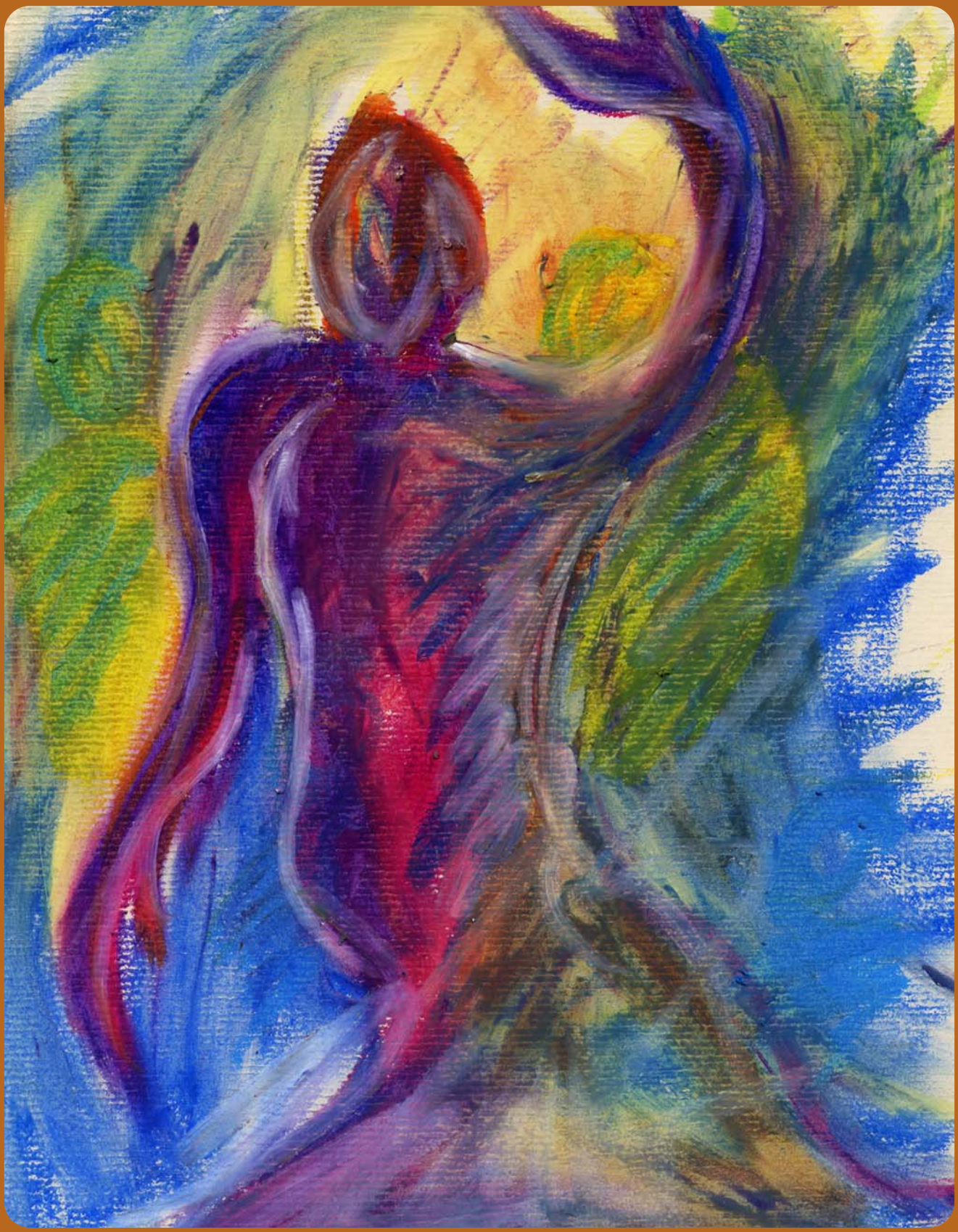


"Anita"

Anushka Virahsawmy

CHAPTER 7
HIV and AIDS

Article 27

Women take to the streets to demand access to anti retro viral therapy in Zimbabwe. *Photo: AFP*

KEY POINTS

- The SGDI for the HIV and AIDS sector is 47% compared to the citizen score of 75%.
- The gap between women's and men's perceptions of government's performance has narrowed with women rating government's performance at 74% compared to men at 76%.
- In 2012, women rated government performance 71%, compared to men's score of 79%.
- The country has made commendable strides in reducing the overall HIV prevalence, now estimated at 15%.
- In 2011, Zimbabwe had reached 79.5% Anti-Retroviral Therapy (ART) coverage; 80% for adults and 46% for children with advanced HIV infection.
- Gender inequalities that fuel the pandemic are still evident in that women have a higher prevalence (18%) than that of men (12%).
- Zimbabwe has a strong policy and strategic framework to address HIV and AIDS. The Zimbabwe Accelerated Country Action for Women, Girls, Gender Equality and HIV(2011-2015) seeks to specifically address the gender dimensions of the pandemic.
- Zimbabwe adopted a progressive policy on care work.

