Situation of Orphans and Care Givers in Zimbabwe

From "Community Based Orphan Assistance in Zimbabwe: Developing and Expanding National Models by Building Partnerships with NGO's, CBO's and the Private Sector."
By Susan Hunter, September 30, 1998

1. Current and Future Estimates of Orphans in Zimbabwe

Zimbabwe's epidemic is among the worst on the continent. Some 35% of Zimbabwe's urban population and 20% of rural adults are HIV positive, for an overall infection rate of 26%. Antenatal seroprevalence varies. Thirty-two percent of pregnant women in Harare were HIV+ in 1995, while 59% of antenatal clinic attenders in Beit Bridge, Masvingo Province were HIV+ in 1996. Recent data shows that infection rates have not leveled. According to the NACP, one-fifth of all Zimbabweans over 15 years of age can expected to die from AIDS, most within the next 10 years.

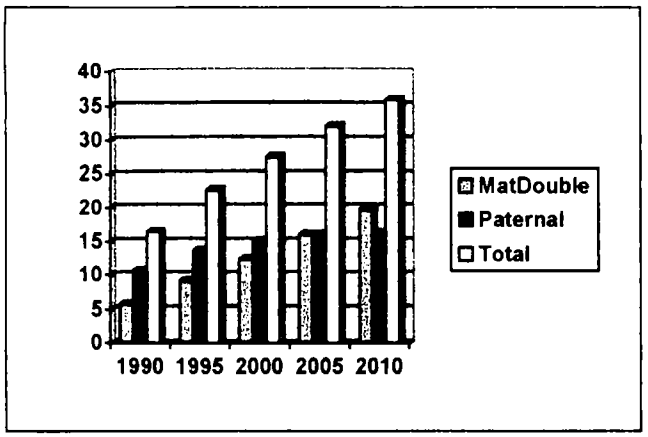
Slightly more than half of Zimbabwe's estimated 1997 population of close to 12 million peopled are under age 18. Over 40% of females under 19 have either had a child or are currently pregnant, giving Zimbabwe one of the highest teen pregnancy rates in the world. According to the 1996 Health Profile, 13,832 children under age 15 had a sexually transmitted infection, and the rates of HIV infection among young people, especially young women, is increasing.

According to the NACP, 60,000 Zimbabwean children lose one or both of their parents to AIDS every year. The total number of children missing their mothers or both parents due to AIDS is projected by the NACP to be 670,000 by 2000, or 1 in 6 of all children in the country. While the proportion of children orphaned is anticipated by official sources to peak at 1.1 million (33% of children under 15) by 2005, seroprevalence increases signal that the peak may not occur until well after than date.

Estimated Children Under 15 Orphaned in Zimbabwe

	***Children on the Brink* Estimates (All Causes)**	**Official Estimates Zimbabwe NACP (AIDS Only)**
Mother or Both Parents Dead	610,713	670,000
Father Dead	746,427	Not Available
Total Orphans	1,357,140	Not Available

The box at right juxtaposes the number of orphans estimated for Zimbabwe in ***Children on the Brink*** (left hand column), and the estimated number of children orphaned by AIDS from the National AIDS Control Program (right hand column). Official government estimates of the number of orphaned children in Zimbabwe are similar to the estimates in ***Children on the Brink***. This is largely because Zimbabwe's seroprevalence data is collected regularly from antenatal clinics at 10 sites in the country, and because there is substantial concurrence on the methods used to estimate maternal orphans (including double orphans) in the international community.



The chart at left shows the proportion of children who will be missing one or both parents for five year intervals through 2010. The mushrooming of the orphan population which will occur in the next 10 years due to the epidemic is a typical result of the exponential growth of AIDS infections and deaths in Zimbabwe and its neighbors in East and Southern Africa.

The National AIDS Control Programme has not developed estimates for children who are paternal orphans (children who have lost their father to AIDS or other causes). As a consequence, there are no comparable official estimates of paternal orphans to those contained in ***Children on the Brink***. These estimates are shown below, along with the total number of children under 15 whose father, mother, or both parents will be dead. These figures are important because many paternal orphans may be *de facto* double orphans (missing father and mother both) due to a number of cultural factors. ***Children on the Brink*** and other orphan estimates do not include parents who are not dead although they may not reside in or provide support to the households in which their children are living.

Estimates of Orphans by Type and Year for Zimbabwe
Number of Orphans and Percent of Children Under 15

Year	Mother/Both Parents Dead (Maternal/Double) #	%	Father Dead (Paternal) #	%	Total Orphans #	%
1990	275,572	5.7%	511,777	10.7%	787,349	16.4%
1995	455,359	9.1%	683,039	13.6%	1,138,398	22.7%
2000	610,713	12.4%	746,427	15.1%	1,357,140	27.4%
2005	742,779	15.9%	742,779	15.9%	1,485,558	31.9%
2010	842,463	19.7%	689,288	16.1%	1,531,751	35.8%

Source: ***Children on the Brink***

When the number of paternal orphans are included, the total number of orphans estimated for Zimbabwe is more than twice the official NACP estimates of maternal orphans due to AIDS. ***Children on the Brink*** estimates that roughly 27% -- one in four – children under 15 are currently orphans from all causes of death.

The estimates of orphans for Zimbabwe contained in ***Children on the Brink*** do not include any children born HIV positive. This group is subtracted because these children are likely to die before their second year of life. Overall growth of the under 15 overall population will be substantially curbed by the epidemic as a result of fertility declines and the deaths of infants and children who are HIV positive. Hence, by 2010, the under 15 population of Zimbabwe is anticipated to be only 4.2 million, only slightly more children than Zimbabwe had in 1990. While they are not included in the model, HIV positive children will number in the hundreds of thousands and represent a substantial burden of care for families, communities, health facilities and health workers.

As a proportion of children under 15, orphan populations will peak in Zimbabwe in 2010 if we assume that seroprevalence stabilizes within the next two years. This assumption may not be realistic. According to Zimbabwe's NACP, sexual behavior has changed little in Zimbabwe. Both adults and young people report little change in behavior in terms of condom use or reduction in the number of sexual partners. Despite the introduction of syndromic management of sexually transmitted diseases in Zimbabwe, infection rates are very high. Coupled with high rates of partner change, these infections increase the probability of HIV transmission substantially.

Beyond 2010...

If we assume that HIV seroprevalence will peak in Zimbabwe by 2000, orphan populations will peak between 2007 and 2010, when AIDS mortality peaks. This is unlikely due to lack of significant behavior change. **This means that Zimbabwe will have a high orphan population, as a proportion of children under 15, through at least 2020.**

Growth in the number of orphans of the epidemic will not level until AIDS deaths stabilize. If seroprevalence stabilizes in 2 or 3 years, then AIDS deaths will stabilize by 2010. If we assume that seroprevalence will not stabilize in 2000 -- likely given the lack of sexual behavior in young and old alike in Zimbabwe -- **the number of orphans will probably continue to grow through the year 2015 or 2020. This means that Zimbabwe could experience unusual numbers of orphaned children through at least the year 2030.**

Zimbabwe Will Rank Fourth Among Sub-Saharan African Populations with Large Orphan Populations by 2010

In Order of Magnitude by Percent of Children Under 15

Zambia	Rwanda
Botswana	Uganda
Zimbabwe	Burkina Faso
Malawi	CAR

Source: **Children on the Brink**

The interaction of tuberculosis and HIV infections has lead to a three to four fold increase in reported TB cases in Zimbabwe since the mid to late 1980s. Virtually all of the increase in TB cases can be attributed to HIV infections, and the majority of all current TB cases in Zimbabwe are occurring in persons infection with HIV and tuberculosis. As a consequence of this interaction, HIV deaths in adults may be even higher than that projected for AIDS alone, with obvious implications for orphan rates in Zimbabwe.

2. Estimates of Other Vulnerable Children in Zimbabwe

It is widely accepted that children orphaned by AIDS and other causes do not constitute the only group of vulnerable children in Zimbabwe, and that through their life cycle, children may move in and out of various categories of vulnerability as their life circumstances change. With 91% of the population on communal lands reported by a 1995 Poverty Survey to be "very poor" or "poor", the majority of children are living in vulnerable situations based on income measures alone. According to a 1998 UNICEF-sponsored situation analysis prepared by the South African Research and Documentation Centre (SARDC), "extreme levels of poverty, parental unemployment, and the impact and stigma of the AIDS pandemic... underlie much of children's

suffering, and are now so commonplace as to cease to be considered unusual." In order to understand the magnitude of the population of vulnerable children in Zimbabwe, it would be useful to have estimates of the following:

Street Children. According to UNICEF's 1998 draft country situation analysis, in 1995 there were approximately 2,000 children under the age of 18 living on the streets or in squatter settlements.

Child Labourers. The national Census reports that 3% of children ages 10 to 14 are in the labour force in Zimbabwe. The labour unions estimate 30 to 35% of children in that age group are working, but there is no way to validate that figure. The ILO is planning a child labour survey in cooperation with the government of Zimbabwe, but results will not be available for some time. The UNICEF-sponsored SARDC study estimates that there are 50,000 child labourers.

Children Who Are Sexually Exploited. While formal estimates of this group of children are not available, almost 14,000 children 0 to 14 were treated for an STI in 1996. The 1992 census reported that 426,398 girls ages 12 to 14 were married, and the 1994 Zimbabwe Demographic and Health Survey reported that 2.9% of 15 year old females had children or were pregnant. While these figures are not a measure of sexual exploitation of children, they indicate that many children are sexually active. As the proportion of children under 15 who are orphaned grows, it is likely that sexual exploitation will increase, particularly for girl children, protection for whom will have diminished. SARDC estimated there are 3,500 abused children in Zimbabwe.

Disabled Children. The 1981 Zimbabwe National Disability Survey identified 14,000 children between the ages of 0 and 15 who had a disability. This includes children with physical, mental, or sensory depravation, whether in vision, hearing or speech. Forty-one percent of children with disabilities were below age 5. Since that time, no other national survey of disability has been carried out. However, in 1996, Ministry of Education reported that 4,427 disabled children were attending school in Zimbabwe, and that 6,951disabled children were not receiving special services.

War Affected Children. According to the SARDC study, refugee children numbered close to 90,000 in 1994, but only 244 remained in Zimbabwe in 1997.

SHOW: NPR MORNING EDITION (NPR 10:00 am ET)

NOVEMBER 12, 1998, THURSDAY

HEADLINE: AIDS Impact on Zimbabwe

BYLINE: Brenda Wilson; Bob Edwards, Washington, DC

HIGHLIGHT:
NPR's Brenda Wilson reports on the problems that AIDS i causing on farms in the African nation of Zimbabwe. She visits a 3,000-acre commercial farm in the Mashonaland region of northeastern Zimbabwe, where an estimated one in five persons is infected with HIV. One of the biggest problems is what to do with the orphans left behind by parents who die from the disease. There may be as many as 500,000 children in Zimbabwe who have lost one or both parents because of AIDS.

BODY:

BOB EDWARDS, HOST: This is NPR's MORNING EDITION. I'm Bob Edwards.

In most parts of the world AIDS has struck hardest in urban areas. It has followed roads into suburbs and small towns, but usually has not taken hold.

The situation is different in Zimbabwe, a mainly agricultural country with one of the best highway systems in Africa, a highly mobile population, and one of the highest rates of HIV infection in the world.

NPR's Brenda Wilson reports that farms in Zimbabwe are beginning to reap the bitter harvest of AIDS.

BRENDA WILSON, NPR REPORTER: Manera (ph) Farm is a 3,000-acre spread in Northeastern Zimbabwe. Late on a Zimbabwe spring afternoon, children at Manera are playing in the workers' dusty compound.

SOUNDBITE OF CHILDREN PLAYING

The farm supports about 400 people, 150 workers and their families. The owner, Ben Gilpin (ph), pays the wages, which in his own words are about average. But he also provides housing for his workers and the compound's necessities --water from a central pump, electricity for some, and basic health care.

At the compound's new two-room schoolhouse, the yard has been swept clean and the day's lesson is well underway.

TEACHER AT MANERA FARM SCHOOL: OK, what is the man doing? The man needs a plow.
Yes, Jesse?

STUDENT: (Unintelligible)

TEACHER: Yes, he is plowing. Say it together: plowing.

STUDENTS: Plowing.

TEACHER: Plowing.

STUDENTS: Plowing.

WILSON: The farm seems like a self-contained world, but Manera is no more immune than the rest of Zimbabwe to a creeping sense that something has gone terribly wrong. Like the rest of Zimbabwe, it has been hit by what some are calling the worst AIDS epidemic in the world. It's a byproduct of people traveling between towns and villages and from country to country. No area is untouched by the virus. In this region, Mashonaland East, it's estimated that one in every five persons is infected with HIV.

Four years ago, Gilpin says, workers and their families started dying. A cemetery on the edge of a clearing that for the longest time had five graves now has markers for 30.

BEN GILPIN, OWNER, MANERA FARM, ZIMBABWE: We've got in the cemetery over there, we've got several kids who have died in the last few years as babies who haven't made it. Whereas preschool enrollment was 25 children, now we're getting down 15, 16. We'll find it difficult in the next few years to actually sustain this class.

WILSON: Gilpin reckons that a third of the adults on the farm are infected with HIV, even though few of the workers have been tested. But Gilpin's wife is a doctor who has treated many of the workers and they both recognize the symptoms. Inside a round red- brick hut with a thatched roof, a woman cradles a two-month-old baby.

SOUNDBITE OF WOMAN TALKING TO BABY

Is it he or she?

SOUNDBITE OF GILPIN TALKING TO WOMAN IN ZIMBABWEAN DIALECT

GILPIN: A little girl.

WILSON: The baby, named Normata, is the daughter of one of Gilpin's tractor drivers who appeared at his door one day with the baby strapped to his back.

GILPIN: The wife gave birth to this baby and died very shortly afterwards. And he was left looking after the baby, unable to cope. And he's taken on a new wife who is now looking after the baby.

WILSON: Gilpin says he tried to explain to the father that he may be infected, but contagion and the idea of a disease like AIDS that lies dormant, only to manifest itself years later, can be disbelieved.

GILPIN: We've had people who we've counseled against having other children who have gone ahead and had more children and while they've lost two babies, the third baby's alive and healthy. Life carries on. And the practical need for this man is that he needs a care giver for the baby.

WILSON: But that means in all likelihood the third wife is being exposed to the virus. The baby, Normata, could end up being orphaned a second time.

There already are orphans living on the farm. Monica Rice (ph), a health worker employed by Gilpin, says that four years ago, four young children, the oldest about 10 years old, were found living in the compound alone.

MONICA RICE, HEALTH WORKER, MANERA FARM: In 1993, Mr. Gilpin asked all the people in this compound who want to help these children (unintelligible) to want to stay with them. And I tell my husband, my husband, he said: yes, we can do it.

WILSON: There are almost no orphanages and adoption is rare in Zimbabwe where the extended family usually assumes such responsibilities. But many families have been dispersed by constant movement and adoption seldom occurs across cultures.

In Zimbabwe, the Shona (ph) people make up the majority of the population. They believe that the spirits of Ingozi (ph), the ghost of the dead, accompany and protect their descendants, often seeking retribution for injustices that were suffered in life.

So the Gilpins came up with a solution: children who lose their parents and have no relatives belong to the community. In this case, the Gilpins pay for food and school fees; Rice and her husband have the main responsibility for the children.

RICE: I told him (unintelligible) hoping somebody could help us when we keep these children.

WILSON: It's estimated that there may be as many as 500,000 children in Zimbabwe who have lost one or both parents because of AIDS. There are at least a million children living with their families on commercial farms, so much of the problem finds its way to the farmer's doorstep.

Gilpin's wife Sue Perry (ph) has joined a movement in Zimbabwe that is trying to head off a crisis of children orphaned by AIDS that is expected to get worse. She's organizing the Farm Orphans Support Trust.

SUE PERRY, ZIMBABWEAN DOCTOR; ORGANIZER, FARM ORPHANS SUPPORT TRUST: Where are we going to put all these children? If only 10 percent of those children require care, require to be put in an institute, it would mean that Zimbabwe would have to build, if you put 50 children per institute, a hundred institutes per month for the next year just to absorb 10 percent of that. And the next year it's going up and the next year it's going up.

WILSON: Perry tells a group of commercial farmers that with their financial support and government assistance more workers like Rice can be encouraged to care for young orphans and to supervise older children who may be able to manage on their own. Sue Perry tells them that it is not only the humane thing to do, it is in the farmers' self-interest.

PERRY: Look at your farms and look at who are the people you depend on most on your farms apart from yourself. Your foreman. Your senior tobacco grower. Your mechanic. Understudy all those key people, preparing against that certainly finding yourself in a situation where your mechanic is no longer there and nobody knows where the keys are. WILSON: On Manera, Ben Gilpin's assistant Isaac Kuroda (ph) has already seen how AIDS can eat away at the routine of simply getting the crops into the ground.

ISAAC KURODA, BEN GILPIN'S ASSISTANT ON MANERA FARM: I can see people dying in the hospitals, at the roadside. This one reportedly was ill, he's not feeling well. He reported the case today and he's going to the clinic. He comes back, started to work again, and he was putting his maximum effort on work, but nowadays he's exhausted. And so a few months later (unintelligible) he has passed away.

WILSON: Life at Manera goes on. Ben Gilpin says he wants to improve living conditions for the workers. New lodging is going up. A center is in the works for the elderly who are now tending the children of the children they outlived.

