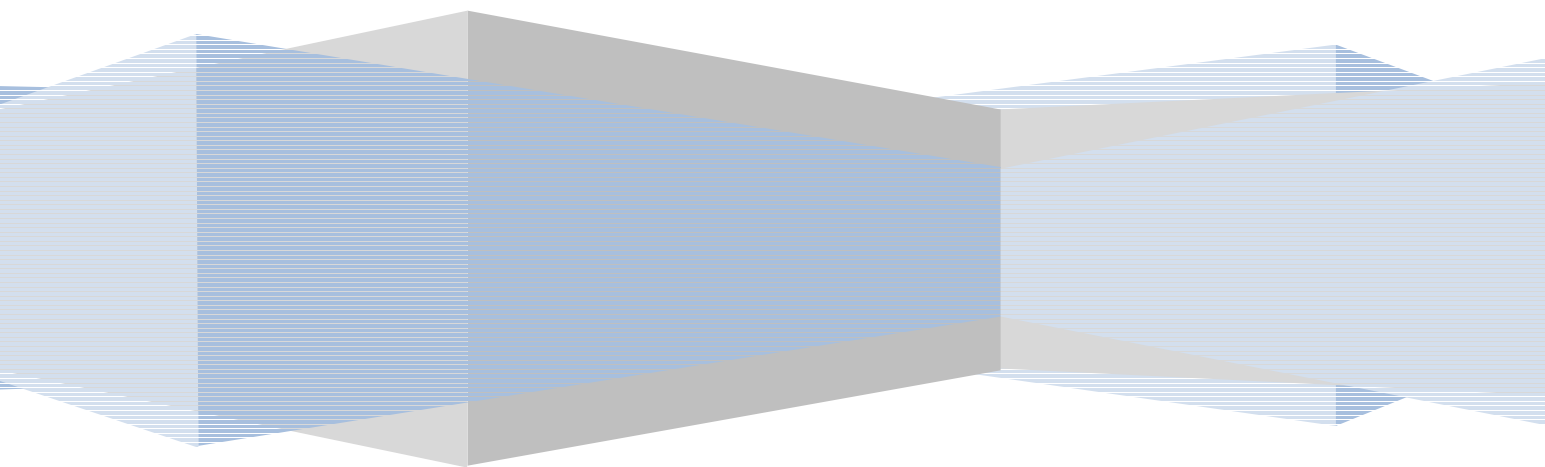


Zimbabwean Civil Society Organisations on HIV and AIDS

A Position paper in preparation for the 2011 United Nations
General Assembly Special Session Meetings (UNGASS) on HIV
and AIDS



Our Position

We, the representatives of civil society actors on Health, HIV and AIDS in Zimbabwe, concur with the Government's position that, considerable progress has been made especially in reducing HIV prevalence from a record 23.7% in 2001, 18.4% in 2005 and 14.3 % in 2009¹. The combined efforts of government, civil society and other key players is acknowledged.

We are however, gravely concerned that despite such remarkable progress, Zimbabwe still has the third largest HIV burden in Southern Africa with about 1.2 million people living with HIV. Significant gains were made in the scale up of access to antiretroviral treatment from 99 408 (9 594 children) at the end of 2007 to 148 144 (13 278 children) in December 2008 and 218 589 (21 521 children) by end of December 2009. This is 56.1% of those in need of treatment. We reaffirm our concern about the welfare of the 49% of adults and children unable to access treatment.

HIV and AIDS therefore, remains a priority challenge to human development and requires renewed vigour political will and commitment to honor national, regional and international commitments in order to achieve the three zero; zero new HIV infections, zero AIDS-related deaths and zero discrimination and the whole spectrum to universal access. We are accordingly calling on the Government of Zimbabwe to;

- Immediately put a stop to political violence and commit to bringing about lasting political settlement that will bring about lasting and sustainable peace in the country. The current volatile political situation is largely affecting HIV and AIDS mitigation initiatives such as supplementary feeding schemes and access to health services in general;
- Implement the Abuja Declaration on HIV and TB - allocate 15% of the national budget to Health, HIV and AIDS;
- Enact legislation that ensures the rights to health to all citizen regardless of sexual orientation.
- Decriminalize laws prohibiting accesses to health services for most at risk populations
- Respect basic human rights

This position was reached at after thorough and rigorous consultations by a core group representative of ASOs, CBOs, Networks and Organizations of PLHIV, Youth representatives, Gender Equality focused and Women's organizations, Media and Information organizations and People living with disability. The paper interrogates progress made in achieving universal access

¹ Calculations done using the EPP and Spectrum Software

to prevention, treatment, care and support as well as the attainment of Millennium Development Goals (MDGs) by 2015.