Table 7.1: SGDI and CSC scores for HIV and AIDS		
	SGDI	*CSC*
Scores	47%	75%
Ranks	9	5

The SGDI score is 47% (72% in 2012) compared to the CSC score at 75% (also 75% in 2012). The SGDI measures comprehensive knowledge on HIV and AIDS, the proportion of women living with HIV as a proportion of the total and HIV positive women receiving Prevention of Mother to Child Transmission PMTCT. Zimbabwe is ranked number nine in the region.

On the other hand, women scored their government 74% and men scored government 76%. The higher score by citizens could be attributed to visible efforts by government and other stakeholders on prevention programmes; improving access to treatment; and addressing the gender dimensions of the pandemic. In 2012, women rated government performance 71%, compared to men's score of 79%.

Background

The human face of HIV and AIDS in Zimbabwe disproportionately continues to be that of women and young women. Gender inequalities, patriarchal and cultural norms and attitudes and gender-based violence increase women's vulnerability to HIV infection. Inter-generational relationships, sexual violence and early marriages within some religious sects increase the HIV risk of adolescent girls and young women.

An estimated 1,168, 263 people were living with HIV at the end of 2010 with 52% of these being women.[1] The peak age group affected in women is 30-39 years (29%) and in men 45-49 (30%).[2]

Also, women still are unable to negotiate safer sex, even within marriage. The National AIDS Council reports that married women in Zimbabwe increasingly have become more vulnerable to HIV infections. And, women continue to carry the burden of providing care to their husbands, children, relatives, community members and orphans. Women constitute more than 95% of the caregivers involved in home-based care in Zimbabwe.[3]

The Criminal Law (Codification and Reform Act) protects women from sexual abuse and criminalizes marital rape and the wilful transmission of HIV and AIDS. The country also has put in place the Zimbabwe Operational Framework on Women, Girls, Gender Equality and HIV (2011-2015) to complement the Zimbabwe National AIDS Strategic Plan II (2011-2015) and to provide direction in making HIV programming more responsive to the needs of women and girls, especially marginalised women - sex workers, migrant and internally displaced women, women living in informal settlements, cross border traders, women and girls with disability and adolescent girls.

This framework, known as the Zimbabwe Agenda for Accelerated Country Action for Women, Girls, Gender Equality and AIDS (ZAACA), has five outcomes[4]:

- Access to comprehensive HIV prevention, treatment, care and support services for women and girls.
- HIV integrated into sexual and reproductive health and other health and social services.
- Women and girls empowered to drive the transformation of social norms and power dynamics with the engagement of men and boys working for gender equality in the context of HIV.
- Developing a research agenda to gather evidence for better planning, programming and implementation of programmes.
- Resource mobilisation for the implementation of ZAACA.
- The Ministry of Health also is spearheading the development of a comprehensive Sexual and Reproductive Health and HIV and AIDS policy.

Getting tested for HIV. *Photo: Mother Nature Network*

1 Zimbabwe 2012 Millennium Development Goal Progress Report.
2 Zimbabwe Demographic and Health Survey, 2010/2011.
3 Combined Report of the Republic of Zimbabwe in terms of the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) 2009.
4 Zimbabwe Accelerated Country Action for Women, Girls, Gender Equality and HIV, A call for action, 2011-2015.

Policies

State parties shall take every step to adopt and implement gender-sensitive policies and programmes, and enact legislation that will address prevention, treatment, care and support in accordance, but not limited to, the Maseru Declaration on HIV and AIDS.

HIV and AIDS prevalence in Zimbabwe has been on a downward trend from 27 % in 1997 to 15 % of adults in the 15-49 age group in 2010. This has been a result of collective efforts by government and civil society to combat new infections through awareness campaigns.

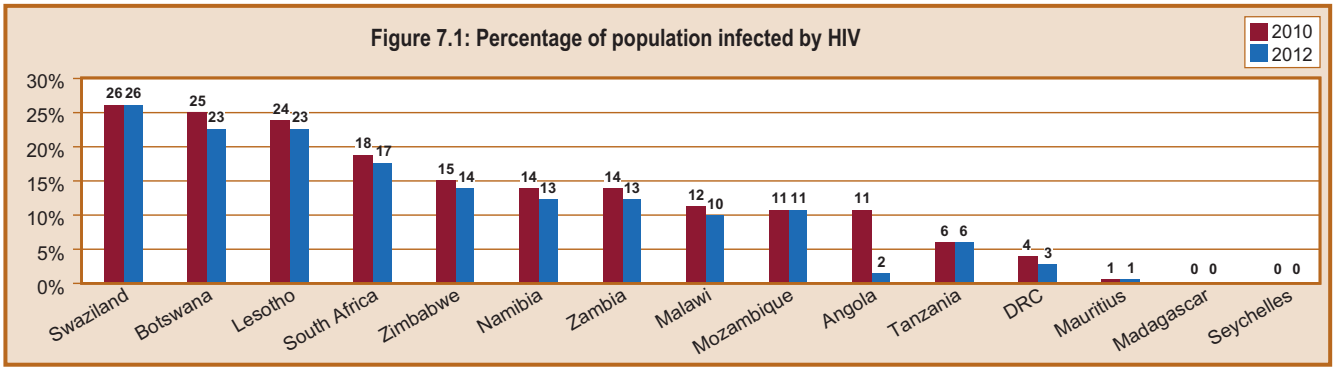
However, Zimbabwe is considered the fifth most HIV-burdened country in the Eastern and Southern Africa region, after Botswana, Lesotho, South Africa and Swaziland.[5]