SOUNDBITE OF THEATRICAL PERFORMANCE

Late one evening, Gilpin brought in a troupe of players whose dramas impart timely messages about AIDS. Instead, this night they poke fun at pompous officials and a foolish worker whose wages are stolen while he's getting drunk -- injecting a note of levity into a place where some shadows go unnoticed, even in the light of a full moon.

SOUNDBITE OF AUDIENCE LAUGHING

Brenda Wilson, NPR News, in Mashonaland East, Zimbabwe.

EDWARDS: That story produced by NPR's Deborah George.

Call For Multi-Sectoral Approach To AIDS

December 23, 1998

HARARE, Zimbabwe (PANA) - The Zimbabwe National AIDS Co-ordinating Programme is calling for a multi-sectoral approach to create AIDS awareness and avoid further spread of the disease.

The approach would invite participation in AIDS awareness campaigns from all government ministries, churches, non-governmental organisations and pressure groups.

In an interview Monday, the programme's youth co-ordinator, Zorodzai Gumbie, said the magnitude of human life devastation by AIDS was making it imperative that everyone should play a part in finding the means to curb the disease.

"Responsibility should not be left to the ministry of health and child welfare alone but every one should cooperate," she said.

Gumbie said there was need to intensify campaigns in rural areas where there was limited media access.

"The provincial medical directors who are in each province for coordinating STD/HIV education to rural communities need support with relative resources to enable effective communication," she added.

She also said AIDS education should be made imperative at every level of the existing education structures in schools to equip children with enough information about AIDS before they contracted it.

"Community theatre groups need support to reach all schools in rural and urban centres as they are an effective form of communication," she said.

There was need for the ministry of information to revive the mobile cinema vans for rural communication as all other forms of communication seemed exhausted, Gumbie said, adding that implementing innovative communication strategies was imperative.

"Resources need to be gathered for some support groups of people living with AIDS to spearhead AIDS campaign in the country," she said.

Zimbabwe is one of the southern African states with high HIV prevalence rates of more than 20 percent. An average of 700 AIDS-related deaths are being recorded every week.

HIV/AIDS Alarms Zimbabwe's Mt. Darwin Area

January 6, 1999

HARARE, Zimbabwe (PANA) - A traditional leader in Zimbabwe, Chief Zabron Kandeya of Mt Darwin in the country's central province of Mashonaland, said the HIV/AIDS pandemic had reached an alarming level in his area mainly because of poverty which drove young people into prostitution.

Kandeya told the country's news agency that young girls and boys engaged in prostitution in exchange for money because many of them had no jobs.

Government should seriously consider giving preference to the youths when implementing the land redistribution programme to combat the problem of prostitution, he said.

"Young girls are given money by adults for intimate relationships and boys, too, are also given money by unscrupulous widows whose husbands might have died of AIDS because they have no other means of surviving," said Kandeya.

The chief said despite the traditional practice of "fencing" (runyoka) which discouraged women and young girls from extra-marital sex, once a common practice in the area, people had not changed their sexual behaviour.

Kandeya said: "If our young people had land to work on, they would not have been engaging in all these things (prostitution) because they would always be occupied."

AIDS is estimated to kill about 700 Zimbabweans every week countrywide.

Daunting Task Ahead For New Family Planning Boss

January 10, 1999
By Daniel Manyandure

Harare - To put it in the words of the new executive director of the Zimbabwe National Family Planning Council (ZNFPC), his promotion to the new post comes "at a time when the ZNFPC is considering the implementation of new strategies aimed at gearing the organisation for the challenges of the new millennium".

"As government's support to the organisation has been dwindling every year in tune with the deteriorating economy, my main challenge as the new director is to put the ZNFPC on an aggressive income-generating campaign to complement the support we receive from government and the donor community. In fact, I wish to instill a business culture in the organisation," Godfrey Tinarwo told The Standard during an interview in his lavishly furnished office at Spilhaus, Southerton, on Wednesday.

He says the organisation has been suffering an enormous brain drain due to poor remuneration, "meaning one of my biggest challenges will be to look at the improvement of the staff working conditions. They are very committed to the organisation, and for this reason they deserve a favourable remuneration."

The ZNFPC is going through a testing time due to the HIV/Aids pandemic, adds the soft-spoken bespectacled Tinarwo.

"The HIV/Aids epidemic has brought a lot of challenges to the organisation. The use of condoms has to be relentlessly encouraged. In the past, men, especially from the rural areas, were resistant to the use of condoms. But our research has revealed that the problem lay in the information dissemination process. We tended to focus more on women instead of both parties. However, we have since embarked on a male-motivation campaign and the response has been encouraging. There is now a conducive environment and Zimbabwe deserves a pat on the back for being one of the few countries in the region which have made enormous strides in encouraging men to respond positively to the call for the use of contraceptive methods."

Tinarwo says the shrinking support from government was indicating that things might take a difficult shape in the future. "In the event that donor support tumbles, we have to be self-sustaining. We have got a number of facilities, including an audio-visual studio, which we can use to generate income for the organisation. We also intend to make people pay for family planning services."

To help reduce the burden on the economically beleaguered government, Tinarwo says there is need to involve the private sector in family planning campaigns. He cites Population Services International as one the of the few private organisations working hand in hand with his organisation. "Medical aid societies have to be encouraged to extend their coverage to people seeking family planning services, as this is part and parcel of the health system."

He welcomed the proliferation of private family planning clinics, saying such a development was alleviating the pressure on his council. "To enable people to receive services from these privately-run clinics, people need the support of the medical aid societies. The owners of these clinics come to us, and we offer them the necessary training before they establish their own outlets." Tinarwo adds that their focus now needs to be directed at HIV positive women so that pregnancies are avoided.

"HIV positive women have to be discouraged from falling pregnant." For Tinarwo, working in the population industry is not by accident. Due to his innate love for population issues, the man has sought extensive training to equip him with the necessary skills. After being expelled from the University of Rhodesia in 1973, Tinarwo left the country for Uganda where he completed his studies in political science and public administration at the University of Makerere.

"After that I returned to Zimbabwe and joined a publishing firm, the College Press, as a commissioning editor. From there I had a two-year stint with another publishing house, Longman, where I was editor of educational humanities books."

In 1984, Tinarwo landed at ZNFPC where he was tasked with publishing information, education, and and communication materials for the organisation's family planning campaigns. From there, he rose through the ranks to occupy his current office of executive director.

"My commitment to population, especially family planning issues, has led me to stay with the organisation. A lot of people who joined the organisation at the same time with me, and even those who came after, have left the organisation for greener pastures. Maybe it was for this reason that the board of directors found it necessary to award me this post, but I must repeat that I have a daunting task ahead of me."
Tinarwo, 47, is married to Marian who works for Msasa-based electronic firm and the couple has three children-Chenai, 17, Tsungai, 16, and Takudzwa, nine.

Aids Drugs Not On Essential List

January 10, 1999

Joyce Hamba .TEXT

Harare - The Zimbabwe government, faced with the task of handling a population with one of the highest incidence of HIV/Aids in the world, has still not listed the available Aids drugs as essential, effectively denying the majority of the people access to the expensive drugs.

Triple therapy, or the Aids cocktails, currently cost between $28 000 and $32 000 a month because of the 20% duty slapped on it by government. Although the medication is not a cure for HIV, it is generally regarded as the most effective way of reversing the symptoms of the disease, and reduces the amount of virus within an Aids patient's system.

The medication needs to be taken daily for the rest of an Aids patient's life. Speaking to The Standard, Keith Gael, the chairman of the Retail Pharmaceutical Association of Zimbabwe-one of the organisations responsible for lobbying the government for the scraping of tax on HIV drugs-said that the private sector and multinationals had played their part in reducing the price of these drugs, and it was left to the government to bring in their contribution.

"There is no doubt that the problem of HIV in Zimbabwe is a big one and recognised as such by the politicians in Zimbabwe. But it is not enough for them to simply stand and state that the incidence of HIV is rising at an alarming rate. These are already agreed facts, but what is being done about it? We already have multinationals that have brought in drugs which are helping a lot of people, and yet there seems to be no real financial commitment from the government," Gael said.

The other alternative to purchasing these expensive drugs would be for a patient to go out of the country and buy the drugs there, since no local company makes them yet.

"This would actually be more expensive because of the poor exchange rates at the moment. Imagine the amount of money you would need to save in order to buy the medication in the United States?" Gael said. Dr David Parirenyatwa, the deputy minister of health and child welfare, said that the government was aware of the crisis, but said there had to be a systematic way of handling the problem."

"The government is fully aware that the cost of the much needed drugs are quite prohibitive to most people in Zimbabwe. What we have done as the ministry of health is to set up a committee which is looking into

the costing of these drugs as well as the most potent regiments at the most affordable price," he said.

Parirenyatwa said that it was important to ensure that when the government intervened, it would be for the long term benefit of all those affected and infected by HIV.

"We do not want to come in with a short term solution to a problem which is threatening to be with us for a long time. Even if we were to lift the duty now, the price of importing would still be too high for most people and they would just buy a course for a short time and stop. Instances like this are what we are trying to avoid," Parirenyatwa said.

The ministry of health was looking at working with other countries in the region to find a regional solution to the problem, said the deputy minister. If the anti-retroviral therapies are taken erratically, the patient might well be wasting their time because the virus is quick to develop resistance to the drugs.

Zimbabwe Denies Selling Defective Condoms

January 13, 1999

Harare, Zimbabwe (PANA) - Zimbabwe's National AIDS Co-ordination Programme director, Everisto Marowa, Monday allayed fears that faulty condoms from South Africa could have infiltrated into the country, saying strict mechanism were in place to test imports.

"Through official and legal channels, they won't infiltrate into Zimbabwe because we have strict mechanism whereby condoms which enter the country have to fulfill specific criteria for quality," he said, adding that only those condoms which passed stringent checks and tests were circulated.

Last week, South African health officials tried to calm down a furore over the distribution of sub-standard condoms after investigations showed that as many as one million condoms in circulation in that country were defective.

They said one brand from an Indian supplier was defective. However, Marowa clarified that smuggled condoms were beyond his department's control and warned the public to be wary of people who could sell sub-standard condoms to make quick money.

For quality of condoms to be maintained people needed to use them correctly.

Condoms in Zimbabwe are distributed through three channels - the public sector which distributes free, the commercial sector and the Population Services International, a non-governmental organisation, which sells condoms to economically disadvantaged persons at rates lower than those of commercial retailers.

Government The Scourge Of National Health

January 15, 1999

Harare - It not being sufficient that government has been the greatest single factor behind the decline of the Zimbabwean economy and the resulting commitment of more than 60% of the population to poverty, government is also the key destructive force of the Zimbabwean health infrastructure.

Blame must be fairly and squarely placed upon the shoulders of government for the very considerable deterioration in the Zimbabwean health services and the draconian deterioration in the quality and availability of health care.

The state has no qualms in providing more than $5 billion to fund defence expenditure which to a very great extent is blatantly unnecessary.

With the sole exceptions of participating from time to time in "peace-keeping" forces elsewhere in Africa, and then in the last six months Zimbabwe's self-created involvement in the Democratic Republic of Congo, Zimbabwe has enjoyed total peace ever since Independence.

Its defence needs have been and are limited only to maintenance of a sufficiently large and capable defence force to react in emergencies and to provide a deterrent to any in the future with untoward designs upon the country. Instead, it has maintained armed forces estimated at more than 55 000, expends billions annually upon armaments, ordnance, munitions and weaponry, and hundreds of millions on buildings and other defence infrastructures.

Now the vast outflows of resources have been intensified and increased through a politically-driven foray in the DRC which is clearly doomed to endure endlessly (unless Zimbabwe develops the wisdom to withdraw!) and which appears to have little prospect of a positive outcome.

We have enough money for defence, but spend a little over half of that amount upon health, for which a critical and desperate need exists. We have the money to fund the killing of people, but not those needed to fund the survival and wellbeing of others.

Zimbabwe is able to find $65 million to fund the monolithic operations of the ruling party. It is able to include in the President's Vote several hundreds of millions of dollars for unspecified, special purposes, mainly not subject to audit. It has enough resources to operate a plethora of diplomatic missions throughout the world, including many countries with whom Zimbabwe's relationships are minimal. But it does not have the money to enable Parirenyatwa Hospital to pay $4 million on arrears for blood supplies, and it does not have the money for Central Medical Stores to honour its payment obligations to suppliers of drugs, medications and other hospital supplies.

It does not have the money to meet the operating costs of hospitals and clinics when due and payable. It does not have the money to maximise the state-of-the-art technologies of Zimbabwe's health facilities. It does not have the money adequately and fairly to remunerate doctors, nurses and other health personnel.

Zimbabwe has gone mad and has lost all ability to determine between the important and the unimportant! It is incapable of prioritisation! Government cannot credibly contend that it has the interests of the people at heart when it so misallocates its meagre fiscal resources.

The nation is afflicted with HIV/Aids, malaria, hepatitis, tuberculosis, glaucoma, malnutrition and the many poverty-created ills that must prevail in a country where 64% of the population is poverty-stricken.

In the last year, the health environment has been worsened even further by the government-created circumstances of the Public Services Medical Aid Society (PSMAS). To all intents and purposes, government has unlawfully misappropriated funds from its own employees, for it withholds contributions payable to PSMAS from the salaries and wages of the Public Service and is obliged under Conditions of Service to match the contributions, with twice the amount thereof, but it has failed to pay over hundreds of millions of dollars when due to PSMAS, diverting the funds instead to other purposes. In the private sector, such actions constitute criminal fraud.

As a result, PSMAS is extraordinarily heavily indebted to the medical profession, to hospitals, laboratories and others. In many instances, debts have been outstanding for more than a year. One hospital is allegedly owed in excess of $10 million, and, therefore, is unable to purchase essential operational supplies.

A non-profit private hospital owed over $4 million has been forced to resort to bank overdraft facilities in order to pay salaries and wages, and has already incurred over $200 000 of interest. A consortium of doctors has disclosed that it has been awaiting payment of $1 million of fees since early 1998.

The very existence of many in the health sector is being placed in jeopardy, to the prejudice of the community as a whole (as was, for example, the situation when one hospital ran out of blood supplies). But the worst sufferers are the Public Service and their dependants, for by now many doctors, physiotherapists, hospitals and clinics are withholding services from PSMAS members unless advance cash payment is forthcoming.

The doctors who have implemented such service constraints have done so reluctantly, and with a conflict of interest, being conscious of their Hippocratic Oath obligations to care for the sick, but financially unable to continue to extend never-ending credit to PSMAS.

The situation has been exacerbated by the actions of the beleaguered management of PSMAS. Desperate to curb the pressures and demands of the PSMAS creditors, management issued payment cheques for portions of the arrears, which cheques were subsequently not met by the society's bankers, due to lack of available funds. Then, a few weeks ago, PSMAS issued post-dated cheques to many doctors and others.

As the cheques fell due, enquiries elicited responses that they should not yet be presented, as they would not be met.

The issue of cheques which are not covered and which will not be met is, in law, a fraud, and an act of insolvency. The circumstance of the Public Services Medical Aid Society have deteriorated to such an appallingly low ebb, that the medical profession creditors should petition the courts for its sequestration, so that a trustee can be appointed to take control of the society, realise assets (inclusive of institution of legal action against government for recovery of contribution monies due), settle liabilities and place the society's affairs in good order.

Hopefully it can be sufficiently restructured and reorganised, so as to restore it to viability and therefore to enable the discharge of the trustee from office. (Possibly the trustee should seek a judicial attachment of government assets such as fighter aircraft, presidential residences, etc. in settlement of government's debts with PSMAS!)

Between the chaos in most of government's hospitals, the disastrous position of the PSMAS, the withholding by many of medical services to civil servants and their families, and the brain drain of the medical profession from Zimbabwe to more remunerative and job-satisfying pastures, Zimbabwean Health Services are in a very sorry state.

The Ministry of Health, under Timothy Stamps and deputy minister David Parirenyatwa strives to serve the nation's needs under very trying circumstances, but is losing an uphill battle as it struggles against not only the ravages of ill-health, but also the gross lack of resources and the absence of governmental support. Government itself has become the greatest scourge of Zimbabwe's health.

1/29

Ms. Thurman—
Ambassador McDonald
asked me to include
this in your packet only.
He may raise this issue
with Acting President
Muzenda at your meeting
on Monday afternoon.

Thank you.
—Shawn

Zimbabwean Army Mistreatment of Two Independent Journalists

On January 10 a Zimbabwean independent weekly newspaper, The Sunday Standard, published a lead story alleging that 23 Zimbabwe National Army officers and soldiers had been arrested for plotting a coup d'etat in mid-December 1998.

On January 12 a Zimbabwe National Army major purporting to be a public affairs of the military called The Sunday Standard's editor, Mark Chavunduka, to come to Cranborne Barracks (military headquarters in Harare) to receive further information about the foiled coup plot. Chavunduka telephoned the newspaper's publisher, Clive Wilson, to inform him he would be a bit late for work because he was going after the story and Wilson warned him not to alone. Chavunduka was detained incommunicado for a week during which time he was allegedly subjected to incidents of torture and constant interrogation. Police and the Central Intelligence Organization then began a manhunt for Ray Choto, assistant editor of "The Sunday Standard" and the coup plot story's reporter and writer. Choto turned himself in to the police at The Sunday Standard's offices on January 19. The police turned both Choto and Chavunduka, who were both arraigned that same day, over to the military. For fifteen hours on January 19 and 20 both journalists were continuously interrogated and tortured. They were released on bail of U.S. $250 each and given a trial date of February 22. The are to answer charges of breaking the Law and Order Maintenance Act, Zimbabwe's all-purpose sedition legislation.

