science	Fata T		071-7531-6	peereducationgroup@yahoo.com
Batsirai group	Gweshe D		067-22398, 24115	batsirai@mweb.co.zw
St. Judes Children's research Hospital	Hurwitz J		USA 901-495-2464	julia.hurwitz@stjude.org
Jesuit AIDS project	Kabambire S		300811	jesuitaids@mango.zw
Africare Zimbabwe	Mutimbanyoka B		745859-61	bmutimbanyoka@africare.co.zw
Youth Alive Zimbabwe	Munakamwe M		301581	yazim@youthalivezimbabwe.co.zw
COSV	Prandini G		744975	cosvzim@yahoo.es, gprandini@earth.co.zw
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PSI	Ziyambi Z		339580	ntaruberekera@psi-zim.co.zw
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MOHCW	Mugwagwa R		702446	rumb@yahoo.com
Tsungirirai	Matambudziko T		062-2996	tsungi@mweb.co.zw

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MOHCW and MSF Spain	Ndebele W		091 913 299	msfc-bulawayo@barcelona.msf.org
ZVITAMBO	Tavengwa N		850732	jhumphrey@zvitambo.co.zw
ZVITAMBO	Hargrove J		850732	jhargrove@zvitambo.co.zw
ZAPP	Stranix-Chibanda L		091 247 175	lstranix@zappuz.co.zw
CESVI	Capello C		091 272 781, 091 283 754	zimbaceci@yahoo.it
CESVI	Fascendini M		091 283 754, 091 272 781	micolfascendini@inwind.it
ISPED Zimbabwe	Orne-Gliemann J		792152	Joanna.Gliemann@diplomatie.fr
ISPED Zimbabwe	Mukotekwa T		792152	mmhpmtct@mutare.mweb.co.zw
ISPED Zimbabwe	Ndoro T		792152	murewamtct@isped.co.zw
MOHCW	Ncube G			getrudezi@africaonline.co.zw
Youth Ahead Zimbabwe	Makaza S		210697, 091 926 102	kuiysap@mango.co.zw
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	Chirenda J			ctbasera@medsch.uz.ac.zw
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ZAPP	Marangwanda c		011 611 436	caroline@zappuz.co.zw
ZAPP	Mr Sostain Moyo		04-770610	sostain@zappuz.co.zw
	Chirapa E			
BRTI	Matambo R		011 413 294	rmatambo@vet.uz.ac.zw
PSI	Mhazo M		339580	ntaruberekera@psi-zim.co.zw
Asikhulemeni HIV and AIDS Prevention Network	Moyo M		09-67545, 482134	
University of Zimbabwe	Gwanzura L		791631, 091240250	lgwanzura@medsch.uz.ac.zw
Shingirirai Women Mabvuku	Davies M		499196	davies@mweb.co.zw
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Annex 7
List of Exhibitors during the Conference

The following organizations exhibited their programmes and what they are doing in HIV and AIDS.

Private Companies	Ngos, Multi- And Bilateral & International Organisations	Government
Datlabs (Pvt) Ltd	Zimbabwe National Quality Assur-	Ministry Of Youth, Gender And Employment Creation
Medsure Healthcare (Pvt) Ltd	Ance Programme / Consult Africa	Ministry Of Public Service, Labour And Social Welfare
Moducare	Tsungirirai Group	Zimbabwe National Family Planning Council
Diagnostic Laboratory Supplies	Batsiranai Group	Ministry Of Higher And Tertiary Education
Standard Chartered Bank Zimbabwe	Zach	Ministry Of Health And Child Welfare
Cimas	Sanaso	National Aids Council
Nutresco Foods	The Salvation Army Masiye Camp	
Nestle Zimbabwe	Crs	
Bp Shell Marketing Services		
Varichem Phamaceuticals (Pvt) Ltd	Child Protection Society	
Pharmaceutical And Chemical Distributors (Pdc)	Zimbabwe Women's Resource Centre	
Crown Agents		
	Zimbabwe Aids Network	
	Zimbabwe Aids Prevention Project	
	Global Health Servings	
	Futures Group International	
	Population Services	
	International Zimbabwe (Psi)	
	World Vision International	
	Southern African Aids Trust (Sat)	
	Delegation Of The European	
	Commission	
	United Nations	
	Sida / Pact Zimbabwe	
	Bible Society Of Zimbabwe / Scripture Union	
	Fact Mutare	
	Mac	
	Zinatha	
	Safaids	
	Zimbabwe Red Cross	
	Network Support For HIV and AIDS	
12 Private Companies	**Total = 29**	**4 Ministries & 2 Councils**

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