Table 7.2: Key Gender, HIV and AIDS Indicators

	% women	% men
Extent of comprehensive knowledge on HIV and AIDS	52%	47-49.5%
HIV infection	53.9%	46.1%
% of women and men ever tested	34%	21%
On ARV treatment - 79.5% ART coverage in 2011	63.6%	36.3%
Pregnant women counselled and tested for HIV during antenatal care	59.1%	-
HIV positive pregnant women receiving treatment to mitigate against PMTCT	92%	-

Source: Zimbabwe Demographic and Health Survey 2010-2011; Zimbabwe 2012 Millennium Development Goals Progress Report; UNAIDS-PMTCT as at the end of 2012, single dose therapy.

Encouragingly, concerted prevention efforts have resulted in steep declines in new infections in the world, with sub-Saharan Africa leading the way. Between 2001 and 2011 in Zimbabwe, the rate of new HIV infections dropped by 50% This picture is heartening as countries continue to make huge strides toward reaching the UNAIDS 2015 target of zero new infections.



Source: UNAIDS 2010 and UNAIDS 2012.

Figure 7.1 illustrates that HIV prevalence rates continue to drop throughout the SADC region. Zimbabwe showed significant reductions between 2001 (26.5%) and 2012 (14%).[6] Studies have linked this decline with population-level changes in sexual behaviour, particularly reductions in the number of sexual partners and increased uptake and use of condoms.

5 Zimbabwe 2012 Millennium Development Goals Progress Report.
6 Government of Zimbabwe. 2010. Factsheet HIV Decline in Zimbabwe - Positive Behaviour Change Makes a Difference. Harare: Ministry of Health and Child Welfare.

Protocol @ work

HIV decline announced at AIDS conference

Zimbabwe's HIV prevalence dropped from a high of 33% in the late 1990s to 14% in 2010. This is largely due to a vigorous national behaviour change campaign according to Oscar Mundida, the Behaviour Change Coordinator at Zimbabwe's National AIDS Council, who shared his country's experiences at the 2011 South African AIDS Conference.

"As a country we do not attribute the decline to any one campaign. We acknowledge the importance of a multi-sectoral response where different players with different strengths work together to achieve the desired result, which is what we have done" said Mundida.

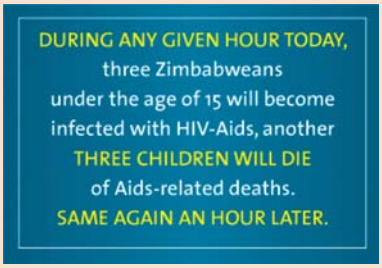
Mundida, who successfully designed the first National Behaviour Change Strategy, said Zimbabwe turned the tide because its citizens took the issue seriously after lawmakers declared HIV and AIDS a national disaster in 1999. He said the country introduced the National AIDS Trust Fund, funded by a 3% tax on all taxable income for Zimbabwean workers, which has largely funded the country's HIV programme with support from the donor community.