On January 22 police arrested Clive Wilson at The Sunday Standard's offices. He was held over the weekend and released on January 25 when a judge found the Government had no case against him under the Law and Order Maintenance Act.

The Government has said that The Sunday Standard's story is a lie. The Sunday Standard stands by its story. This is the first time in memory since independence that the Government of Zimbabwe has detained and tortured journalists. Also unprecedented about the case is the fact that the military deliberately ignored a habeas corpus order issued by a judge at the request of Clive Wilson who was seeking Chavunduka's release from illegal detention. We have protested these abuses to the Government of Zimbabwe both in Harare and in Washington. The European Union also has objected to this illegal conduct.

Corruption and torture in Mugabe's Zimbabwe

By Robert I. Rotberg, 02/14/99

President Robert Mugabe of Zimbabwe says it is permissible in his democracy to arrest and torture journalists, ban unions, and force critical jurists to resign. He also sends troops to Congo without parliamentary approval, thumbing his nose at brave critics at home and horrified African and world leaders. It is not clear what his opponents, Washington, London, or Pretoria can do to restore reason.

Meanwhile, Zimbabwe's debilitating economic crisis worsens by the day. Last week in Harare, the capital, and in other cities, Africans rioted for food. The maize meal that every Zimbabwean eats every day has been unobtainable since the first of the month. Inflation is galloping ahead at 60 percent a year; the country's currency has depreciated against the US dollar by 100 percent in a year. Bus fares have increased 60 percent. Unemployment is over 50 percent, and economic growth was below 2 percent per year in 1998. The telephone system breaks down. There are electricity shortages. The medical system has collapsed, and hospitals are without essential supplies. Late last year, Harare could not afford a critical water pump and much of the sprawling municipality was without water.

The war in Congo has been costing near-bankrupt Zimbabwe about $5 million a week since October. Mugabe and his government ministers are continually abroad, at conferences and workshops, or, in the president's case, purchasing houses and furniture. Last week he was in Jamaica for a conference, fiddling while Rome burns at home.

Allegations of corruption are commonplace. The president's nephew has obtained a number of major construction contracts. Relatives of Cabinet ministers also do well. A Zimbabwean is running several key mines in Congo, possibly in exchange for the troops that are assisting President Laurent Kabila's battle against Rwandan-backed rebels. The mayor of Harare is building a $3 million official house for himself when there are opulent houses on the local market for a sixth of that sum.

Zimbabwe has a captive daily press owned by the government. Television and radio is also government owned. But there are four brave independent weekly newspapers in Harare. In January, the independent Sunday Standard reported that there had been an aborted military coup against Mugabe's government. This echoed reports of military mutinies by Zimbabwean troops in Congo in December.

The army grabbed Mark Chavunduka, the Standard's editor, and Ray Choto, a journalist, for interrogation. They were then brutally tortured by military intelligence, possibly with the assistance of Mugabe's much-feared Central Intelligence Organization. Zimbabwe's judges ordered the release of the two journalist, but to no avail. When they were finally dumped back in Harare after several days of electric shocks, near-drowning, and multiple beatings, they were in very poor shape (as attested by two African medical specialists). Minister of Defense Moven Mahachi said

they could not have been tortured; they must have "scratched" themselves.

White and black Zimbabwean professionals marched on Parliament and were tear-gassed and threatened. Students have also marched and battled with police. The mood in Harare is ugly. Three judges of the Supreme Court, one white and two black, protested directly to Mugabe, requesting that he affirm the rule of law and speak out against torture of innocent persons.

Mugabe's answer, last week, was a tirade against the judges, journalists who "think they can tell lies," and foreign "spies" who must be behind Zimbabwe's problems. If the journalists had not acted "dishonestly," Mugabe told the nation in a broadcast, they would not have been tortured. He said that the journalists had "forfeited the right to legal protection." He told the judges who had complained that they were being impertinent and impudent and invited them to resign and enter the political arena. Mugabe further blamed his country's problems on "insidious attempts by British agents planted or recruited in Zimbabwe." Those agents were sowing discord.

Last week, after the president's tough speech, four more journalists were arrested, two for days. They included the editor and several writers for the Mirror. Their crime was reporting in October that the head only of a dead Zimbabwean soldier from Congo had been sent back to next-of-kin and that his body was still missing. The government later denied the story. But why the men were arrested this month is a mystery, except for the obvious continued intimidation of the press.

The International Monetary Fund is considering a support payment to Zimbabwe of $53 million. Presumably that grant is in jeopardy, but the IMF also fears weak countries like Zimbabwe reneging on their debts and plunging more deeply into financial hardship. Washington is urging the IMF to focus on Zimbabwe's human rights deficiencies. London, with Mugabe's allegations ringing in its ears, presumably wonders how to exert itself. Pretoria, disgusted by Mugabe's actions, wishes it could intervene directly.

Zimbabwe's next parliamentary election is in 2000, and there is a presidential election in 2002. University students do not want to wait that long. Other Zimbabwens may soon join them.

Robert I. Rotberg is teaches at the Kennedy School of Government and is president of the World Peace Foundation in Cambridge.

This story ran on page D07 of the Boston Globe on 02/14/99.

Galz Calls Banana A Hypocrite

February 14, 1999
By Staff Writer

Harare - The Gays and Lesbians Association of Zimbabwe (Galz) has called the former president of Zimbabwe, Reverend Canaan Banana, a hypocrite and a sell-out for lashing out at homosexuality. Rev Banana recently described the practice as "deviant, abominable and wrong according to the scriptures and according to Zimbabwean culture".

Banana has categorically denied participating in any homosexual activities, even though he was convicted of 11 counts of sodomy and indecent assault. Keith Goddard, programme director of Galz, in a lengthy letter written to Banana and copied to The Standard, said that the gay community had for a long time known of Banana's homosexuality, but because of their policy of confidentiality and in respect his safety, they had not exposed him.

"We have consistently maintained a policy never to out people, believing this to be highly dangerous in a homophobic climate which borders on hysteria," said Goddard.

Banana's homosexuality had been rumoured in Zimbabwe for a long time, but it took the shooting to death of a police officer-after he had called his senior "Banana's wife"-for it to surface. Jefta Dube, who was Banana's aide-de-camp, shot dead a colleague who had accused him of having a sexual relation with Banana.

In the scathing letter to Banana, Goddard said Banana ought to be ashamed of himself. "As an African leader and a man of the cloth, you are expected to act with integrity. As a former leader of this country we expect better of you. It is one thing for you to remain silent or neutral about homosexuality; it is quite another for you to castigate us when you have been convicted of engaging in homosexual activities yourself."

"To describe your own kind as deviant and abominable is to define yourself as a sell-out." Goddard said Banana's claim that homosexuality was deviant and alien to African culture was nonsense. "Deviant behaviour is that which harms others: abuse of power, assault, pedophilia, and rape are wrong because they hurt people.

Why should a consensual sexual relationship between two people of the same sex be abominable when it is fulfilling and socially constructive? "To say that homosexuality is un-African is absurd. Same-sex activity is known to exist in one form or another in at least 55 African cultures.

It is homophobia (hate of homosexuals) that has been imported from the West and not homosexuality." In Zimbabwe, homosexuality is illegal and often prejudiced. President Mugabe is well known for his anti-homosexual stance, branding those who practise it "worse than pigs".

FAX MEMORANDUM

Date: January 5, 1999

To: **Todd Summers - ONAP**
FAX: 212-456-2438

From: Sr. Ann Duggan
CRS AIDS Coordinator
Catholic Relief Services
209 West Fayette Street
Baltimore, MD 21201
Tel: 410-625-2220- Ext. 3516
FAX: 410-456-7890

Re: **ZIMBABWE: CRS AIDS-Related Projects**

Todd:
Here is some information on CRS AIDS-related projects in Zimbabwe. It will give you an idea of what we are doing.

List of Projects
Profiles on Zimbabwe Projects
Directory for Southern Africa

John Donahue is the Regional Director for southern Africa and Ms Krista Riddley is the newly appointed Country Rep.

Good luck as you plan this trip. Thanks and kind regards.
sr. ann

TOTAL 8 pages (incl. cover)

ID	Country	Project No.	Title
BX01	BENIN	608-95-003	Caritas AIDS Counseling and Care
BX03	BENIN	608-98-003	Caritas AIDS Counselling & Care - Phase II
BX02	BENIN	608-96-200	CMMB Assistance to Caritas AIDS Counselling & Care
BO01	BOLIVIA	714-96-012	Constructing Hope: AIDS Prevention & Accompaniment
BZ05	BRAZIL	716-96-004	Support for PWAs & AIDS Prevention in Pernambuco
BZ08	BRAZIL	716-97-906	GESTOS Human Rights & AIDS Seminar
BZ06	BRAZIL	716-97-001	Solidarity & Hope: Confronting AIDS in Bahia & Sergipe
BZ07	BRAZIL	716-97-901	Pilot Caritas Paraiba HIV/AIDS Preventive Education
BI02	BURUNDI	614-95-007	AIDS Prevention Education & Com'ty Awareness
KH03	CAMBODIA	810-97-001	Community-Based TB/AIDS/STD Program
KH02	CAMBODIA	810-96-004	Maryknoll HIV/AIDS
KH04	CAMBODIA	810-97-908	Water Festival & World AIDS Day Campaign
KH01	CAMBODIA	810-95-915	Consultancy: Catholic Agencies & AIDS
CU01	CUBA	723-97-002	Caritas Cuba AIDS Workshop
EC01	ECUADOR	730-97-003	Cuenca Pilot HIV/AIDS Prevention
EG01	EGYPT	814-96-004	Caritas HIV/AIDS Counselling Center
ET05	ETHIOPIA	634-95-900	Small Scale Income Generating Activities for PWAs
ET06	ETHIOPIA	634-95-007	Community Home-Based Care & Support for Orphans
GM02	GAMBIA	638-98-	Hope & Empowerment for Persons with HIV/AIDS
GH03	GHANA	640-94-009	Tamale Archdiocese AIDS Prevention
GH04	GHANA	640-95-904	HIV/AIDS Education
GH05	GHANA	640-96-900	Navrongo-Bolgatanga HIV/AIDS Baseline Survey
GH06	GHANA	640-97-004	Wa Diocese HIV/AIDS Prevention
GT01	GUATEMALA	738-98-	AIDS Prevention in Izabal
HQ03	HEADQUARTE	900-95-915	AIDS Education for Prevention
HN05	HONDURAS	744-97-901	AIDS Workshop for Water Counterparts - COCEPRADIL
HN04	HONDURAS	744-96-909	NCCB AIDS Pastoral Seminar
HN06	HONDURAS	744-97-001	Good Samaritan AIDS Education, Prevention & Counselling
ID07	INDIA	833-98-005	Sahara Shelter for Women & Children
ID04	INDIA	833-96-006	Delhi AIDS Awareness in High Schools
ID05	INDIA	833-96-009	Delhi: Sahara House AIDS Care Project
ID06	INDIA	833-97-007	Delhi - Michael's Care Home
IN17	INDONESIA	838-97-313	Minimizing Risks of HIV/AIDS
IN21	INDONESIA	838-98-907	Training for MITRA/Indonesia Counselors
IN20	INDONESIA	838-98-905	Workshop and Training for HIV/AIDS Prevention
IN18	INDONESIA	838-97-315	Increasing Sex Workers Self-Esteem & Strengthening STD/
IN16	INDONESIA	838-97-312	World AIDS Day 1997
IN11	INDONESIA	838-96-902	Development of AIDS Monopoly Games
IN14	INDONESIA	838-97-305	Integrating H/A Prevention Thru Awareness Bldg & Counsel
IN19	INDONESIA	838-98-011	Int'l AIDS Candlelight Memorial & Mobilization
IN13	INDONESIA	838-96-009	Semarang HIV/AIDS Training & Education
IN12	INDONESIA	838-96-903	HIV/AIDS Photography Exhibit
IN10	INDONESIA	838-96-901	Staff Training & Establishment AIDS Hotline
IN15	INDONESIA	838-97-308	HIV/AIDS Prevention among Migranr Workers
KE03	KENYA	648-96-003	Homa Bay STD Information & Education Program
KE06	KENYA	648-98-006	Maasai AIDS Prevention
KE05	KENYA	648-97-027	Karatina Home-Care and Counselling

INDIA 833-98-006 Michael's Care Home - II

ID	Country	Project Nu	Title
KE04	KENYA	648-97-900	AIDS Awareness Program in Kajiado District
MG01	MADAGASCA	656-97-901	Fort Dauphin STD/AIDS Education
MW02	MALAWI	658-95-003	Mzuzu AIDS Education & Home-Based Care
MO02	MOROCCO	867-95-005	Meknes Detection Center
MZ01	MOZAMBIQUE	666-94-006	Community AIDS Education Maputo
NE01	NEPAL	833-95-907	Caritas AIDS Awareness
PH06	PHILIPPINES	878-97-010	AIDS Education Training
PH07	PHILIPPINES	878-98-003	AIDS Prevention Program for Sailors
PH05	PHILIPPINES	878-97-901	AIDS Education Training - Antipolo Diocese
PH04	PHILIPPINES	878-95-015	Echo Training in AIDS Education
RW04	RWANDA	676-95-904	Pilot Inc.Gen.Activities for AIDS Widows
SN05	SENEGAL	678-98-	SIDA-Service Consultation & Counseling Center
SN04	SENEGAL	678-95-003	Integration Com'ty AIDS Prevention & APSPCS Training
SL02	SIERRA LEON	682-96-004	Shepherd's Hospice Volunteer Training
SL01	SIERRA LEON	682-96-900	HIV Needs Assessment Survey
ZA03	SOUTH AFRIC	686-96-001	Zikhulule AIDS Project
ZA04	SOUTH AFRIC	686-97-903	De Aar Diocese Middelburg AIDS Hospice
TZ03	TANZANIA	692-93-004	Mwanza AIDS Home Care/Counselling II
TZ04	TANZANIA	692-93-006	Dar es Salaam AIDS Project
TZ05	TANZANIA	692-95-905	Youth Education Program
UG15	UGANDA	695-96-905	Kamwokya World AIDS Day
UG21	UGANDA	695-97-012	Rubaga AIDS Counselling and Care III
UG20	UGANDA	695-97-011	Villa Maria Community Care & Counselling III
UG19	UGANDA	695-97-009	Medicines for AIDS Patients 1997
UG18	UGANDA	695-97-004	Kamwokya Christian Community Support to PWAs
UG09	UGANDA	695-95-003	1996 Medicines for AIDS Patients
UG06	UGANDA	695-94-001	Nsambya Hospital AIDS Project
UG07	UGANDA	695-95-001	Rubaga AIDS Care & Counselling II
UG17	UGANDA	695-97-003	Nsambya Hospital Integrated AIDS Care
UG08	UGANDA	695-95-002	Villa Maria Com'ty AIDS Care & Counselling II
UG16	UGANDA	695-97-900	Impact of Patient Education & Com'ty Awareness ...TB Trea
UG10	UGANDA	695-96-900	CDA Scholarships & TV Video for Villa Maria
UG11	UGANDA	695-96-901	Kamwokya Skills Training
UG12	UGANDA	695-96-902	AIDS Care Pediatric Counselling
UG13	UGANDA	695-96-903	Villa Maria Institution Building Workshops I & II
UG14	UGANDA	695-96-904	Rubaga Hospital Institution Building Workshops I & II
VI02	VIETNAM	896-96-917	Youth Who Love Life Book
VI03	VIETNAM	896-97-915	AIDS Education for Secondary School Youth
ZW06	ZIMBABWE	699-97-002	Mutare Community Home Care to Support PLWH/A -Phase
ZW07	ZIMBABWE	699-97-007	Medical Supplies for Church Health Centres with H/A Progr
ZW08	ZIMBABWE	699-97-903	Consultancy to Develop Proposal for NGO H/A Prog.Strengt
ZW09	ZIMBABWE	699-97-905	Staff Development for Jesuit AIDS Project
ZW10	ZIMBABWE	699-97-906	Consultancy for AIDS Awareness Baseline Survey-CADEC
ZW05	ZIMBABWE	699-97-001	Hwange Diocese AIDS Project - II

* PAKISTAN 877-98-911 Training in AIDS Awareness + Couns. Techniques

82. ZIMBABWE 699-97-001 HWANGE DIOCESE AIDS PROJECT - II

Project Duration:	01/01/97 - 12/31/99 36 months
Project Location:	Hwange Diocese, Matabeleland North Province, northwest Zimbabwe
Project Holder:	Sr. Mary Elizabeth Share, FSDM, RN Hwange Diocese AIDS Coordinator
Direct Target Group:	100,000 persons including school children, military, commercial sex workers, community and youth leaders, PWH/As, congregations, villagers and Hwange urban dwellers
Total Project Cost:	$186,574
Requested of CRS:	$152,350
Requested of CAFOD:	$ 33,900
Unfunded Balance:	-0-

Project Description:

This project builds on the successful AIDS program initiated under a previous project (699-93-002). Hwange Diocese commands an estimated population of just below 300,000. Hwange, the largest town in the Diocese, has a population of 60,000 of which an estimated 35% is HIV positive, well above the national average of 20%. This high incidence is attributed to the presence of migrant labor in the mining town of Hwange (home of the Wankie Colliery), tourism in Victoria Falls and Hwange National Game Park, the fishing camps along the Zambezi and the two international borders (Zambia and Botswana) where long distance truck drivers often spend days before crossing borders. Faced with a problem of this magnitude the Hwange Diocese AIDS Project will aim at reducing the incidence of HIV and help alleviate the suffering caused by HIV/AIDS in the Hwange Diocese. In an attempt to attain this goal the project will: a) seek to increase awareness of how to prevent HIV infection among 100,000 school children and adults and identify and promote/discouraage those cultural beliefs and practices that inhibit/aggravate the spread of HIV in Hwange Diocese; b) provide counselling services to 7,700 PWH/As and their families; c) provide material and spiritual support to PWH/As and dependents whose breadwinners die of AIDS; and d) impart training, counselling and community drama skills to staff. Thus the program has four major components: education, counselling, support and staff training.