Background

In 2006, the international community committed to a historic political declaration, at the United Nations, to scale up the AIDS response toward Universal Access to HIV prevention, treatment, care and support by 2010. The foundation of this declaration was the 2001 Declaration on HIV and AIDS (UNGASS). Zimbabwe is a signatory to the declarations and commitments as well as other national, regional and international commitments namely; 2006 Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa and MDGs.

In September 2010, a high level MDG summit was convened at the UN and participants at the meeting renewed and reinforced their commitment to “...***making every effort to achieve the MDGs by 2015, including through actions, policies and strategies in support of developing countries, particular those countries that are lagging most behind and those goals that are most off-track, thus improving the life of the poorest people.***”²

The Government of Zimbabwe continues to demonstrate commitment and leadership in the national response to HIV and AIDS through the establishment of a National AIDS Council (NAC), in 1999, to coordinate the national response. NAC through the Zimbabwe National Strategic Action Plan (ZNASP II), has improved coordination in HIV and AIDS responses at all levels through the “Three Ones”, namely, one strategic plan, one monitoring and evaluation system and one coordinating authority.

AIDS Service Organisations (ASO) and other Civil Society organisations in Zimbabwe have continued to play a crucial role in complementing Government’s efforts in HIV and AIDS mitigations and in the provision of health services. This unit of purpose has seen HIV prevalence in the country declining from a record high of 23.7% in 2001 to 14.3 % in 2009.

It is certain that through such guidance and complimenting efforts between civil society, government and other actors, HIV prevalence will continue to decline. Continued and sustained successful implementation of behavior change programmes are largely to continue to contribute to the decline in HIV prevalence in the country. We are therefore calling on the Government to continue pouring more resources in Prevention Programmes. More and more young people are delaying having sex, fewer young people have causal or multiple sex partners and many young people are using condoms with non-regular partners.

We also recognize that natural dynamics where groups at higher risk are already infected or have died, new infections go down as there are fewer HIV negative persons at higher risk to be newly infected.

² The Millennium Development Goals, (MDGs) are eight specific development goals that all 192 United Nations member states and at least 23 international organizations have agreed to achieve by the year 2015. Zimbabwe, as a member of the United Nations, was among the UN member states promising to work hard towards attainment of the MDGs.

As Civil Society in Zimbabwe, we are calling for the full implementation of the Declaration of Commitment on HIV and AIDS (2001) and the Political Declaration on HIV and AIDS (2006). We would like to acknowledge the commendable progress, through concerted government, private, public and civil society efforts, made in:

- Significantly increasing access to treatment, community based care and support services for people living with HIV (PLHIV);
- HIV Prevention efforts that have contributed to the decline in HIV prevalence.

However, looking forward and in response to the new UNAIDS Treatment 2.0 vision of zero new infections, zero discrimination and zero AIDS-related deaths, we would like to raise/emphasis strategies which have been effective in our national response, and which need to be scaled up, as well as new or, additional initiatives that are needed, if the objectives of the ZNASP II as well as our global commitments are to be realised.

What has worked so far in the response?

- Zimbabwe's HIV prevention efforts have yielded positive results with the decline in HIV prevalence.
- There is a national fund established to compliment the national HIV and AIDS response.
- There is immense human resource capital and commitment to the national HIV and AIDS response by both service providers, community based organizations and community actors.

The gaps

- Creation of an enabling legislative framework to address the bottlenecks faced in accessing services. Zimbabwe still has the third largest HIV burden in Southern Africa with about 1.2 million people living with HIV.
- The National fund on its own cannot adequately repond to HIV and AIDS issues. Therefore, the Abuja declaration where 15% of the total government budget should go

towards health care for the nation should be enforced in order to support the provision of integrated services.

- There is continued need to commit to interventions for most at risk populations, in terms of estimating population size and providing appropriately targeted services;
- Strengthening integration of prevention into treatment care and support programmes;
- Civil society support for conducting parallel research in order to garner evidence that contribute to the on-going monitoring of programmes and interventions;
- Political will and commitment to addressing the volatile political environment affecting HIV and AIDS mitigation/responses.

The CSO's role in addressing the gaps

Recognising the partnership that needs to exist among all key actors, government and CSOs, we would want to highlight that most of the response to HIV has come from the mobilisation and activism of people living with HIV and civil society through meaningful involvement in HIV responses. As civil society, we therefore undertake to continue to;

- Demand creation for uptake and utilization of HIV and AIDS prevention, treatment and care services.
- Promote community based sensitization and mobilization activities to ensure zero HIV and AIDS related discrimination and that the human rights of PLHIV and affected households are recognised and respected.
- Monitor quality of services and undertaking advocacy for full implementation of national and international commitments.