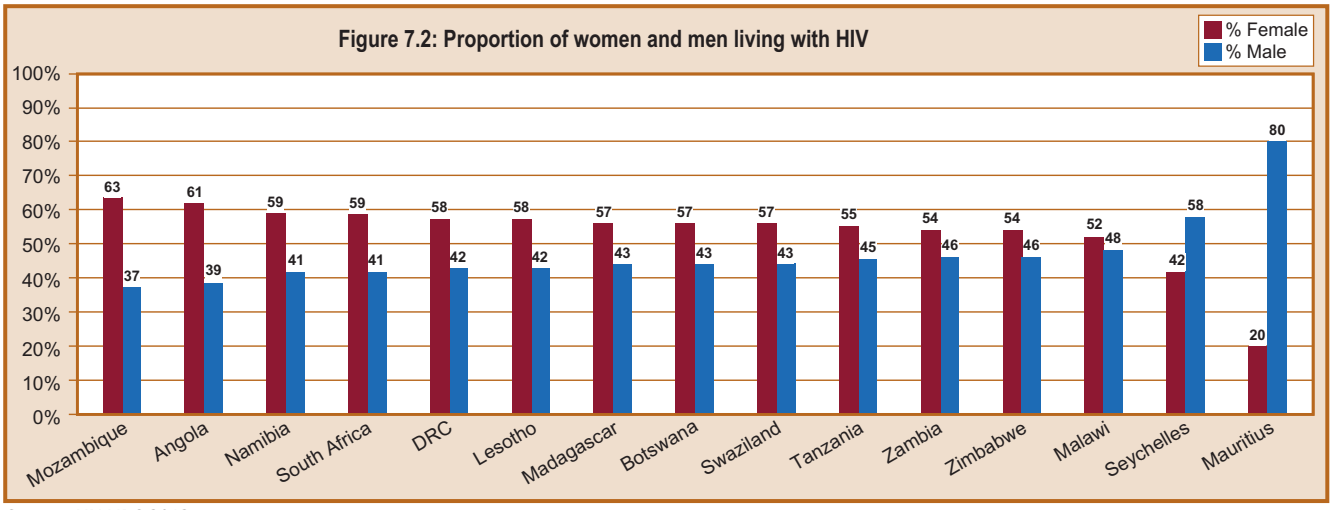
He noted Zimbabwe has also adopted prevention strategies, such as male circumcision and the "One love campaign," which encourage fidelity and partner reduction, delayed sexual debut in youths and abstinence. This has led to a reduction in the number of people with casual sex partners. "We are working with every player to get results. The media plays its role in disseminating educational information to the public while civil society runs several awareness campaigns across the country," he said. "However the urban areas have more access to the information and messages and as a result we saw the decline happen first in urban areas where information from the media and campaigns is easily accessible compared to rural areas."

Mundida said Zimbabwe's battle with HIV is far from over as new infections largely occur in stable relationships and marriages, showing that while people may no longer engage in short term casual relationships, they continue to take on multiple long term partners. Condom use is low in these relationships, which may last for years, according to several studies conducted in Zimbabwe.

Mundida said Zimbabwe stakeholders continue to look for ways to effectively respond to gaps in fighting the epidemic.

Source: SAfAIDS Media (2011)





Source: UNAIDS 2012.

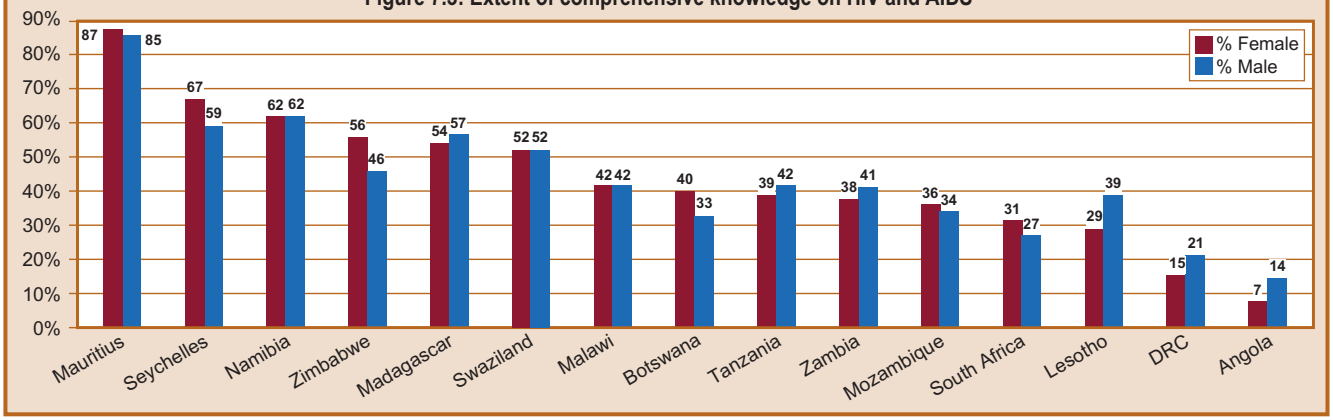
As illustrated in Figure 7.2, more women continue to live with HIV than men. As in 2011, 13 SADC countries have a greater proportion of females than males living with HIV. Of the total population infected by HIV in Zimbabwe, 54% are women while 46% are men.

Prevention

The Protocol requires that by 2015, State Parties shall develop gender-sensitive strategies to prevent new infections, taking account of the unequal status of women, and in particular the vulnerability of the girl child as well as harmful practices and biological factors that result in women constituting the majority of those infected and affected by HIV and AIDS.