83. ZIMBABWE 699-97-002 MUTARE COMMUNITY HOME CARE TO SUPPORT PWH/A PHASE II

Project Duration:	03/01/97 - 02/28/2000 36 months
Project Location:	Diocese of Mutare comprising 6 Districts (Nyanga, Makoni, Chitepo, Mutare Chipinge, Chimanimani) in Manicaland Province in eastern Zimbabwe on the Mozambique border.
Project Holder:	Health Commission of CADEC (Catholic Development Commission) Mutare Diocese
Direct Target Group:	600 AIDS & HIV+ people and their families, congregations, school children, and villagers mostly in rural areas for a total of 100,000 people
Total Project Cost:	$153, 723
Requested of CRS:	$ 61, 862
Requested of CAFOD:	$ 61, 861
Local Contribution:	$ 30,000
Unfunded Balance:	$-0-

Project Description:

The goal of this project, which follows-on from project 699-92-006, is to assist PLWH/A and their families and their communities and to encourage them to develop and establish community home-based care structures and initiatives that will enable them to deal with the AIDS crisis in an effective and sustainable manner. Project objectives include: a) to provide pyschological and spiritual support to 600 people living with HIV/AIDS, their family members, destitute dependents of the disabled and deceased persons; b) to provide material suppoort to 600 people living with HIV/AIDS, family members and destitute dependents of disabled and deceased persons; c) to empower communities with skills and knowledge for quality home-care of people with HIV/AIDS; d) to raise community awareness on HIV/AIDS/STDs and encourage the community to organize themselves to prevent the spread of the diseases.

84. ZIMBABWE 699-97-007 MEDICAL SUPPLIES FOR CHURCH HEALTH CENTRES WITH HIV/AIDS PROGRAMS

Project Duration:	01/01/98-12/31/02
Project Location:	Hwange and Mutare Dioceses
Project Holder:	Health Department of the Catholic Development Commission of Mutare Diocese and Lubhancho House of Hwange Diocese
Direct Target Group:	10,000 AIDS and HIV positive people and their families, and poor people mostly in rural areas (villagers) for a total of 231,186 people in Mutare and Hwange dioceses
Total Project Cost:	$2,500,000
Requested of CRS:	$ 450,000
Requested Other :	$ 450,000
Local Contribution:	$ 150,000
In-Kind Medical Supplies:	$1,500,000

Project Description:

This project will provide drugs and nutritious foodstuffs (therapeutic and breastmilk substitutes) to people affected by HIV/AIDS (patients and orphans) in order to prolong life and decrease pain. This project will also greatly prevent HIV transmission through early treatment of STIs (which promote HIV transmission), by artificial feeding of infants born to HIV infected mothers (as breast feeding leads to 15% mother-child infection), and by post HIV test counselling to reduce risky behavior and make informed choice on reproductive behaviour. Beneficiaries for this project will be mostly people who are unable to meet their own needs due to illness (AIDS patients) and/or poverty or young age (orphaned children) and whose government has greatly experienced shrinking capacity to assist their own citizens. CRS/SARO is currently supporting two AIDS projects in the Hwange and Mutare Dioceses of Zimbabwe. These two projects are assisting PLWH/A and their families with psychosocial, material and financial support. CRS has also been supporting 46 Catholic mission hospitals and clinics in Zimbabwe with medicines and medical supplies for the past three years. These donations were sourced from the Catholic Medical Mission Board (CMMB) and the 1997 shipments to Zimbabwe were valued at US$523.612. An increasing body of information suggest that STI treatment and management significantly (by approximately 40%) reduce HIV transmission. The two AIDs projects are running under the direction of 14 mostly Catholic mission hospitals and clinics in Mutare and Hwange Dioceses. Based on the achievements of these two projects and the high need for STI and HIV related diseases' treatment and management medicines and medical supplies, therapeutic feeding materials and child supplementary food, CRS/Zimbabwe requests funding for these health centres to enable them to purchase high nutrient-content foods for poor AIDS patients and supplementary foods for infants whose mothers have died of AIDS. Furthermore, it is envisaged that such funding will enable these health centres to address needs they have not been able to work on such as testing and baby food. The global goal for this project is to prevent HIV transmission and mitigate the effects of increasing costs, declining incomes and the HIV/AIDS epidemic on the provision of health care. This will be achieved by increasing the supply of essential medicines for STI treatment and management and the supply of medical supplies, HIV testing facilities, therapeutic food supplies for HIV/AIDS patients and breast milk substitutes for orphaned infants and for use by children with HIV-positive mothers, to Catholic hospitals and clinics within the catchment area of the CRS-supported AIDS projects in Hwange and Mutare. It will provide HIV testing equipment to selected hospitals and funds to the Diocesan Health Commissions to locally purchase therapeutic food supplies for AIDS patients and breast milk substitutes for infants who would have lost their mothers and for use by those with HIV positive mothers. The project will provide health and nutrition education to PLWH/A and volunteer and primary care-givers, and to ante-natal and post-natal HIV positive mothers. The total budget for this five-year project is $2,500,000. CMMB medical supplies will amount to $1,500,000 and local contribution will be $150,000.

85. ZIMBABWE 699-97-903 CONSULTANCY TO DEVELOP PROPOSAL FOR NGO PROGRAM STRENGTHENING IN HIV/AIDS SECTOR

Project Duration:	08/01/97-08/31/97
Project Location:	Zimbabwe

Project Holder: Emthunzini
Direct Target Group: Selected NGOs
Total Project Cost: $4,894
Requested of CRS: $4,894
Unfunded Balance: -0-
Project Description:
The purpose of this consultancy was to assist CRS/Zimbabwe prepare a proposal in response to an RFA by USAID to design an NGO strengthening program for NGOs in the HIV/AIDS sector. It was later decided that given the differences between USAID and CRS in terms of ethical position on the use of prevention methods, that CRS could not submit a proposal as a lead agency, but did submit an application as a sub-grantee.

86. ZIMBABWE 699-97-905 STAFF DEVELOPMENT FOR THE JESUIT AIDS PROJECT

Project Duration: 08/01/97-08/31/97
Project Location: Harare, Zimbabwe
Project Holder: Jesuit AIDS Project
Direct Target Group: Project Director and Coordinator
Total Project Cost: $1,200
Requested of CRS: $1,200
Unfunded Balance: -0-
Project Description:
This project provided funds towards travel and living expenses for two staff members of the Jesuit AIDs Project to attend the SANASO Regional Conference in Mbabane, Swaziland. This conference was to allow exchange among different organizations working in the AIDS sector in Southern Africa. The participants presented papers of their experience at the workshop. They were pleased that their presentations we well received.

87. ZIMBABWE 699-97-906 CONSULTANCY FOR AIDS AWARENESS BASELINE SURVEY CADEC MUTARE

Project Duration: 12/01/97-01/31/98
Project Location: Mutare, Diocese
Project Holder: CADEC Mutare
Direct Target Group: 10 health centers and the population they serve (131,000)
Total Project Cost: $3,790
Requested of CRS: $3,790
Unfunded Balance: -0-
Project Description:
This baseline survey will serve to demonstrate the impact that the Mutare AIDS project has had in terms of awareness of the population and behavior change. It will serve to advise the project on strengths, weaknesses and new areas which need to be addressed.

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ime difference: (summer/winter)

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HARARE 407

From: AMEMBASSY HARARE
MRN: 407
Date/Time: 211242Z JAN 99
Subject: ZIMBABWE: THE STATE OF THE AIDS EPIDEMIC AND USAID'S RESPONSE
ICNbr: TED7272
Precedence: ROUTINE

Cable Text:

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ACTION AID-00

INFO LOG-00 AF-01 CIAE-00 DODE-00 SRPP-00 EB-00 UTED-00
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R 211242Z JAN 99
FM AMEMBASSY HARARE
INFO SECSTATE WASHDC 2254
AMEMBASSY PRETORIA
AMEMBASSY NAIROBI
AMEMBASSY LUSAKA
AMEMBASSY GABORONE
AMEMBASSY LILONGWE
AMEMBASSY MAPUTO
AMEMBASSY WINDHOEK
AMEMBASSY DAR ES SALAAM
AMEMBASSY LUSAKA
AMEMBASSY ADDIS ABABA
AMEMBASSY KAMPALA

UNCLAS SECTION 01 OF 05 HARARE 000407

AIDAC

FOR STATE, PDAS JCARSON, DAS SCHNEIDMAN, AF/S JBLANEY AND PKIM-SCOTT, AID/W, AA/AFR VDERRYCK, AFR/SA WJEFFERS AND DCOHN, AFR/SD JWOLGIN AND HSUKIN, G/PHN, PAUL DELAY, MISSIONS FOR PEN OFFICERS

E.O. 12958: N/A
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HARARE 01 OF 05 407

SUBJECT: ZIMBABWE: THE STATE OF THE AIDS EPIDEMIC AND USAID'S RESPONSE

1. SUMMARY: ZIMBABWE, WITH A POPULATION OF 12 MILLION, HAS ONE OF THE NIGHEST HIV/AIDS INFECTION RATES IN THE WORLD. UNAIDS ESTIMATES THAT 25% OF THE SEXUALLY ACTIVE ADULT POPULATION IS HIV-INFECTED. ALTHOUGH THE EFFECTS OF THE EPIDEMIC ARE ALREADY BEING FELT, THE FULL SOCIAL AND ECONOMIC IMPACT IS YET TO COME. MORTALITY RATES ARE INCREASING, THE NUMBER OF ORPHANS GROWING, TUBERCULOSIS (TB) INFECTION kites EXPLODING. ECONOMICALLY, THE DISEASE WILL HAVE A SIGNIFICANT DEBILITATING IMPACT ON

THE BUSINESS SECTOR. USAID'S RESPONSE TO THE EPIDEMIC COMPRISES A COMPLEMENTARY RANGE OF COORDINATED ACTIVITIES INCLUDING CONDOM SOCIAL MARKETING, CAPACITY BUILDING AND ORGANIZATIONAL DEVELOPMENT OF ZIMBABWEAN NGOS, POLICY ADVOCACY AND A NEW VOLUNTARY COUNSELING AND

TESTING INITIATIVE.

2. BACKGROUND: SOUTHERN AFRICA IS PRESENTLY THE MOST SEVERELY AFFECTED REGION BY THE HIV/AIDS PANDEMIC, WITH ZIMBABWE AND BOTSWANA LEADING IN NUMBERS OF INFECTED PEOPLE. SINCE FIRST DESCRIBED IN THE 1980S, THE CENTER OF THE AFRICAN EPIDEMIC HAS SHIFTED FROM EAST AND CENTRAL AFRICA TO THE SOUTHERN REGION. ZINBABWE, BEARS ONE OF THE HEAVIEST BURDENS OF HIV/ATDS IN THE WORLD. INITIALLY, INFECTIONS AND RISKY BEHAVIOR WERE RECORDED AMONG IDENTIFIABLE HIGH-RISK GROUPS, SUCH AS COMMERCIAL SEX WORKERS (CSWS), TRUCK DRIVERS AND MILITARY PERSONNEL. IN RECENT YEARS HOWEVER, SURVEILLANCE DATA SHOW THAT THE GENERAL POPULATION IS ALSO AT A HIGH RISK OF CONTRACTING THE DISEASE.

3. AS OF JUNE 1998, UNAIDS ESTIMATED THAT 25% OF THE SEXUALLY ACTIVE ADULT POPULATION IS HIV-INFECTED, WITH 2000 PEOPLE ACQUIRING NEW HIV INFECTIONS EVERY WEEK. IT HAS ALSO ESTIMATED THAT MORE THAN 700 PEOPLE DIE OF AIDS BELATED ILLNESS EVERY WEEK. A SIGNIFICANT INCREASE IN THE NUMBER OF DEATHS FROM 500 PER WEEK REPORTED IN 1996, AND MORE THAN A 200% INCREASE IN THE NUMBER OF DEATHS COMPARED TO 1985. OVER 30 PERCENT OF THE WOMEN ATTENDING ANTENATAL CLINICS IN HIGH-DENSITY AREAS OF THE CAPITAL CITY, HARARE, ARE HIV-INFECTED. BASED ON RECENT DATA THE U.S. BUREAU OF CENSUS ESTIMATE THAT THE DISEASE HAS REDUCED LIFE EXPECTANCY BY 26 YEARS, FROM 65 TO 39 YEARS. HIV/AIDS HAS REACHED SUCH PROPORTIONS THAT IT MUST BE RECOGNIZED AS A SERIOUS NATIONAL DEVELOPMENT ISSUE WITH TRAGIC HUMAN IMPLICATIONS.

4. SOCIAL AND ECONOMIC IMPACT: ALTHOUGH THE EFFECTS OF THE EPIDEMIC ARE ALREADY BEING FELT, THE FULL SOCIAL AND ECONOMIC IMPACT WILL NOT BE EVIDENT FOR SEVERAL YEARS. BY THE YEAR 2005 IT IS ESTIMATED THAT THESE WILL INCLUDE A CUMULATIVE TOTAL OF 1.8 MILLION PEOPLE INFECTED, AND 1.9 MILLION DEATHS OF MOSTLY ADULTS IN THEIR PRIME WORKING AGES AND CHILDREN UNER THE AGE OF FIVE. SOME OF THE PARTICULARLY DEVASTATING CONSEQUENCES ARE DESCRIBED BELOW.

5. ORPHANS: AS A CONSEQUENCE OF AIDS DEATHS TO MEN AND WOMEN, THE NUMBER OF ORPHANS IS PROJECTED TO RISE QUICKLY, FROM A SMALL NUMBER IN 1990 TO 150,000 IN 1995, 543,000 IN THE YEAR 2000 AND 910,000 IN 2005. THIS WILL PUT A TREMENDOUS STRAIN ON BOTH FORMAL AND FAMILIAR SOCIAL SYSTEMS TO COPE WITH SUCH LARGE NUMBERS AND PROVIDE THE NEEDED SUPPORT AND CARE. AT THE HOUSEHOLD LEVEL, THERE IS ALREADY AN INCR
EASED BURDEN AND STRESS
ON THE EXTENDED FAMILY WHICH HAS TRADITIONAL RESPONSIBILITY OF CARING FOR ORPHANS. MANY GRANDPARENTS ARE LEFT TO TAKE CARE OF THE YOUNG, AND IN SOME CASES CHILDREN OR ADOLESCENTS ARE HEADING FAMILIES. AT PROVINCIAL AND NATIONAL LEVELS, SOCIETY IS ALREADY

SADDLED WITH AN INCREASED BURDEN OF PROVIDING SERVICES FOR CHILDREN, INCLUDING ORPHANAGES, HEALTH CARE AND SCHOOL FEES. THIS BURDEN WILL GROW IN THE COMING YEARS. ALREADY, THE NUMBER OF STREET CHILDREN IN URBAN AREAS HAS DEMONSTRABLY INCREASED, AND WITH IT THE BELATED PROBLEMS SUCH AS THEFT, STREET VIOLENCE, DRUG USE AND

TRAGIC DEATHS AT YOUNG AGES. IN SOME CASES, BECAUSE OF THE STIGMA AND OTHER REASONS, THE EXTENDED FAMILY SYSTEM IS BREAKING DOWN AS THE NUMBERS OF ORPHANS INCREASE AND THE FAMILIES ARE UNABLE TO COPE FINANCIALLY OR PSYCHOLOGICALLY.

6. HEALTH: ZIMBABWE'S CONSIDERABLE GAINS IN THE HEALTH SECTOR SINCE INDEPENDENCE IN 1980 ARE NOW IN JEOPARDY. THE IMPACT OF THE AIDS EPIDEMIC HAS BEEN EXACERBATED BY THE CONCURRENT ECONOMIC CRISIS OF THE 1990S WHICH HAS LED TO REDUCED GOVERNMENT OF ZIMBABWE EXPENDITURE, LIMITING THE MINISTRY OF HEALTH'S (MOB) ABILITY TO COMBAT THE AIDS EPIDEMIC. CONSEQUENTLY, THE HEALTH CARE INFRASTRUCTURE IS LEFT CRIPPLED: THERE IS LOW MORALE AMONG SERVICE PROVIDERS AND SUBSEQUENTLY A HIGH ATTRITION RATE; INCREASINGLY FREQUENT DRUG SHORTAGES IN CLINICS; LACK OF AMBULANCE SERVICES AND OTHER FORMS OF TRANSPORTS LACK OF VITAL TELEPHONE AND OTHER COMMUNICATION FACILITIES; AND REDUCED EXPENDITURES ON CRITICAL DISCRETIONARY ACTIVITIES SUCH AS SUPERVISION. INDEED, THE STAFF OF THE NATIONAL AIDS COORDINATION PROGRAM (NACP), A DEPARTMENT OF THE MOB, IS ALMOST ENTIRELY DONOR FUNDED AND SUBJECT TO THE VICISSITUDES OF PROJECT END DATES AND FUNDING CUTS. ITS LIMITED STAFF AND TIGHT BUDGET ARE TESTIMONY THAT IT SIMPLY DOES NOT HAVE THE CAPACITY TO EFFECTIVELY COMBAT AIDS.