OUR KEY MESSAGES

In order to attain zero new HIV infections, zero AIDS-related deaths and zero discrimination in line with the UNAIDS Treatment 2.0 vision, we underscore the need to respond in accordance to the indicators here below boxed in grey through **key messages** we consider vital in addressing the concerns of communities.

1. TO GET ZERO NEW INFECTION

Where:

- Sexual transmission of HIV is reduced by half, including in young people, in men who have sex with men, and transmission in the context of sex.
- Vertical transmission of HIV eliminated and AIDS-related maternal mortality reduced by half
- All new HIV infections prevented among people who use drugs
- There is roll back the socio- economic impact of HIV on communities, families, women, girls and children as poverty, food insecurity and other development challenges contribute to and reinforce HIV infection and its impact on the individual, household and community levels, in a vicious cycle.

OUR KEY MESSAGES`

1. The current budget for reproductive health is supported mainly by Donors instead of the Zimbabwe Government taking the lead. This is an area where the government should adhere to the provisions of under the Abuja Declaration of 1998, where a minimum of 15% of total government budget should go towards health care for the nation. To date the health budget has been way below the 15% mark.
2. Criminalization of same sex relationships such as the MSM continues to prohibit them to access services and thereby shooting down the efforts of achieving zero infections. Laws, policies and regulations that create obstacles to effective HIV responses by failing to ensure access to services; protection against discrimination; and upholding the rights of people living with HIV; women; children; sex workers; lesbian, gay, bisexual, transgender and intersex people; people with disabilities; prisoners; youth; people who inject drugs and others

with special needs and vulnerabilities should be instituted. In settings where protective legal frameworks exist, implementation and enforcement should be inconsistent;

3. There is a notable rise in STIs. This is a great cause for concern as transactional unprotected sex in heterosexual sex is the key driver of new infections. Government statistics on STIs in the country are inconsistent and mixed. The number of STI episodes recorded at public health facilities is said to be declining, from 624,000 STI episodes in 2005 to 268,000 in 2009. Inaccurate STI projections results in inadequate responses. We therefore urge for more resources to be availed for research and documentation to aid planning of response interventions.
4. There are still major gaps in the programming for the youth due to the policy environment, with special reference to the Ministry of Education which does not allow condom distribution in schools and no mechanisms are in place to reach the out of school youth. Our government need to realize they are increasing the risk of HIV infection among young people by not dealing adequately with sexual and life skills education and by providing full and comprehensive information and access to prevention methods through the curriculum in and in the school setting. This vulnerability of young man and women (youth) is a major concern as there are contradictions within our responses to this group – we acknowledge the vulnerabilities but do not want to talk of condoms for fear of encouraging sexual promiscuity among the youth. The Ministry of Education, Sports and Culture needs to introduce comprehensive approaches which must include sexual education. Women and girls in the region are disproportionately infected with and affected by HIV, due to biological and other vulnerabilities, the underlying causes of which include gender inequality; poverty; harmful cultural, social and gender norms and practices; gender-based violence and social marginalization, still prevailing in the region. The school therefore presents opportunities for redressing some of the challenges.
5. HIV and AIDS Life Skills Strategic Plan for the period 2006 to 2010 was developed and finalized in 2008, however, it is yet to be endorsed by the Ministry of Education. There is also weak coordination of youth programmes and absence of focal persons to focus on implementation of HIV prevention activities in tertiary institutions
6. Many Zimbabweans still do not know their HIV status despite the availability of HIV Counseling and Testing Services (HCT). There is need for intensified community mobilization and empowerment to ensure uptake and utilization of available services. Gender based violence in the private and public domains, including during times of political instability, must be addressed. SRHR of young girls is also an area which is being neglected/ under resourced and where much more needs to be done, particularly given the specific vulnerabilities of young women to HIV infection in the Zimbabwean context. Routine testing for HIV for patients presenting themselves for treatment is one way of promoting openness and uptake of ART services.
7. Limited or a reduction in donor funding has affected the coverage of most HIV and AIDS preventive, treatment and care programmes. There is need for domestic and international resource mobilization to cover the existing funding gaps. Observance of the Abuja Declaration of

1998, where heads of governments committed that a minimum of 15% of total government budget should go towards health care for the nation. Zimbabwe is still to meet that obligation.