Comprehensive, accurate knowledge of HIV and AIDS is fundamental to ensuring citizens use HIV services and engage in behavioural change. In Zimbabwe, comprehensive knowledge is higher among women (52%) than men (47%-49.5%). An average of 50% of young people have a comprehensive knowledge of HIV and preventive methods, and almost 80% of young women and men know that the use of condoms reduces the risk of HIV infection.[7]

Figure 7.3: Extent of comprehensive knowledge on HIV and AIDS

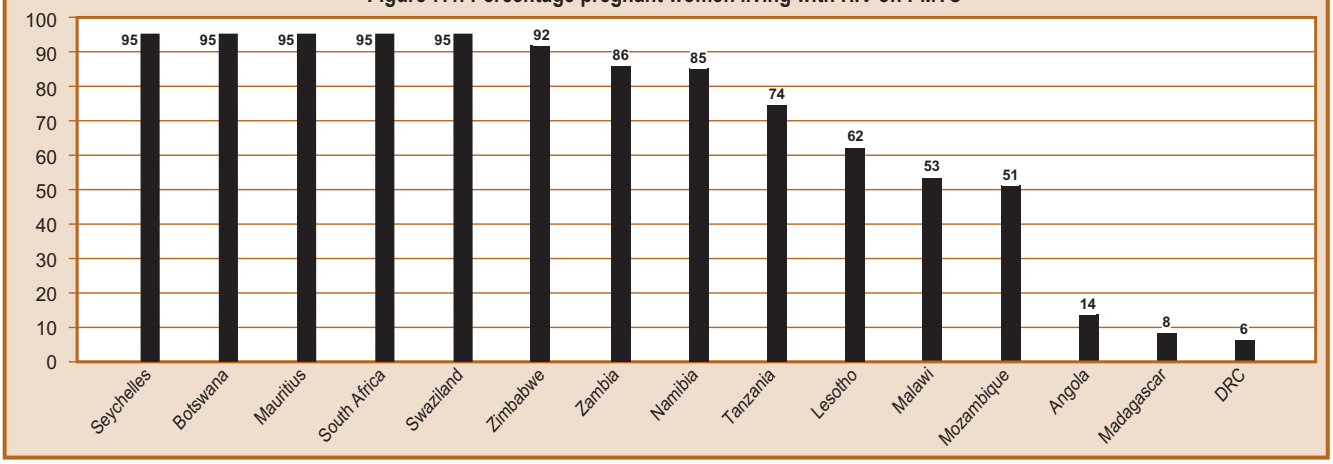


Source: 2013 SADC Gender Protocol Barometer; Zimbabwe 2012 Millennium Development Goals Progress Report.

Figure 7.3 shows that Zimbabwe is among the only six countries in the SADC region where comprehensive knowledge is above 50% among young women and young men in the 15-24 years aged group. Women are more knowledgeable about HIV and AIDS, at 56% than men at 46%.

Mother and child

Figure 7.4: Percentage pregnant women living with HIV on PMTC



Source: UNAIDS 2012.

7 Zimbabwe 2012 Millennium Development Goals Progress Report.

The PMTCT coverage also continues to expand in the country. As of 2010, 86% of pregnant women received treatment to prevent HIV infection in their unborn child, and by the end of December 2012, this had increased to 92% using the single does therapy known as Option A.

Figure 7.4 shows that he PMTCT uptake in the SADC region still remains uneven, and only Seychelles, Botswana, Mauritius, South Africa, Swaziland, Zimbabwe, Zambia and Namibia have reached the WHO target of 80% coverage.

While Zimbabwe has not reached the goal of universal access to HIV and AIDS treatment, the Zimbabwe MDG 2012 Status Report attributes the decline in both prevalence and incidence to a major expansion of access to HIV prevention and treatment services; behaviour change and communication, the promotion of the use of both male and female condoms, HIV testing and counselling and the expansion of PMTCT. PMTCT services in the country have expanded from a three-site pilot in 1999 to over 1,560 health facilities, the majority (940) of which are comprehensive sites.[8] Some 59% of pregnant women are counselled and tested for HIV during antenatal care.[9] The country also has strengthened local production of HIV and AIDS-related medication.[10]

Zimbabwe adopts Option B+

Joyce Mujuru, Vice President of Zimbabwe. *Photo: AFP*

All pregnant women who test HIV positive will immediately be placed on anti-retroviral treatment despite their CD4 count, Vice President Joyce Mujuru said on November 14 at the launch of Option B+ and the *Elimination of Mother to Child Transmission week.*

Option B+ is an approach to integrate PMTCT and ART at the primary care level. Under this Option, all pregnant women living with HIV are offered life-long ART, regardless of their CD4 count. This approach was first conceived and implemented in Malawi, and in April 2012, the World Health Organization (WHO) released a programmatic update explaining the advantages of this option for treating pregnant women and preventing HIV infection in infants. The update also explains how Option B+ goes beyond PMTCT by providing better protection for maternal health and greater reduction in the sexual transmission of HIV.