7. ZIMBABWE'S HEALTH INDICATORS ARE BEGINNING TO SHOW THE IMPACT OF THE EPIDEMIC. THE 1997 INTERCENSAL DEMOGRAPHIC SURVEY (ICDS) CONDUCTED BY THE CENTRAL STATISTICAL OFFICE REPORTED DETERIORATION IN KEY INDICATORS. THE INFANT MORTALITY RATE ROSE BY 21.2% BETWEEN 1992 AND 1997, FROM 66 TO 80 DEATHS PER 1,000 BIRTHS, WHILE THE CRUDE DEATH RATE ROSE BY 28% FROM 9.5 TO 12.2 PER 1000 POPULATION DURING THE SAME PERIOD. THE 1999 DEMOGRAPHIC AND HEALTH SURVEY IS EXPECTED TO REPORT FURTHER DETERIORATION IN INFANT, CHILD AND MATERNAL MORTALITY.

8. THE HIV EPIDEMIC IN ZIMBABWE HAS LED TO AN EXPLOSIVE EPIDEMIC OF TUBERCULOSIS (TB). THE NUMBER OF TB CASES HAS RISEN RAPIDLY, FROM 5,233 IN 1985 TO 43,752 IN 1997, AN INCREASE OF MORE THAN 836%. THUS, THE IMPACT OF HIV INFECTION ON TUBERCULOSIS POSES A SERIOUS PUBLIC HEALTH CHALLENGE BECAUSE TB IS TRANSMITTED THROUGH CASUAL CONTACT, THEREBY INCREASING THE RISK OF TB FOR THE ENTIRE POPULATION.

9. POPULATION GROWTH: INCREASED MORTALITY RATES DUE TO AIDS WILL CONTRIBUTE TOWARDS A LOWER POPULATION GROWTH

RATE. INDEED, THE ICDS REPORTED AN AVENGE INTERCENSAL POPULATION GROWTH RATE OF 2.5%, CONSIDERABLY LOWER THAN THE AVERAGE INTERCENSAL RATE OF 3.1% REPORTED IN 1992. (HIGHER MORTALITY, DECREASED FERTILITY AND DECREASED IMMIGRATION WERE ALL CONTRIBUTING FACTORS.) HOWEVER, WITH 43% OF ZIMBABWEANS UNDER THE AGE OF 15 AND RELATIVELY HIGH ALBEIT DECLINING FERTILITY LEVELS, POPULATION GROWTH RATE IS LIKELY TO CONTINUE ITS DOWNWARD TREND BUT UNLIKELY TO BECOME NEGATIVE. DIFFERENT MODELS, BASED ON VARYING ASSUMPTIONS, HAVE PROJECTED DIFFERING SCENARIOS: THE U.S. BUREAU OF CENSUS, FOR EXAMPLE, FORECAST THAT POPULATION GROWTH WILL SLOW DOWN TO 0.3% BY THE YEAR 2010, WHILE THE FUTURES GROUP AND NACP FORECAST A POPULATION GROWTH OF 0.7% DURING THE SAME PERIOD. ALL MODELS CONSISTENTLY SHOW THAT DUE TO INCREASED MORTALITY RATES IN THE POPULATION AGED BETWEEN 15 AND 6QNCY RATIO,
WHICH
HAS IMPROVED SINCE 1980, WILL BEGIN TO WORSEN.

10. ECONOMIC IMPACT: THE IMPACT OF AIDS WILL HINDER ACHIEVEMENT OF ZIMBABWE'S GOAL OF RAPID ECONOMIC AND SOCIAL TRANSFORMATION, ARTICULATED IN THE POLICY PAPER "ZIMPREST" (ZIMBABWE PROGRAMME FOR ECONOMIC AND SOCIAL TRANSFORMATION). THE DISEASE AND ITS ASSOCIATED MORTALITY ARE STRIKING THE WORKING AGE POPULATION DISPROPORTIONATELY. THE EPIDEMIC WILL INCREASINGLY

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SUBJECT: ZIMBABWE: THE STATE OF THE AIDS EPIDEMIC AND USAID'S RESPONSE

DISRUPT PRODUCTION, AS UP TO 90 PERCENT OF HIV/AIDS INFECTIONS ARE AMONG ADULTS IN THEIR PRIME WORKING YEARS, 20-29 YEARS FOR FEMALES AND 30-39 YEARS FOR MALES. THIS REPRESENTS A SIGNIFICANT LOSS OF PRODUCTIVE LABOR, EDUCATION, TRAINED SKILLS AND EXPERIENCE. ZIMBABWEAN COMPANIES HAVE REPORTED LOSS OF EXPERIENCED PERSONNEL, INCREASED EXPENDITURE TO HIRE AND TRAIN REPLACEMENTS (SOME COMPANIES HIRE TWO PERSONS FOR EACH VACANCY), INCREASED ABSENTEEISM, INCREASED LABOR TURNOVER, DECREASED PRODUCTIVITY, A SHRINKING POOL OF AVAILABLE HIRES, AND INCREASED HEALTH CARE COSTS DUE TO HIV/AIDS. AIDS CAN ALSO RE EXPECTED TO HAVE ADVERSE EFFECTS ON THE MAINSTAY OF ZIMBABWE'S ECONOMY, THE AGRICULTURE SECTOR.

11. IN SUM, HIV/AIDS HAS POTENTIALLY MORE SERIOUS CONSEQUENCES ON DEVELOPMENT THAN ANY EPIDEMIC IN MODERN HISTORY. IDENTIFICATION OF EFFECTIVE, AFFORDABLE AND SUSTAINABLE INTERVENTIONS IS A CHALLENGE AND AN URGENT PUBLIC HEALTH PRIORITY.

12. USAID RESPONSE: SINCE 1994, THE THRUST OF USAID HIV/AIDS STRATEGY HAS BEEN COMMUNICATION TO ENCOURAGE RESPONSIBLE BEHAVIOR CHANGE. THE STRATEGY COMPRISED A COMPREHENSIVE RANGE OF COORDINATED ACTIVITIES TARGETING HIGH-RISK POPULATIONS IN THE COMMERCIAL FARMS, THE TRANSPORT INDUSTRY, THE MILITARY, AND THE PRIVATE SECTOR. MASS MEDIA (PRINT, ELECTRONIC AND RADIO MESSAGES) WAS USED TO TARGET THE GENERAL POPULATION. TO REACH THE YOUNG GENERATION, HIV/AIDS EDUCATION WAS

INTEGRATED INTO COLLEGE AND SCHOOL CURRICULA. OVER THE LAST FEW YEARS, THE STRATEGY HAS CONTRIBUTED TO UNIVERSAL AWARENESS -- MOST STUDIES SHOW THAT 98-100 PERCENT OF THE GENERAL POPULATION IS AWARE OF HIV/AIDS, WITH FEW EXHIBITING ANY MYTHS OR MISCONCEPTIONS REGARDING THE TRANSMISSION OF HIV. THE CORE OF THE MISSION'S STRATEGY HAS TO MOTIVATE FOR BEHAVIOR CHANGE. UNFORTUNATELY, AS IN OTHER AFRICAN PROGRAMS, ATTEMPTS BY USAID AND OTHER PARTNERS TO TRANSLATE AWARENESS INTO DEFINITIVE BEHAVIOR CHANGE AND SLOW THE HIV EPIDEMIC HAS HAD VERY LIMITED SUCCESS.

13. IN 1997, THE MISSION MADE A STRATEGIC SHIFT IN VIEW OF ITS RESULTS TO DATE. AFTER A CAREFUL ANALYSIS OF BEST PRACTICES IN HIV PREVENTION IN OTHER AFRICAN CONTEXTS, THE MISSION REFOCUSED ITS EFFORTS. A NEW HIV VOLUNTARY COUNSELING AND TESTING (VCT) INITIATIVE HAS BECOME THE CENTERPIECE OF A PORTFOLIO THAT INCLUDES SEVERAL COMPLEMENTARY ACTIVITIES THAT SEEK TO PROMOTE RESPONSIBLE BEHAVIOR CHANGE. THE USAID/ZINBABWE TEAM NOW SEES THIS AS THE CORNERSTONE OF A PROMISING NEW STRATEGY FOR THE FUTURE--FACE-TO-FACE COUNSELLING SUPPLEMENTED WITH AFFORDABLE, ACCESSIBLE HIV TEST RESULTS.

14. VCT: STUDIES HAVE SHOWN THAT VCT IS EFFECTIVE IN REDUCING HIGH RISK SEXUAL BEHAVIOR AMONG MEN AND WOMEN IN DEVELOPING COUNTRTES. UNFORTUNATELY, SUCH SERVICES ARE PRACTICALLY NON-EXISTENT TN ZIMBABWE. CONSEQUENTLY, USAID IS NOW FUNDING A PROGRAM THAT SEEKS TO MAKE VCT SERVICES AVAILABLE IN STRATEGIC LOCATIONS ACROSS THE COUNTRY BY THE END OF 1999. THE PRIORITY FOR THE MISSION IS TO MAKE VCT AFFORDABLE AND ACCESSIBLE TO THE MAJORITY OF ZIMBABWEANS. THE FIRST OF THESE "MODEL" VCT CENTERS WILL OPEN ITS DOORS IN MARCH 1999. DATA WILL BE COLLECTED TO CAREFULLY MONITOR AND EVALUATE IMPACT BEFORE THE PROGRAM IS REPLICATED NATIONWIDE. WE ARE CAUTIOUSLY OPTIMISTIC THAT EARLY SUCCESSES WILL ENABLE ZIMBABWE TO LEVERAGE MORE RESOURCES--INCLUDING FROM OTHER DONORS WHO ARE DESPERATELY LOOKING FOR PROMISING INTERVENTIONS TO SUPPORT.

Will these work?

15. NGO CAPACITY BUILDING: NGOS WORKING IN HIV/AIDS HAVE PROLIFERATED RAPIDLY IN THE LAST FEW YEARS. WHILE THE MAJORITY OF THESE ORGANIZATIONS SEEK TO PREVENT HIV TRANSMISSION, OR TO MITIGATE ITS CONSEQUENCES, THEIR COMBINED IMPACT HAS BEEN MINIMAL -- THE EPIDEMIC HAS NOT

SLOWED DOWN. FACED WTTH AN HIV/AIDS EPIDEMIC THAT HAS WOVEN ITSELF INTO THE FABRIC OF ZINBABWEAN SOCIETY, NGOS TODAY NEED TO REDIRECT AND STRENGTHEN THEIR APPROACHES TO COMBATING THE SPREAD OF HIV AT THE COMMUNITY LEVEL. MOST NGOS WERE REGISTERED FAIRLY RECENTLY AND LACK INSTITUTIONAL HISTORY OR LONG-TERM EXPERIENCE. BASIC MANAGEMENT SKILLS, SUCH AS EXPERTTSE IN PLANNING, MONITORING AND EVALUATION, ACCOUNTING, MARKETING AND EVEN PUBLIC RELATIONS ARE NEEDED. TO ADDRESS THIS SHORTCOMING AND INCREASE THE SUSTAINABILITY AND

So what have (exactly) NGO's been doing in the meantime? What about support for CBO's?

Exchange opportunities

Part of Res

Good any support from people who have benefited?

EFFECTIVENESS OF HIV/AIDS NGOS, USAID IS SUPPORTING A PROJECT THAT PROVIDES TECHNICAL ASSISTANCE FOR ORGANIZATIONAL DEVELOPMENT. THE FOURTEEN STRATEGIC NGOS THAT ARE RECEIVING THIS ASSISTANCE WILL IN TURN MENTOR OTHER NGOS AND CBOS (COMMUNITY BASED ORGANIZATIONS) AS THEIR CAPACITY IS STRENGTHENED.

16. CONDOM SOCIAL MARKETING: ZIMBABWE HAS HAD A STRONG PUBLIC SECTOR CONDOM DISTRIBUTION PROGRAM- ALMOST 50 MILLION CONDOMS ARE ISSUED FROM THE CENTRAL MOB WAREHOUSE ANNUALLY. HOWEVER, THE DISTRIBUTION IS LIMITED TO CLINICS AND PUBLIC HEALTH FACILITIES OPEN ONLY DURING WORKING HOURS. IN THE PAST, NON-TRADITIONAL OUTLETS SUCH AS BARS AND SMALL KIOSKS RARELY CARRIED CONDOMS. IN THE LAST FEW YEARS, THE MOB HAS FALTERED IN THE PROVISION OF TRANSPORTATION OF CONDOMS TO PUBLIC SECTOR INSTITUTIONS, FURTHER LIMITING ACCESS. DISTRICT LEVEL CLINICS FACE INCREASINGLY FREQUENT STOCK OUTS. USAID IS THEREFORE SUPPORTING A SOCIAL MARKETING EFFORT THAT SEEKS TO ENSURE THAT CONDOMS ARE ACCESSIBLE AND AFFORDABLE -- AT PLACES AND TIMES MOST NEEDED. THIS EFFORT TO SOCIALLY MARKET MALE CONDOMS HAS BEEN HIGHLY SUCCESSFUL, EXCEEDING SALES TARGETS BY 70%. GIVEN THE SOCIETAL AND CULTURAL CONTEXT, WOMEN ARE PARTICULARLY VULNERABLE TO HIV/AIDS INFECTION, YET MANY WOMEN ARE UNABLE TO NEGOTIATE CONDOM USE WITH THEIR PARTNERS. IN RECOGNITION OF THIS, USAID INTRODUCED A SOCIALLY MARKETED FEMALE CONDOM -- LOCALLY KNOWN AS CARE CONTRACEPTIVE SHEATH -- AS AN OPTION FOR WOMEN. WHILE SALES OF THE FEMALE CONDOM ARE STILL RELATIVELY LOW, GROUNDBREAKING LESSONS ARE BEING LEARNED ABOUT ADVOCACY, SOCIAL MOBILIZATION OF WOMEN, AND OTHER PERTINENT ISSUES TO CONSIDER WHEN INTRODUCING A NEW REPRODUCTIVE HEALTH PRODUCT WITH MAJOR CULTURAL IMPLICATIONS. MORE IMPORTANTLY, A FEMALE-CONTROLLED BARRIER METHOD IS NOW WIDELY AVAILABLE FOR THOSE WOMEN WHO DO CHOOSE TO USE IT.

Bull

17. POLICY:POLITICAL WILL AND LEVEL OF COMMITMENT AT THE HIGHEST LEVELS IN ZIMBABWE DO NOT MATCH THE SERIOUSNESS OF THE SITUATION. PRESIDENT MUGABE HAS SAID LITTLE ABOUT HIV/AIDS. MAJOR POLITICAL FIGURES INCLUDING THE PRESIDENT, NEED TO GIVE THE ISSUE THE ATTENTION IT DESERVES. HIV/AIDS IS STILL A VERY HIGHLY STIGMATIZED DISEASE AND THOSE INFECTED ARE DISCRIMINATED AGAINST AND MARGINALIZED. AT FUNERALS IN THE CITIES AND IN RURAL AREAS, WHERE FAMILY, FRIENDS, COLLEAGUES AND PARTY OFFICIALS GATHER TO BURY YET ANOTHER LOVED ONE, AIDS IS SHROUDED IN WHISPERS AND MURMURS. THE MEDIA LAMENT THE SHOCKING AND SUDDEN PASSING AWAY OF AN ILLUSTRIOUS PERSONALITY "AFTER A SHORT ILLNESS." RELATIVES EXPRESS RELIEF THAT THE DECEASED HAS BEEN MERCIFULLY "CALLED HOME" AFTER SUFFERING A "LONG ILLNESS." BUT NOWHERE IS AIDS ACKNOWLEDGED AS THE CAUSE OF DEATH. CONSEQUENTLY, USAID IS SUPPORTING THE NATIONAL AIDS COORDINATION PROGRAM AND THE MINISTRY OF INFORMATION TO SEEK PRACTICAL WAYS TO HELP THE NATION TO FIND ITS COLLECTIVE VOICE AND BREAK THE NATIONAL CODE OF SILENCE. BY SUPPORTING THE DEVELOPMENT AND DISSEMINATION OF COMPREHENSIVE NATIONAL HIV/AIDS POLICY, AND TECHNICAL ASSISTANCE FOR A NATIONAL COMMUNICATION STRATEGY, THE MISSION HOPES TO INCREASE THE VISIBILITY OF HIV/AIDS WITHIN THE NATIONAL DEVELOPMENT AGENDA. PUBLIC ENDORSEMENTS AND SUPPORTIVE ACTION BY THE NIGHEST LEVEL OF LEADERSHIP PARTICULARLY THE PRESIDENT AT BOTH THE

Is this policy complete?

NATIONAL AND COMMUNITY LEVELS WILL HEIGHTEN AWARENESS OF THE EPIDEMIC AND PROMOTE A MULTISECTORAL RESPONSE TO

SUBJECT: ZIMBABWE: THE STATE OF THE AIDS EPIDEMIC AND USAID'S RESPONSE

AIDS AT EVERY LEVEL OF SOCIETY.