2. TO GET ZERO DISCRIMINATION

- Punitive laws and practices around HIV transmission, sex work, drug use or homosexuality reduced by half.
- HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions.
- HIV-specific needs of women and girls addressed in at least half of all national HIV responses.
- Zero tolerance for gender-based violence

OUR KEY MESSAGES

1. Discrimination of PLHIV is prohibited by the Government of Zimbabwe under the National HIV and AIDS Policy of 2000. However, these policies are unclear in terms of protecting Most at Risk Populations (MARPs), hence these groups have no legal status in Zimbabwe. These include sex workers, men who have sex with men (MSM), women who have sex with women (WSW), and prisoners.
2. Due to the lack of conducive policy environment for marginalized and vulnerable populations (people in same sex relationships, sex workers, prisoners and internally displaced and mobile populations) the country has no data on the population size of these groups and very limited access to, and virtually no specific, HIV and AIDS services for these groups. We, representatives of civil society in Zimbabwe, are calling for the de-criminalisation and observance of fundamental human rights to create a conducive environment where services targeted to the needs of marginalised groups is prioritized. The government needs to openly admit existence of the diversity of sexual orientations and practices and open room for programmes to address risks.
3. There is an urgent need to conduct a research on MARPs in Zimbabwe that will look at various issues such as the size estimates and understanding the nature of the epidemic among these populations. Other variables would include an assessment of patterns, meeting points; behaviors which will also help develop relevant interventions.

4. Zimbabwe has legislation criminalizing domestic and gender based violence in Zimbabwe, however, there are a lot of enforcement challenges by the judiciary. Because of the socialization of some girls and women most GBV cases are not reported and those reported are often withdrawn rendering the rule of law futile. Civil society will therefore continue to sensitize communities on its provisions, strengthen the capacity of service providers to provide services, advocate for the full implementation and monitor implementation at all levels. We are calling for collaboration of the gender based violence units in the police in order to let the rule of law take its course

3. TO GET ZERO AIDS-RELATED DEATHS

- Universal access to antiretroviral therapy for people living with HIV are eligible for treatment.
- Tuberculosis deaths among people living with HIV reduced by half.
- People living with HIV and households affected by HIV addressed in a; national social protection strategies and have access to essential care and support.

OUR KEY MESSAGES:-

1. Whilst significant progress was made in terms of increasing the number of people on treatment the 2009 figures show as a result of the implementation of the WHO Treatment Guidelines 2009; approximately 51.6% of adults and children are still in need of treatment. Laboratory and diagnostic services as well, user fees and other practical barriers remain barriers to access to HIV and AIDS prevention and treatment services
2. Health staff retention challenges and economic challenges result in many people with advanced HIV infection being cared for within communities rather than in health institutions. As a result civil society will continue to work with communities to provide a continuum of care at community level.
3. Linkages between TB and HIV treatment/ services are still weak. Zimbabwe has the second highest tuberculosis (TB) mortality rate in the world and is ranked 17th amongst the 22 high burden countries which collectively constitute 80% of TB cases globally. Tuberculosis is among the top 10 diseases of public health importance in Zimbabwe and is the leading cause of death for people with compromised immune systems, including people

living with HIV, despite being completely curable. Civil society in Zimbabwe will seek to strengthen community based prevention, treatment and management of HIV-TB co-infection at community level including through providing adherence support, and care and support to affected individuals and their families. A capacity development framework for civil society to strengthen community based programming for TB-HIV to be developed. We are also calling the government and the donor community to invest in research and development of technology for early TB detection/diagnosis of TB especially pediatric TB. The Ministry of Health and Child Welfare should work towards integrating HIV and TB responses to get more people on treatment programmes.

Conclusion

As representatives of civil society actors on Health, HIV and AIDS in Zimbabwe, we reiterate our call to government to move from commitment to action in the response to HIV and AIDS. The Strategic Plan (ZNASP 2011 – 2015), is a good indicator for the Government's commitment to scale up the multi-sectoral response to the epidemic. As HIV and AIDS remains a priority challenge to human development we call upon the government to; commit to curbing the volatile political situation largely affecting HIV and AIDS mitigation; observe the Abuja Declaration and allocate 15% of the national budget to Health, HIV and AIDS; institute reforms in legislative frameworks and decriminalize laws prohibiting accesses to health services for most at risk populations. Most importantly, the government should empower civil society to conduct independent research to aid monitoring and evaluation of progress in achieving universal access to HIV and AIDS prevention, treatment, care and support as well as the Millennium Development Goals by 2015. **More than ever before is political will and commitment needed from the government to realize the set targets.**