VP Mujuru said HIV-positive women would now take a three-in-one pill everyday, instead of the previous plan where they took three different ARVs at a time. She said the government is fully committed to end HIV and AIDS and supports programmes such as Option B+ which addresses the root cause of new born HIV infections. "Our being here today marks another significant milestone in our endeavour to have an HIV free generation by 2015," she said. "Furthermore, it demonstrates government's commitment to the attainment of Millennium Development Goals 4, 5 and 6 that seeks to reduce child mortality, improve maternal health and combat HIV and AIDS, malaria and other diseases respectively by 2015." She said Option B+ was necessitated by the fact that huge numbers of new infections in children and HIV-related deaths continue to be recorded in the country. An estimated 10 000 new infections were recorded each year, with 90 percent of these being through mother to child transmission. Furthermore, 21 percent of under five deaths were also HIV associated.

She said this situation can be prevented through the Prevention of Mother to Child Transmission of HIV. "This week-long programme provides a platform to promote utilization of services for the prevention of mother to child transmission of HIV," she said.

VP Mujuru also said the new three-in-one pill was simpler and easier to take than the previous ones. "From today onwards, HIV positive pregnant women will be offered a single tablet that contains three anti-retrovirals, the three in one pill, which will be taken once per day for life. It protects the health of the HIV positive woman and also prevents transmission of the virus to the baby," she said.

She said this intervention would protect mothers in future pregnancies, as well as the male partner in the event that they may be HIV negative. Research has shown that continuous uptake of ARVs lowers the virus to undetectable levels reducing chances of HIV transmission to other people. VP Mujuru urged men to support interventions such as Option B+ and male circumcision among other health programmes.

Acting secretary in the Ministry of Health and Child Care, Dr Gibson Mhlanga, said the launch of Option B+ and the elimination of mother to child transmission week was part of pre-launch activities lined up for the World AIDS Day festivities, commemorated in Chikomba district, Mashonaland East Province."All these activities are meant to sustain momentum to eliminate new HIV infections in children," he said.

Paidamoyo Chipunza Health Reporter

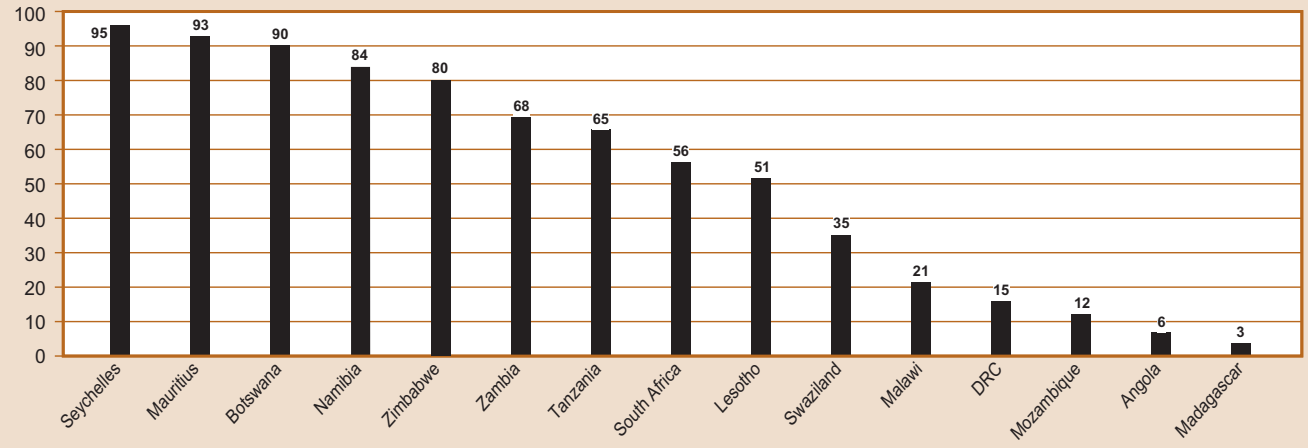
Source: http://www.herald.co.zw/vp-mujuru-launches-option-b/

[8] Comprehensive sites offer both HIV testing and antiretrovirals. A Situational Analysis on the Status of Women's and Children's Rights in Zimbabwe, 2005-2010: A Call for Reducing Disparities and Improving Equity, UNICEF, Government of Zimbabwe.
[9] Zimbabwe Demographic and Health Survey, 2010-2011.
[10] 2010 Millennium Development Goals Status Report, Zimbabwe.

Treatment

The Protocol requires State Parties to ensure universal access to HIV and AIDS treatment for infected women, men, boys and girls.

Figure 7.5: Percentage of people receiving ARVs



Source: 2013 SADC Gender Protocol Barometer; Zimbabwe 2012 Millennium Development Goals Progress Report.