18. NEXT STEPS. ZIMBABWE IS AT THE CENTER OF THE MOST INSIDIOUS, DEBILITATING SOCIAL CRISIS IN MODERN HISTORY. THE HIV/AIDS EPIDEMIC SHOWS NO SIGNS OF SLOWING; THE GOVERNMENT--EVEN IF IT HAD THE WILL--HAS NO RESOURCES FOR INTERVENTIONS, LEAVING A VACUUM THAT HAS BEEN FILLED BY NGOS. AT THE MOMENT, THE WELL-INTENTIONED NGO COMMUNITY HAS LIMITED ORGANIZATIONAL SKILLS AND TECHNICAL SUPPORT TO ASSIST. THE DONOR COMMUNITY ON THE OTHER HAND HAS RESOURCES BUT IS LOOKING FOR LEADERSHIP TO DEMONSTRATE EFFECTIVE STRATEGIES TO COPE WITH THE DEVASTATING EPIDEMIC. USAID HAS THE COMPARATIVE ADVANTAGES TO BE THE LEAD DONOR IN ASSISTING THE GOVERNMENT OF ZIMBABWE, THE DONOR AND THE NGO COMMUNITY IN DEVELOPING A COORDINATED EFFORT THAT WILL LEAD TO THE LOWERING OF HIV TRANSMISSION AND MITIGATING ITS IMPACT.

19. CONSEQUENTLY, THE MISSION INTENDS TO MAKE HIV PREVENTION A CENTRAL FOCUS OF ITS NEW "TRANSITION" STRATEGY THAT WILL BE SUBMITTED TO AFR IN THE FIRST QUARTER OF CY 1999. WE INTEND TO REQUEST ADDITIONAL RESOURCES AND EXTRA TIME BEYOND THE MISSION'S CURRENT CLOSE-OUT DATE OF 2003 TO BOLSTER OUR MATERIAL AND FINANCIAL SUPPORT AND JUSTIFY STAYING ENGAGED IN THE BATTLE. CLEARLY, THE EPIDEMIC IS NOT GOING TO GO AWAY IN 2003 AND USAID MUST REMAIN INVOLVED AND PROVIDE NEEDED LEADERSHIP TO REVERSE THE CURRENT TREND CHARACTERIZED BY HIGH TRANSMISSION RATE.

Why closeout in 2003?

20. ALTHOUGH THE NEW STRATEGY WILL MAINTAIN OUR CORE PROGRAM OF SUPPORT FOR CONDOM SOCIAL MARKETING, NGO CAPACITY BUILDING AND POLICY ADVOCACY -- ADJUSTING AS APPROPRIATE FOR MAXIMUM EFFECTIVENESS, OUR CORNERSTONE PROGRAM WILL BE HIV VOLUNTARY COUNSELING AND TESTING. VCT IS AN ENTRY POINT INTO THE CARE AND SUPPORT NETWORK. IT IDENTIFIES THOSE WHO ARE INFECTED AND THOSE WHO ARE NOT AND REFERS THE FORMER FOR APPROPRIATE CARE. USAID IS COLLABORATING WITH OTHER DONORS TO SUPPORT AND STRENGTHEN SUCH REFERRAL SERVICES. IN YEARS AHEAD, WE HOPE TO EXPAND TO A NATIONWIDE INTERVENTION THAT WILL BUILD UPON LESSONS LEARNED FROM THE ORIGINAL SITES- TO STRENGTHEN OUR NEW HIV/AIDS STRATEGY, IT IS CRITICAL TO CONTINUE THE SUPPORT FOR ASPECTS OF THE ZIMBABWE'S FAMILY PLANNING PROGRAM. THE HISTORICALLY OUTSTANDING FAMILY PLANNING PROGRAM HAS BEEN UNDERUTILIZED FOR HIV/AIDS PREVENTION, CARE AND SUPPORT AND CONSEQUENTLY MANY OPPORTUNITIES LOST. USAID AND GOZ RELIEVE THAT THE INTEGRATION OF HIV AND FP INTERVENTIONS IS ABSOLUTELY ESSENTIAL IN ORDER TO HAVE THE MAXIMUM POSSIBLE IMPACT ON HIV TRANSMISSION WHILE PROVIDING A COMPREHENSIVE PACKAGE OF REPRODUCTIVE HEALTH SERVICES TO ZIMBABWEAN FAMILIES. THE MERE FACT THAT OVER 30% OF ZIMBABWEAN WOMEN PRESENTING AT ANTENATAL CLINICS ARE HIV-INFECTED AND ARE LIKELY TO HAVE 30-50% HIV-INFECTED INFANTS

VCT ~~Policy~~ Policy Advocacy
(Please explain what that means)
SM-Condoms

— can we work with this?

↑30% HIV at antenatal clinics

PROVIDE CHILLING EVIDENCE OF THE NEED FOR THE AVAILABILITY OF AFFORDABLE CONTRACEPTIVE TECHNOLOGY AND SERVICES.

21. FINALLY, USAID/ZIMBABWE IS WORKING COLLABORATIVELY WITH NEIGHBORING MISSIONS TO DEVELOP A REGIONAL STRATEGY THAT IS WITHIN OUR MANAGEABLE INTEREST BUT BEGINS TO TACKLE THE EPIDEMIC THAT SEES NO BORDERS. THREE STRATEGIC REGIONAL ACTIVITIES THAT COMPLEMENT AND ADD VALUE TO BILATERAL PROGRAMS WERE IDENTIFIED AT THE RECENT MEETING IN PRETORIA OF REGIONAL MISSIONS AND COOPERATING AGENCIES. RECOMMENDATIONS FROM THAT MEETING WILL BE REPORTED BY PRETORIA IN A SEPARATE CABLE.

22. THE EMBASSY AND USAID/ZIMBABWE WELCOME COMMENTS AND SUPPORT FROM AFRICAN BUREAU OF STATE, USAID/WASHINGTON OFFICES AND OPERATING UNITS. MCDONALD
NNNN

End Cable Text

Printed By: Marlene U Breen 01/22/4499 11:22:58 AM

Printed By: Marlene U Breen 01/22/4499 11:22:13 AM

HARARE 409

From: AMEMBASSY HARARE
Subject: COUNTRY CLEARANCE FOR DELEGATION OF SANDRA THURMAN, OFFICE FOR NATIONAL AIDS POLICY

MRN: 409
ICNbr: TED7458

Date/Time: 211254Z JAN 99
Precedence: ROUTINE

Cable Text:

TED7458
ACTION AF-01

INFO LOG-00 AID-00 CIAE-00 SRPP-00 EB-00 UTED-00 HHS-01
IM-01 TEDE-00 INR-00 IO-00 ADS-00 DCP-01 G-00
CCR-01 SAS-00 /005W
----------994216 211253Z /38

R 211254Z JAN 99
FM AMEMBASSY HARARE
TO SECSTATE WASHDC 2259
USAID WASHINGTON DC
USIA WASHDC 0534
INFO SOUTHERN AFRICAN DEVELOPMENT COMMUNITY

UNCLAS SECTION 01 OF 02 HARARE 000409

DEPT FOR AF/S - SUSAN RICE AND PATTY KIM-SCOTT

DEPT PASS TO SANDRA THURMAN, OFFICE FOR NATIONAL AIDS POLICY

USAID FOR G/PHN - PAUL DELAY
USAID FOR AFR/SA - BILL JEFFERS
USAID FOR A/AID - RYAN CONROY
USAID FOR AFR/CD - HOPE SUKIN

USIA FOR AF -PATIN

E.O. 12958: N/A
TAGS: OTRA, EAID, ECON, SOCI, TBIO, ZI
SUBJECT: COUNTRY CLEARANCE FOR DELEGATION OF SANDRA THURMAN, OFFICE FOR NATIONAL AIDS POLICY

REF: (A) SECSTATE 04596 (B) SECSTATE 07875

HARARE 01 OF 02 409

1. POST GRANTS COUNTRY CLEARANCE AND WARMLY WELCOMES SANDRA THURMAN, DIRECTOR OF THE OFFICE FOR NATIONAL AIDS POLICY (ONAP), AND HER DELEGATION TO HARARE FROM JANUARY 31 TO FEBRUARY 3, 1999. MS. THURMAN'S PROGRAM CONTROL OFFICER RESPONSIBLE FOR MEETINGS AND BRIEFING PAPERS WILL BE MS. ROXANA ROGERS, USAID HEALTH TEAM LEADER. MS. ROGERS MAY BE REACHED AT:

OFFICE PHONE (263-4) 720630 OR 720739
OFFICE FAX (263-4) 722418 OR 720722
HOME PHONE (263-4) 885840

2. MS. THURMAN'S ADMINISTRATIVE CONTROL OFFICER RESPONSIBLE FOR ACCOMMODATIONS, TRANSPORTATION, AND OTHER LOGISTICS OF THE VISIT WILL BE MS. SHAWN THORNE, EMBASSY LABOR/ECON OFFICER. MS. THORNE MAY BE REACHED AT:

OFFICE PHONE (263-4) 794521-3
OFFICE FAX (263-4) 796487
CELL PHONE (263-4) 011207556
HOME PHONE (263-4) 497256

3. PER REFTELS (A) AND (B), WE HAVE MADE SEVEN SINGLE ROOM RESERVATIONS FOR MS. THURMAN'S DELEGATION AT HARARE'S MEIKLES HOTEL (CORNER OF JASON MOYO AND THIRD STREETS IN DOWNTOWN HARARE; TEL. 263-4-795655; FAX 263-4-707753), TO ARRIVE JANUARY 31 AND DEPART FEBRUARY 3. CONFIRMATION NUMBERS ARE: 4002/SANDRA THURMAN; 4003/MICHAEL ISCOWITZ; 4004/BILL HARRIS; 4005/STEVE STERNBERG; 4009/EILEEN BLASS; 4010/PHILIP DROUIN; AND 5955/BARBARA ZALDUONDO. THE COST OF EACH ROOM IS US$117 (GOVERNMENT RATE) PER NIGHT, WHICH INCLUDES ALL TAXES EXCEPT THE TWO PERCENT TOURISM LEVY. NON-SMOKING ROOMS ARE AVAILABLE ON REQUEST.

4. GROUND TRANSPORTATION WILL BE PROVIDED FOR ARRIVAL, DEPARTURE, AND IN-COUNTRY MOVEMENTS. USAID IS PROVIDING SUGGESTIONS FOR MEETINGS, SCENESETTERS, AND BACKGROUND PAPERS TO ONAP VIA E-MAIL TO USAID/G/PHN PAUL DELAY. USIS WILL COORDINATE PRESS COVERAGE FOR SPECIFIC MEETINGS ONCE THEY HAVE BEEN ARRANGED BY USAID. ROXANA ROGERS AND SHAWN THORNE WILL ACCOMPANY MS. THURMAN'S DELEGATION TO THEIR MEETINGS; MS. THORNE WILL ACT AS PRINCIPAL NOTETAKER.

5. POST REQUESTS THAT ONAP PROVIDE FUND SITES IMMEDIATELY SO THAT WE CAN BEGIN MAKING THE NECESSARY ARRANGEMENTS.

6. POST REQUESTS THAT MS. THURMAN'S DELEGATION CONSIDER GRANTING FUNDING APPROVAL FOR ONE EVENT IN PARTICULAR DURING THEIR TRIP: A VISIT TO THE COUNTRY'S ONLY ACTIVE VOLUNTARY COUNSELING AND TESTING (VCT) CLINIC IN BULAWAYO, ZIMBABWE'S SECOND LARGEST CITY (APPROXIMATELY 400 KILOMETERS FROM HARARE). THE CLINIC RECENTLY RECEIVED BRIDGE FUNDING FROM USAID AND WILL BE ONE OF SIX VCT SITES TO BE OPENED IN 1999 AS PART OF THE NATIONAL EFFORT TO MAKE HIV/AIDS TESTING AND COUNSELING AVAILABLE TO ALL ZIMBABWEANS. AS FUTURE CODELS ARE POSSIBLE, WE RECOMMEND THIS VISIT SINCE THE VCT CLINIC IS A USG-FUNDED SITE. BULAWAYO IS A FOUR-HOUR DRIVE FROM HARARE; IN ORDER TO MAKE THE TRIP IN LESS THAN ONE DAY, WE RECOMMEND TWO PRIVATELY CHARTERED SIX-SEATER AIRCRAFT, AT A COST OF APPROXIMATELY US$1300 EACH. IF MS. THURMAN'S DELEGATION IS INTERESTED IN THIS OPTION, POST REQUESTS THAT FUNDING SITES BE PROVIDED ASAP.

7. WHILE HARARE IS A CLEAN AND PLEASANT CITY, STREET CRIME IS A SERIOUS PROBLEM, PARTICULARLY IN TOURIST AREAS. WE URGE VISITORS TO USE THE SAME SECURITY PRECAUTIONS THEY WOULD EXERCISE IN ANY URBAN AREA OF THE DEVELOPING WORLD.

8. MALARIA IS PREVALENT THROUGHOUT ZIMBABWE, EXCEPT IN HARARE. WE STRONGLY RECOMMEND THE USE OF MALARIA PROPHYLAXIS AND ADJUNCTIVE MEASURES WHEN TRAVELING OUTSIDE OF HARARE.

HARARE 02 OF 02 409

SUBJECT: COUNTRY CLEARANCE FOR DELEGATION OF SANDRA THURMAN, OFFICE FOR NATIONAL AIDS POLICY

9. AS SEVERAL MEMBERS OF MS. THURMAN'S DELEGATION ARE NOT USG EMPLOYEES, WE URGE THEM TO OBTAIN MEDEVAC INSURANCE IN CASE THEY MUST BE MEDICALLY EVACUATED FROM ZIMBABWE.

10. THE EXCHANGE RATE IS APPROXIMATELY 40 ZIMBABWEAN DOLLARS TO THE U.S. DOLLAR.

11. THERE IS A NON-WAIVABLE US$20 PER PERSON DEPARTURE TAX, PAYABLE AT THE AIRPORT UPON LEAVING ZIMBABWE IN EITHER ONE U.S. TWENTY OR TWO U.S. TEN DOLLAR BILLS ONLY. IN ADDITION, THE ZIMBABWEAN GOVERNMENT RECENTLY BEGAN LEVYING A US$30 FEE FOR U.S. VISITORS TO ZIMBABWE; AIRPORT AUTHORITIES HAVE BEEN INSTRUCTED TO WAIVE THIS FEE ONLY FOR TRAVELERS WITH U.S. DIPLOMATIC PASSPORTS. HOLDERS OF DIPLOMATIC PASSPORTS WILL THEREFORE PAY ONLY THE $US20 DEPARTURE FEE, WHILE HOLDERS OF NON-DIPLOMATIC PASSPORTS WILL PAY US$30 UPON ARRIVAL AND US$20 UPON DEPARTURE FROM ZIMBABWE.

MCDONALD
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End Cable Text

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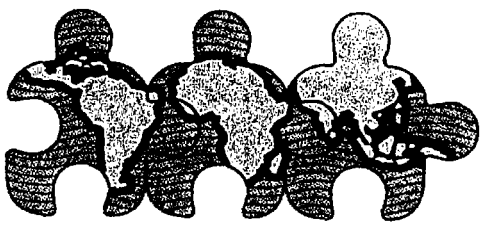
SOUTH-SOUTH EXCHANGE PROGRAMME INITIATIVES IN ZIMBABWE

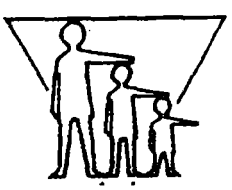


PARTNERS IN POPULATION & DEVELOPMENT

GOVERNMENT OF ZIMBABWE

REPRODUCTIVE HEALTH TRAINING AND STUDY TOUR OPPORTUNITIES

1999 EDITION



Community Care of Orphans in Zimbabwe
The Farm Orphans Support Trust (FOST)
by Dr Sue Parry
Westgate, Harare, Zimbabwe

Introduction

Zimbabwe is a country where for many years the presence of HIV/AIDS as a threat in the country was not only not openly acknowledged, but also was actually strongly denied. The concept of orphans was not an alarming spectre because of the belief that (1) the extended family is always there and that there is no such thing as a real orphan in Africa, and (2) if there ever did exist a problem, the Government would resolve it with orphanages. Now that AIDS is openly acknowledged, the country lacks the resources to deal with what appears to be a runaway situation.

The Farm Orphan Support Trust of Zimbabwe (FOST) is a state registered Private Voluntary Organisation. It is a national programme which solicits and facilitates support for children in especially difficult circumstances, particularly orphans, on commercial farms in Zimbabwe. It seeks to avoid costly and culturally undesirable institutional care, by keeping children in their communities of origin.

The overall aim is to proactively increase the capacities of the farming communities to respond to the impending orphan crisis and ensure that systems are in place to protect and care for the most vulnerable individuals. It is not yet a well-established model, with hundreds of foster homes to view and evaluate, though eventually it will become that.

The programme is based on the belief that orphaned children have the best opportunity for development within a family, remaining in their family groups without sibling separation, in an environment that is familiar and where they have opportunity to learn their culture first hand.

To date, FOST has concentrated its efforts in this area by:
- Researching the problem of orphans on commercial farms
- Creating awareness at all levels of the magnitude of the coming crisis
- Enlightening communities of the unrealistic expectations that Govt. could provide orphanages
- Encouraging communities to identify their problems and possible coping solutions
- Setting the wheels in motion, networking with other organisations, to develop a national programme of community based care for these children.

Changing attitudes is a lengthy process, particularly in a climate of prolonged denial. For many the idea of fostering non-related children requires a paradigm shift, but we have seen, and are seeing, that it is possible. Cultural sensitivity, open dialogue including dialogue with traditional leaders, community problem solving and most of all, examples of "success stories" of childcare make this paradigm shift possible.

There is the danger of glibly talking about 'community', but what really is a 'community?' Unless it is inclusive, unless there is cohesion and acceptance and above all a sense of commitment the one to the other, I do not believe we really have "a community." Community building is another pre-requisite to any successful "community based child care scheme."

If we do not put a lot of effort into these areas, both initially and ongoing, there can only be sporadic success stories and, should external support become limited, the programme runs the risk of failure. Childcare requires long term commitment. There are no easy solutions and certainly no 'blue-print' to adopt, the world has never faced AIDS before.

How serious is the problem in Zimbabwe?

Zimbabwe has a population of approximately 11 million, 47% of whom are 15 years old or younger. An estimated 35% of urban adults and 20% of rural adults, or 1.2 million people, have HIV. Masvingo is most affected, with over 50% of antenatal patients HIV-positive. An estimated 200 000 Zimbabweans have developed AIDS and 90 000 have died from AIDS. It is not yet evident when or at what infection level the epidemic will plateau.

Numbers of orphans are rising alarmingly. The NACP estimates the orphan population to be growing by 60 000 children per year. By the year 2000, the total number of orphans will have risen to 670 000. By that time 1 in 6 children may be an orphan.

The proportion of orphans in Zimbabwe may peak between the year 2000 and 2005 when it may reach 1.1 million or 1/3 of all children under 15 years of age.

Options for Care

By 1994, 38 registered Institutes in Zimbabwe, operating at a capacity of up to 126%, were catering for 2 794 children. If only 10% of the anticipated number of orphans require institutional care, it would involve some 60 000 children. If one assumes an average of 50 children per institute, Zimbabwe would have to construct over 100 institutes per month for the next year just to cater for those 10%, and the number of orphans is rising yearly.

Formal adoption is not readily accepted because of the cultural beliefs, which mitigate against taking unrelated children into the family. The fear of invoking 'ngozi' or avenging spirits is very prevalent and the highest number of adoptions in any one year in Zimbabwe was 45.

Formal fostering is more acceptable, although it is not common practice to foster non-relations for the same reasons. In total there are approximately 755 formal foster parents caring for just over 1000 children.

The numbers of children traditionally absorbed into extended families, without the involvement of external agencies, is unknown.

The last year has seen much social upheaval in the country. Conditions of poverty, unemployment and illness in Zimbabwe are rising rapidly. A number of factors are contributing to this situation including the effects of the structural adjustment policies,the fall in the value of the dollar, lack of investment, the escalating cost of living, the effects of severe droughts and the emergence of HIV/AIDS. The AIDS crisis has hit at a time when public resources are at their lowest and per capita expenditure on welfare programmes is declining.

The Agriculture Sector

The economy of Zimbabwe is largely based on Agriculture, Mining and Manufacturing. It has a relatively well-developed infrastructure. Extensive road networks and an effective public transport system contribute to a highly mobile population. Over 50% of the population live in communal lands, 17% in large-scale commercial farms and 3% in resettlement areas.

Some 80% of the total population presently derive their livelihood either directly or indirectly from agriculture. In terms of employment, the large -scale commercial farming sector is the largest single employer of labour (currently 340 000 workers) which result in some 2 million people living on farms.

Historically many farm workers (over 30%) are from neighbouring countries, predominantly Malawi and Mozambique, and have married locally, raised families. Second, third and even fourth generations now exist on some farms. For many of them, the links with their country of origin and, in particular, their extended families left behind are very tenuous or non-existent. Furthermore, few have formalised their status and, together with their children, remain "foreigners" – both in the eyes of Government and their peers. The present Land Reform policies are as yet unclear with regard to the status of farm workers and their future.

Government expenditure has largely by-passed the farm worker. Provision of facilities for their welfare, accommodation, water, sanitation, health, education and recreational facilities has, for the most part, been left to the responsibility of the individual farm employers. The economic viability of the farming enterprise, as well as the goodwill and motivation of the farmer to provide, has determined what resources are available for development. Consequently, some farming areas are very developed in terms of social amenities and others are appalling.

Farming enterprises are, for the most part, labour intensive and the number of employees on farms, particularly in the cropping areas, tend to be very high.

Farm villages usually comprise a core of permanent workers, many of whom may have been born on the farm and lived there all their lives. The numbers of inhabitants may swell at peak times, when the demand for seasonal labour increases and many of the casual labourers are single women. These women are more often than not from broken marriages, widows, and single mothers, whose circumstances have forced them onto the job market as the sole breadwinner. They move from farm to farm, district to district, in search of employment, supplementing income whenever and however, even through casual sex and with no lack of men prepared to capitalise on their misfortune.

Farm communities often lack cohesion and though the individual families may befriend each other and work together, they seldom function as an interdependent group and initiate community projects themselves.

Accommodation is usually tied to their employment and this contributes to their apparent lack of motivation in community issues.

In the rural communal areas, there exists a well- established system of community leaders with Chiefs, Sub-Chiefs, Elders and Ward Leaders who have varying degrees of familial relationship with their communities. This is lacking on farms. Instead there exists a work-related hierarchy of managers, foremen, supervisors, clerks and the workers.

Traditional elders play a pivotal role in the Shona culture in terms of negotiation for marriage, arbitration in disputes, moral guidance and cultural heritage. Where there is no reference back to these elders, as on farms, marriages are often not formalised and are loose unions easily dissolved, with abdicated responsibility and occasional abandonment of children.

The absence of these community leaders on farms is being addressed by the introduction of "Farm Development Committees" (FADCO's). These committees are comprised of key permanent members, such as pre-school teachers, farm health workers and community elected members, together with either the farmer or his wife.

FADCO's are tasked to motivate and involve people in their own social programmes such as women's clubs, pre-schools, adult literacy groups, nutrition programmes and to liase between the people and farm management on farm social and amenity development issues.

These groups will also form the core of Child Care Committees on farms as HIV/AIDS erodes families.

Children of the farm worker, whether they are of permanent workers or of single mothers, are particularly at risk. Absence of traceable extended families, dislocation from familial totem groups, marginalisation from society and of multi-ethnic backgrounds increase their vulnerability.

The formation of FOST was instigated by the plight of one family in precisely the circumstances already alluded to.

Case Study

About five years ago an elderly man with a young woman and four children came looking for work. The man was too old for normal work and was assigned light duties as a "special" worker. The woman was free to work with the other women on the farm. This she did from time to time but she shortly left the farm and was not seen again. All efforts to trace her failed.

It emerged that she was a Zimbabwean who had married a Mozambican who had been repatriated leaving her with four boys. The eldest child, aged seven, was followed by twins of four and a toddler of two years. The woman's association with the old man was simply one of convenience and had no formal status. After she disappeared, he soon left, abandoning the four boys. The farmer sought assistance from the Department of Social Welfare and it appeared that only three options of care were possible:

Institutionalisation of the children. Sibling separation would be entailed as the institutions were at capacity and one child, a twin, was disabled and required special care. This seemed a harsh option for the children.

The farmer could formally foster the children but as Zimbabwean law only permits the fostering of four children, what would become of the many others in similar circumstances when the full impact of AIDS was felt on the farm?

The farmer could build an institute with all the prerequisites to be fulfilled for such care.

None of these options seemed appropriate. Another solution had to be found. Eventually the farm health worker and her husband agreed to take in the children on conditions the farmer provided the shelter, food and clothing and met any other expenses. The children were thus informally fostered and are now well adjusted and integrated into the family with a chance in the future.

The Search for a Solution

The plight of these children and the difficulty in finding a solution, and concern over the coming orphan crisis, prompted us to instigate research into the situation of orphans on farms, current coping mechanisms and attitudes towards foster care.

In August 1995 a national seminar was held to present the findings. The research had shown that an intervention was not only necessary but also feasible. Though there were many cultural problems to be overcome, there was an encouraging expression of support among the national sample of farmers and a high degree of acceptance of the concept of fostering among farmers, key workers, general workers and among the children themselves.

A Steering Committee was elected to carry forward the recommendations for a national intervention and an organization, the Farm Orphan Support Trust (FOST) was constituted. FOST was formally launched in March 1996 with the support of the Ministry of Social Welfare who tasked FOST to

work with the Ministry in developing a farm model of community care. In April 1997, FOST received official registration as a Private Voluntary Organization.

The Committee has representation from farmers, the Agricultural Labour Bureau, the General Agriculture and Plantation Workers' Union, a Social Worker from SAfAIDS, the Department of Community Medicine of the University and two NGO's, one of whom is the Farm Worker Programme Manager. It is supported by influential Trustees and has the mandate to co-opt Consultants. The Director of the Dept. of Social Welfare is invited to all meetings.

The Commercial Farmers Union provides accountancy backup, an office at the Headquarters, and access, through its extensive network and infra structure, to all districts nationwide through the offices of the Regional Executives and Farmers' Associations to the farmers and farm workers.

Aims and Objectives were decided on and methods of implementation were explored. These objectives included the following:

ESTABLISH AN INTEGRATED NATIONAL PROGRAMME To support and advocate for orphans and children in need on commercial farms. This involves networking with all the relevant players in this field.

SENSITIZATION AND AWARENESS CREATION amongst farmers, farmers' wives, farm worker communities, policy makers and traditional leaders stressing the extent of the crisis and the necessity for all to respond.

RESEARCH to ensure appropriate intervention.

FACILITATE THE ESTABLISHMENT OF FOSTER CARE SCHEMES ON FARMS.

This involves identifying the need; using existing farm structures such as the farm development committees to facilitate awareness creation amongst the communities and in selection of Child Care Committees; training caregivers, establishing monitoring channels; promoting "community projects" and disseminating information re: models of care to farmers and farming communities.

REGISTRATION OF ORPHANED CHILDREN.

Registration is essential to identify, amongst other things, the size of the problem, areas of need, levels of support necessary and assistance with relative tracing.

TRAINING PROGRAMMES

It is the intention that FOST will facilitate the training of:
- Caregivers in aspects of child care and HIV/AIDS educationParents in legal education, inheritance law and writing of wills
- Community members involved in child care, in laws affecting children, child rights, gender specific programming and resource mobilisation
- Youth in HIV/AIDS education, vocational and life skills so that they can become economically self reliant
- Monitors in legal administrative and welfare requirements.

MONITORING

Monitoring will involve community members in Child- Care Committees, representatives of existing services in the area, and the Dept. of Social Welfare or their designate.

FUND RAISING AND DISBURSEMENT

The strategy is to target both national and international donors as well as to identify sources of income and support within the farming communities.

EVALUATION AND DISSEMINATION OF INFORMATION

Where are we now?

Whilst the first two objectives were being developed, and training programmes with the Farm Development Committees initiated, FOST undertook to tackle the research component as a priority. The initial research was replicated in another larger Province of Zimbabwe. It was further decided to deepen the scope of the research and to undertake socio-economic profiles of families already fostering children, to explore further the farm workers' traditional and current attitudes toward fostering, particularly non-related children, to hold consultative meetings with traditional leaders and to talk more to the children themselves.

An enumeration study was also undertaken, together with the Dept. of Social Welfare in selected areas in the Mashonaland Central Province.

Not only did these studies entirely validate the original findings but also many other interesting and useful observations emerged. Most of all the studies demonstrated the willingness of families to care for children, given some support. This willingness is there in spite of cultural fears. However, to overcome these fears and concerns of destabilizing the sanctity and unity of their own extended families, potential caregivers have indicated their preference for informal fostering arrangements. The children would still be incorporated into their homes, or overseen within their original homes, cared for and protected but would not become official members of the family.

The magnitude of the coming orphan crisis in Zimbabwe is such that all forms of acceptable caring community responses must be considered, and legislation will need to address the question of "guardianship." In the situation of informal fostering, who becomes the "Legal Guardian?" Is it the caregiver, or the Department of Social Welfare or its designate? On the farms, is it the caregiver, the community or the farmer?

Should the terminology be reduced to "Guardian" when the situation arises requiring signatories for documents, indemnity forms for school trips etc?

Legal provisions need to be considered to safeguard the rights of the child and the caregiver.

For children on the farms without identifiable relatives to assume responsibility for them, very few options exist for orphans at this time.

Models of Care

Based on the research a five-tier response is envisaged for the farming community, in line with the following principles:

The voluntary aspect must be emphasized at all times and at all levels. No farmer, farming community or caregiver should be forced or coerced into response. Motivation must be genuine because childcare is a long-term response. No person must seek financial reward for his or her efforts. Children should be reunited with their own family members wherever possible. There should be minimal disruption for the children and no sibling separation. Vulnerable children to be absorbed into known family units with preservation of culture and identity. Community involvement and participation is essential at every level from planning to monitoring. Monitoring is

an essential component and should involve sensitized committed people from community level to dept. of Social Welfare personnel or their designate.

Five Levels of Priority Care

LEVEL 1: The Extended Family

This is the preferred strategy of care for orphaned children and every reasonable attempt must be made to trace relatives.

The extended family on the farms however needs support and must be included in any intervention to assist orphans and children in need.

Furthermore it must be borne in mind that children may be absorbed into HIV positive households, given the high sero-prevalence in existence, and the children may be subject to repeated grief and uncertainty. By including them in support programmes some of these problems may be partially alleviated.

LEVEL 2 : Substitute or Foster care families.

Vulnerable children, particularly those without traceable extended family, are absorbed into known, non-relative family units after careful caregiver selection.

Fostercare will be on an informal basis, taking cognisance of traditional norms, and ensuring the children are appropriately cared for, protected, supported and monitored.

LEVEL 3 : Family Type Group.

This level of care consists of paid foster mothers living together with small groups of orphans within the community: quasi-substitute family.

LEVEL 4 : Child-Headed Households.

This level consists of adolescents caring for younger siblings, preferably within the family home, with the support of the community.

LEVEL 5 : Orphanages.

As a last resort, when all other options are inappropriate, there is a place for orphanages.

The situation of babies and very young children needing care may fall into this category of care until alternative solutions can be found for them.

All levels must be adaptable to the needs and resources of the farm, farmer, community and geographical region, as well as the level of commitment of the communities involved.

By linking into already established infrastructure, the programme can be cost effective and sustainable The wider the awareness, the greater will be the reservoir for response.

Registration

The next priority that the FOST Committee tackled was registration. It was felt that it is necessary to establish the extent of the problem and to map out areas of most need in order to allocate resources appropriately.

Orphan registration is only beneficial and efficient if the data is timely and accurately collected, updated and monitored with minimal cost and total commitment. To this end FOST developed a system whereby each individual farm has its own registration book on site, one page per orphan, so that minimal delays occur between orphanhood and registration. Minimum cost is involved in data collection – an envelope and stamp with the enclosed registration form from the farm- and up to date information should be available at all times. The information is being data banked at the CFU Headquarters on a special computer programme designed for this purpose. To date 43% of all farms in Zimbabwe have received a registration book and training on data collection is ongoing.

The Way Forward

Since its inception, FOST has been run on an entirely voluntary bases. However the programme is growing daily as the needs arise and the problem of orphans continue to emerge. FOST has largely concentrated on a facilitatory role in putting in place a mechanism of support for orphans. There also remains the question of the huge welfare support needed.

General community mobilisation and development issues are important, but they take time, whereas orphans' needs are often immediate and the actual support given must be sufficient to make a difference for them. By simply being included as "orphans" in overall community development programmes, the orphaned children run the risk of being sidelined. Their needs are specific and require special care and attention. But how best to sustainably meet these needs and by which route of service delivery?

Thus in March 1998, a further seminar was convened to plan a way forward.

Consensus was reached that there is now need for programme expansion, with the employment of full time staff, to investigate these issues through different models of care and service provision. This would be achieved through linking into different organizations; already operational within the farming community and with whom FOST is already cooperating, and being flexible and adaptable to the differing needs and resources of the various areas. The aim is long term sustainability, local ownership and reduced dependency on external personnel and funding.

It was decided to employ a Coordinating Director and Field Officers to work intensively in three of the eight Provinces where the Farm Worker Programmes are most advanced, and where there is the highest concentration of farm workers. The modus operandi of service delivery will be different in each province and will be constantly evaluated and documented over the next three years. This could provide the information, appropriate models and experience needed for ultimate development in the remaining five provinces of Zimbabwe.

Innovative forms of funding from Industry and Commerce are being explored. The identification of potential areas of indirect Government support, such as free education and healthcare for orphans, and the introduction of tax credits, are other areas to be pursued. Local initiative is also being widely encouraged. Competition for international resources will increasingly outstrip the supply as the impact of AIDS escalates worldwide.

Summary

The FOST programme can thus be summarized as having four aspects:

• The Structural: this is a skeletal organization with a largely facilitatory role in awareness creation, networking, and in developing community care for orphans, and children in need, on commercial farms

• The Farm Worker Community who will continue to care for their children and will, in innovative ways, contribute to their corporate upbringing
• The Farmers who can provide many of the necessary resources essential to the well-being of children
• The Agricultural Industry and the Society at large who have a corporate responsibility to assist in meeting the cost of raising the orphan generation. It is everyone's responsibility.

Conclusion

The problems of orphans and children in need are there and will escalate. The children deserve a chance, if only an equal chance to that of their non-affected peers. Not only do they deserve a chance but we must do all we can to ensure that the crisis which occasioned their orphanhood is not repeated in the next generation.