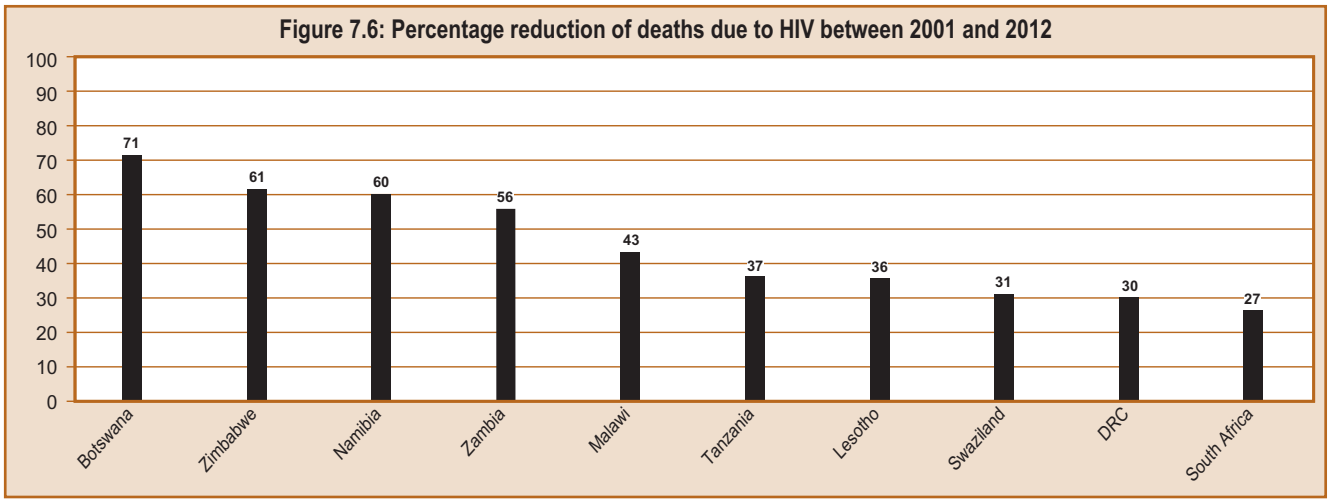
Zimbabwe has increased the ART coverage from 53% in 2009 to 80% in 2011. As illustrated in Figure 7.5, 80% of the adult population with advanced HIV infection has access to treatment, while 46% of children with advanced HIV infection are on treatment. The majority of those on treatment are aged 15 years and above.

In 2011, of those with advanced HIV infection, more women (63.6%) than men (36.3%) received ART. The country is among the five countries in the SADC region - the others are Seychelles, Mauritius, Botswana, Namibia - that have achieved 80% or above ARV coverage for people with advanced HIV infection.

A number of policy documents, including *Guidelines for Antiretroviral Therapy in Zimbabwe (2005), Zimbabwe National Guidelines on Testing and Counselling, National Behaviour Change Strategy for Prevention of Sexual Transmission of HIV (2006-2010) and the National Plan of Action for Women, Girls and HIV and AIDS*, all allude to the importance of PEP when citizens find themselves at risk of HIV exposure and infection. The *Guidelines for Antiretroviral Therapy* clearly outlines the procedure for PEP administration. However, policy guidelines are silent on PEP for non-occupational exposure (rape and sexual abuse), as PEP drugs and services remain mostly available for health personnel.[11]

A 2007 Zimbabwe Women's Resource Centre and Network study showed that 95% of respondents who had received PEP were health workers, while 5% were sexually abused girls.[12] Generally, there is lack of knowledge about the benefits and availability of PEP by women and girls in the country. There are also various barriers to women effectively receiving PEP. Although there is no recognised time guideline, it is generally encouraged that PEP should be administered 24-36 hours after possible exposure to HIV through rape or unprotected sex. In rural areas, this is not always possible due to travel distances and lack of transport infrastructure. Furthermore, women may lack financial means and information about how and where to obtain PEP. They may also fear reporting the assault or seeing health-care professionals because of the risk of stigmatisation faced by rape victims.

[11] ZWRCN, 2009.
[12] Ibid.



Source: Graph compiled from UNAIDS 2013 World Aids Day Result Report.

The rapid expansion of treatment has resulted in a marked reduction in the number of deaths in the region. The UNAIDS 2013 Results report notes that sub-Saharan Africa has cut the number of deaths from AIDS-related causes by 32% between 2005 and 2011, with the largest drop in AIDS-related deaths recorded in some of those countries where HIV has the strongest grip. For example, Figure 7.6 illustrates that Botswana saw the largest per capita reduction at 71%, followed by Zimbabwe at 61%.

Care work

The Protocol requires Member States to develop and implement policies and programmes to ensure the appropriate recognition of the work carried out by care givers; the majority of whom are women, to allocate resources and psychological support for care givers as well as promote the involvement of men in the care and support of people living with AIDS.

Zimbabwe's health care infrastructure, like that in most of the SADC countries, cannot provide palliative care, shifting this to the elderly and children, the majority of whom are women and girls. Caring for an AIDS patient can increase the workload of a family caretaker by one third, an onerous burden for the poor. A rural woman interviewed in Southern Africa estimated that it took 24 buckets of water a day, fetched by hand, to care for a family member ill with AIDS - water to wash clothes, the sheets and the patient after regular bouts of diarrhoea.[13]

Community and home-based care programmes remain popular in Southern Africa and continue to provide a relatively cost-effective, sustainable and comprehensive continuum of care that complements institutional care. Still driven by volunteers, community and home-based care enhances the capacity of families and communities to offer affordable quality care for the sick.[14]

In 2010, inspired by Article 27(c) of the SADC Protocol on Gender and Development, Gender and Media Southern Africa (GEMSA) and VSO-RAISA developed the *Making Care Work Count Policy Handbook*. The objectives of the handbook include to influence the development, adoption, implementation and enforcement of policy frameworks that promote the recognition and support of care providers in the context of HIV and AIDS, and to promote public engagement on care work related issues.

[13] SADC Regional Gender Protocol Barometer 2013, Gender Links.
[14] SADC Regional Gender Protocol 2013 Barometer, Gender Links.

The handbook proposes six principles that need to inform care work policies:

- **Remuneration:** People doing the work of government have a right to be financially rewarded.
- **Logistic and material Support:** It is imperative that care providers are provided with care kits as well as other support, such as uniforms for identification, bicycles, food packs, monthly monetary allowances, soap, free medical treatment, financial support for income generating projects, raincoats, umbrellas, agricultural inputs, stationery and transport allowances, among others, to provide quality care.
- **Training and professional recognition:** Protocols of training and accreditation should be developed through a governing body within the country to regulate and standardise the training.
- **Psychosocial support:** Care for care providers should be prioritised with psycho-social support programmes developed and provided to care providers.
- **Gender equality:** The gender dimensions of HIV should be recognised and catered for.
- **Public private partnerships:** There is a need to advocate for stronger public private partnerships in the delivery of PHC services through C&HBC programmes.

Table 7.3: Review of care work policies in Zimbabwe

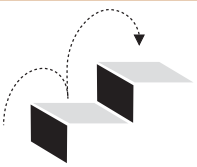
Remuneration	Logistics and material support	Training/Professional recognition	Psychosocial support	Gender equality
A stand alone policy has been adopted. Government recommends communities mobilise funds for care giver costs. Consideration is being given to the extent to which the National AIDS Levy can be used to fund remuneration of care givers.	Despite an advanced policy outlining provision of sufficient materials and equipment, access to these is limited. Fundraising is underway and an entity has been identified to purchase home-based care kits.	A training package exists that covers: training of trainers, nutrition and other areas. National package includes treatment support for clients and handbooks for participants in two of the major national languages. Progress hampered by shortage of funds.	The new community and home-based care guidelines recognise that care givers need appropriate psychosocial support to prevent stress and burn out. Care workers are benefitting from this where available; access is not guaranteed for all care givers.	No policy. However, in 2010, men's involvement in care work stood at 19%. Also, there was training for children- with the assistance of international organisations - in order to ensure the safety of children forced to care for sick adults.

Source: Gender Links 2013.

Funding for the national AIDS response

Zimbabwe's National AIDS Trust Fund (NATF) via the AIDS levy has provided the bulk of the national investment for the response to HIV and AIDS. The AIDS levy is a 3% tax on individual and institutional income in the formal sector. Since dollarisation of the economy, NAFT's collections were expected to top US$30 million by the end of 2012, a massive increase from US$7 million in 2009. Other funding sources include, a pooled funding mechanism, the Expanded Support Programme, which includes The Global Fund, the United States government, DFID, CIDA, Irish Aid, Norway and SIDA.[15]

In the 2013 National Budget, government allocated US$1,000,000 to Anti-retroviral drugs down from US$1,050,000 in the 2012 revised budget, and the allocation towards TB drugs increased from $349,000 in 2012 to $500,000 in 2013.[16] The increase on TB drugs is due to the high levels of HIV/TB co-infection, with 80% of TB cases estimated to be co-infected with HIV. TB continues to be one of the leading causes of morbidity and mortality in Zimbabwe.[17]



Next steps

- The government must continue to invest resources in prevention and treatment to meet the MDG and SADC Gender Protocol targets of universal access.
- Research commissioned to assess the impact of the Zimbabwe Agenda for Accelerated Country Action for Women, Girls, Gender Equality and AIDS (ZAACA) and other policies on addressing the gender dimensions of the pandemic.
- Develop and/or intensify advocacy and IEC campaigns to address the factors that continue to fuel HIV infection in young women.
- Zimbabwe's 2012 MDG Progress Report calls for the strengthening and scaling-up of private-public-partnerships to address HIV and AIDS, as well as strengthening the involvement of communities in HIV programming.
- Increase the engagement of care providers in the national processes to review and strengthen community and home-based care policies.
- Promote community and local government involvement in care work to reduce the burden on women and girls.

[15] Zimbabwe 2012 Millennium Development Goals Progress Report.
[16] ZWRCN 2013 National Budget Gender Analysis.
[17] Zimbabwe 2012 Millennium Development Goals Progress Report.