There is no doubt that both in human development and financial terms, the cost of care now will be less than the price society will ultimately pay for the neglect of these children to the streets, the bush or their life in institutions.

We can and must offer them HOPE.

FAX MEMORANDUM

Date: January 5, 1999

To: **Todd Summers - ONAP**
FAX: 212-456-2438

From: Sr. Ann Duggan
CRS AIDS Coordinator
Catholic Relief Services
209 West Fayette Street
Baltimore, MD 21201
Tel: 410-625-2220- Ext. 3516
FAX: 410-456-7890

Re: **ZIMBABWE: CRS AIDS-Related Projects**

Todd:
Here is some information on CRS AIDS-related projects in Zimbabwe. It will give you an idea of what we are doing.

List of Projects
Profiles on Zimbabwe Projects
Directory for Southern Africa

John Donahue is the Regional Director for southern Africa and Ms Krista Riddley is the newly appointed Country Rep.

Good luck as you plan this trip. Thanks and kind regards.
sr. ann

TOTAL 8 pages (incl. cover)

ID	Country	Project No.	Title
BX01	BENIN	608-95-003	Caritas AIDS Counseling and Care
BX03	BENIN	608-98-003	Caritas AIDS Counselling & Care - Phase II
BX02	BENIN	608-96-200	CMMB Assistance to Caritas AIDS Counselling & Care
BO01	BOLIVIA	714-96-012	Constructing Hope: AIDS Prevention & Accompaniment
BZ05	BRAZIL	716-96-004	Support for PWAs & AIDS Prevention in Pernambuco
BZ08	BRAZIL	716-97-906	GESTOS Human Rights & AIDS Seminar
BZ06	BRAZIL	716-97-001	Solidarity & Hope: Confronting AIDS in Bahia & Sergipe
BZ07	BRAZIL	716-97-901	Pilot Caritas Paraiba HIV/AIDS Preventive Education
BI02	BURUNDI	614-95-007	AIDS Prevention Education & Com'ty Awareness
KH03	CAMBODIA	810-97-001	Community-Based TB/AIDS/STD Program
KH02	CAMBODIA	810-96-004	Maryknoll HIV/AIDS
KH04	CAMBODIA	810-97-908	Water Festival & World AIDS Day Campaign
KH01	CAMBODIA	810-95-915	Consultancy: Catholic Agencies & AIDS
CU01	CUBA	723-97-002	Caritas Cuba AIDS Workshop
EC01	ECUADOR	730-97-003	Cuenca Pilot HIV/AIDS Prevention
EG01	EGYPT	814-96-004	Caritas HIV/AIDS Counselling Center
ET05	ETHIOPIA	634-95-900	Small Scale Income Generating Activities for PWAs
ET06	ETHIOPIA	634-95-007	Community Home-Based Care & Support for Orphans
GM02	GAMBIA	638-98-	Hope & Empowerment for Persons with HIV/AIDS
GH03	GHANA	640-94-009	Tamale Archdiocese AIDS Prevention
GH04	GHANA	640-95-904	HIV/AIDS Education
GH05	GHANA	640-96-900	Navrongo-Bolgatanga HIV/AIDS Baseline Survey
GH06	GHANA	640-97-004	Wa Diocese HIV/AIDS Prevention
GT01	GUATEMALA	738-98-	AIDS Prevention in Izabal
HQ03	HEADQUARTE	900-95-915	AIDS Education for Prevention
HN05	HONDURAS	744-97-901	AIDS Workshop for Water Counterparts - COCEPRADIL
HN04	HONDURAS	744-96-909	NCCB AIDS Pastoral Seminar
HN06	HONDURAS	744-97-001	Good Samaritan AIDS Education, Prevention & Counselling
ID07	INDIA	833-98-005	Sahara Shelter for Women & Children
ID04	INDIA	833-96-006	Delhi AIDS Awareness in High Schools
ID05	INDIA	833-96-009	Delhi: Sahara House AIDS Care Project
ID06	INDIA	833-97-007	Delhi - Michael's Care Home
IN17	INDONESIA	838-97-313	Minimizing Risks of HIV/AIDS
IN21	INDONESIA	838-98-907	Training for MITRA/Indonesia Counselors
IN20	INDONESIA	838-98-905	Workshop and Training for HIV/AIDS Prevention
IN18	INDONESIA	838-97-315	Increasing Sex Workers Self-Esteem & Strengthening STD/
IN16	INDONESIA	838-97-312	World AIDS Day 1997
IN11	INDONESIA	838-96-902	Development of AIDS Monopoly Games
IN14	INDONESIA	838-97-305	Integrating H/A Prevention Thru Awareness Bldg & Counsel
IN19	INDONESIA	838-98-011	Int'l AIDS Candlelight Memorial & Mobilization
IN13	INDONESIA	838-96-009	Semarang HIV/AIDS Training & Education
IN12	INDONESIA	838-96-903	HIV/AIDS Photography Exhibit
IN10	INDONESIA	838-96-901	Staff Training & Establishment AIDS Hotline
IN15	INDONESIA	838-97-308	HIV/AIDS Prevention among Migranr Workers
KE03	KENYA	648-96-003	Homa Bay STD Information & Education Program
KE06	KENYA	648-98-006	Maasai AIDS Prevention
KE05	KENYA	648-97-027	Karatina Home-Care and Counselling

INDIA 833-98-006 Michael's Care Home - II

ID	Country	Project Nu	Title
KE04	KENYA	648-97-900	AIDS Awareness Program in Kajiado District
MG01	MADAGASCA	656-97-901	Fort Dauphin STD/AIDS Education
MW02	MALAWI	658-95-003	Mzuzu AIDS Education & Home-Based Care
MO02	MOROCCO	867-95-005	Meknes Detection Center
MZ01	MOZAMBIQUE	666-94-006	Community AIDS Education Maputo
NE01	NEPAL	833-95-907	Caritas AIDS Awareness
PH06	PHILIPPINES	878-97-010	AIDS Education Training
PH07	PHILIPPINES	878-98-003	AIDS Prevention Program for Sailors
PH05	PHILIPPINES	878-97-901	AIDS Education Training - Antipolo Diocese
PH04	PHILIPPINES	878-95-015	Echo Training in AIDS Education
RW04	RWANDA	676-95-904	Pilot Inc.Gen.Activities for AIDS Widows
SN05	SENEGAL	678-98-	SIDA-Service Consultation & Counseling Center
SN04	SENEGAL	678-95-003	Integration Com'ty AIDS Prevention & APSPCS Training
SL02	SIERRA LEON	682-96-004	Shepherd's Hospice Volunteer Training
SL01	SIERRA LEON	682-96-900	HIV Needs Assessment Survey
ZA03	SOUTH AFRIC	686-96-001	Zikhulule AIDS Project
ZA04	SOUTH AFRIC	686-97-903	De Aar Diocese Middelburg AIDS Hospice
TZ03	TANZANIA	692-93-004	Mwanza AIDS Home Care/Counselling II
TZ04	TANZANIA	692-93-006	Dar es Salaam AIDS Project
TZ05	TANZANIA	692-95-905	Youth Education Program
UG15	UGANDA	695-96-905	Kamwokya World AIDS Day
UG21	UGANDA	695-97-012	Rubaga AIDS Counselling and Care III
UG20	UGANDA	695-97-011	Villa Maria Community Care & Counselling III
UG19	UGANDA	695-97-009	Medicines for AIDS Patients 1997
UG18	UGANDA	695-97-004	Kamwokya Christian Community Support to PWAs
UG09	UGANDA	695-95-003	1996 Medicines for AIDS Patients
UG06	UGANDA	695-94-001	Nsambya Hospital AIDS Project
UG07	UGANDA	695-95-001	Rubaga AIDS Care & Counselling II
UG17	UGANDA	695-97-003	Nsambya Hospital Integrated AIDS Care
UG08	UGANDA	695-95-002	Villa Maria Com'ty AIDS Care & Counselling II
UG16	UGANDA	695-97-900	Impact of Patient Education & Com'ty Awareness ...TB Trea
UG10	UGANDA	695-96-900	CDA Scholarships & TV Video for Villa Maria
UG11	UGANDA	695-96-901	Kamwokya Skills Training
UG12	UGANDA	695-96-902	AIDS Care Pediatric Counselling
UG13	UGANDA	695-96-903	Villa Maria Institution Building Workshops I & II
UG14	UGANDA	695-96-904	Rubaga Hospital Institution Building Workshops I & II
VI02	VIETNAM	896-96-917	Youth Who Love Life Book
VI03	VIETNAM	896-97-915	AIDS Education for Secondary School Youth
ZW06	ZIMBABWE	699-97-002	Mutare Community Home Care to Support PLWH/A -Phase
ZW07	ZIMBABWE	699-97-007	Medical Supplies for Church Health Centres with H/A Progr
ZW08	ZIMBABWE	699-97-903	Consultancy to Develop Proposal for NGO H/A Prog.Strengt
ZW09	ZIMBABWE	699-97-905	Staff Development for Jesuit AIDS Project
ZW10	ZIMBABWE	699-97-906	Consultancy for AIDS Awareness Baseline Survey-CADEC
ZW05	ZIMBABWE	699-97-001	Hwange Diocese AIDS Project - II

* PAKISTAN 877-98-911 Training in AIDS Awareness + Couns. Techniques

82. ZIMBABWE 699-97-001 HWANGE DIOCESE AIDS PROJECT - II

Project Duration:	01/01/97 - 12/31/99 36 months
Project Location:	Hwange Diocese, Matabeleland North Province, northwest Zimbabwe
Project Holder:	Sr. Mary Elizabeth Share, FSDM, RN Hwange Diocese AIDS Coordinator
Direct Target Group:	100,000 persons including school children, military, commercial sex workers, community and youth leaders, PWH/As, congregations, villagers and Hwange urban dwellers
Total Project Cost:	$186,574
Requested of CRS:	$152,350
Requested of CAFOD:	$ 33,900
Unfunded Balance:	-0-

Project Description:

This project builds on the successful AIDS program initiated under a previous project (699-93-002). Hwange Diocese commands an estimated population of just below 300,000. Hwange, the largest town in the Diocese, has a population of 60,000 of which an estimated 35% is HIV positive, well above the national average of 20%. This high incidence is attributed to the presence of migrant labor in the mining town of Hwange (home of the Wankie Colliery), tourism in Victoria Falls and Hwange National Game Park, the fishing camps along the Zambezi and the two international borders (Zambia and Botswana) where long distance truck drivers often spend days before crossing borders. Faced with a problem of this magnitude the Hwange Diocese AIDS Project will aim at reducing the incidence of HIV and help alleviate the suffering caused by HIV/AIDS in the Hwange Diocese. In an attempt to attain this goal the project will: a) seek to increase awareness of how to prevent HIV infection among 100,000 school children and adults and identify and promote/discouraage those cultural beliefs and practices that inhibit/aggravate the spread of HIV in Hwange Diocese; b) provide counselling services to 7,700 PWH/As and their families; c) provide material and spiritual support to PWH/As and dependents whose breadwinners die of AIDS; and d) impart training, counselling and community drama skills to staff. Thus the program has four major components: education, counselling, support and staff training.

83. ZIMBABWE 699-97-002 MUTARE COMMUNITY HOME CARE TO SUPPORT PWH/A PHASE II

Project Duration:	03/01/97 - 02/28/2000 36 months
Project Location:	Diocese of Mutare comprising 6 Districts (Nyanga, Makoni, Chitepo, Mutare Chipinge, Chimanimani) in Manicaland Province in eastern Zimbabwe on the Mozambique border.
Project Holder:	Health Commission of CADEC (Catholic Development Commission) Mutare Diocese
Direct Target Group:	600 AIDS & HIV+ people and their families, congregations, school children, and villagers mostly in rural areas for a total of 100,000 people
Total Project Cost:	$153, 723
Requested of CRS:	$ 61, 862
Requested of CAFOD:	$ 61, 861
Local Contribution:	$ 30,000
Unfunded Balance:	$-0-

Project Description:

The goal of this project, which follows-on from project 699-92-006, is to assist PLWH/A and their families and their communities and to encourage them to develop and establish community home-based care structures and initiatives that will enable them to deal with the AIDS crisis in an effective and sustainable manner. Project objectives include: a) to provide pyschological and spiritual support to 600 people living with HIV/AIDS, their family members, destitute dependents of the disabled and deceased persons; b) to provide material suppoort to 600 people living with HIV/AIDS, family members and destitute dependents of disabled and deceased persons; c) to empower communities with skills and knowledge for quality home-care of people with HIV/AIDS; d) to raise community awareness on HIV/AIDS/STDs and encourage the community to organize themselves to prevent the spread of the diseases.

84. ZIMBABWE 699-97-007 MEDICAL SUPPLIES FOR CHURCH HEALTH CENTRES WITH HIV/AIDS PROGRAMS

Project Duration:	01/01/98-12/31/02
Project Location:	Hwange and Mutare Dioceses
Project Holder:	Health Department of the Catholic Development Commission of Mutare Diocese and Lubhancho House of Hwange Diocese
Direct Target Group:	10,000 AIDS and HIV positive people and their families, and poor people mostly in rural areas (villagers) for a total of 231,186 people in Mutare and Hwange dioceses
Total Project Cost:	$2,500,000
Requested of CRS:	$ 450,000
Requested Other :	$ 450,000
Local Contribution:	$ 150,000
In-Kind Medical Supplies:	$1,500,000

Project Description:

This project will provide drugs and nutritious foodstuffs (therapeutic and breastmilk substitutes) to people affected by HIV/AIDS (patients and orphans) in order to prolong life and decrease pain. This project will also greatly prevent HIV transmission through early treatment of STIs (which promote HIV transmission), by artificial feeding of infants born to HIV infected mothers (as breast feeding leads to 15% mother-child infection), and by post HIV test counselling to reduce risky behavior and make informed choice on reproductive behaviour. Beneficiaries for this project will be mostly people who are unable to meet their own needs due to illness (AIDS patients) and/or poverty or young age (orphaned children) and whose government has greatly experienced shrinking capacity to assist their own citizens. CRS/SARO is currently supporting two AIDS projects in the Hwange and Mutare Dioceses of Zimbabwe. These two projects are assisting PLWH/A and their families with psychosocial, material and financial support. CRS has also been supporting 46 Catholic mission hospitals and clinics in Zimbabwe with medicines and medical supplies for the past three years. These donations were sourced from the Catholic Medical Mission Board (CMMB) and the 1997 shipments to Zimbabwe were valued at US$523.612. An increasing body of information suggest that STI treatment and management significantly (by approximately 40%) reduce HIV transmission. The two AIDs projects are running under the direction of 14 mostly Catholic mission hospitals and clinics in Mutare and Hwange Dioceses. Based on the achievements of these two projects and the high need for STI and HIV related diseases' treatment and management medicines and medical supplies, therapeutic feeding materials and child supplementary food, CRS/Zimbabwe requests funding for these health centres to enable them to purchase high nutrient-content foods for poor AIDS patients and supplementary foods for infants whose mothers have died of AIDS. Furthermore, it is envisaged that such funding will enable these health centres to address needs they have not been able to work on such as testing and baby food. The global goal for this project is to prevent HIV transmission and mitigate the effects of increasing costs, declining incomes and the HIV/AIDS epidemic on the provision of health care. This will be achieved by increasing the supply of essential medicines for STI treatment and management and the supply of medical supplies, HIV testing facilities, therapeutic food supplies for HIV/AIDS patients and breast milk substitutes for orphaned infants and for use by children with HIV-positive mothers, to Catholic hospitals and clinics within the catchment area of the CRS-supported AIDS projects in Hwange and Mutare. It will provide HIV testing equipment to selected hospitals and funds to the Diocesan Health Commissions to locally purchase therapeutic food supplies for AIDS patients and breast milk substitutes for infants who would have lost their mothers and for use by those with HIV positive mothers. The project will provide health and nutrition education to PLWH/A and volunteer and primary care-givers, and to ante-natal and post-natal HIV positive mothers. The total budget for this five-year project is $2,500,000. CMMB medical supplies will amount to $1,500,000 and local contribution will be $150,000.

85. ZIMBABWE 699-97-903 CONSULTANCY TO DEVELOP PROPOSAL FOR NGO PROGRAM STRENGTHENING IN HIV/AIDS SECTOR

Project Duration:	08/01/97-08/31/97
Project Location:	Zimbabwe

Project Holder: Emthunzini
Direct Target Group: Selected NGOs
Total Project Cost: $4,894
Requested of CRS: $4,894
Unfunded Balance: -0-
Project Description:
The purpose of this consultancy was to assist CRS/Zimbabwe prepare a proposal in response to an RFA by USAID to design an NGO strengthening program for NGOs in the HIV/AIDS sector. It was later decided that given the differences between USAID and CRS in terms of ethical position on the use of prevention methods, that CRS could not submit a proposal as a lead agency, but did submit an application as a sub-grantee.

86. ZIMBABWE 699-97-905 STAFF DEVELOPMENT FOR THE JESUIT AIDS PROJECT

Project Duration: 08/01/97-08/31/97
Project Location: Harare, Zimbabwe
Project Holder: Jesuit AIDS Project
Direct Target Group: Project Director and Coordinator
Total Project Cost: $1,200
Requested of CRS: $1,200
Unfunded Balance: -0-
Project Description:
This project provided funds towards travel and living expenses for two staff members of the Jesuit AIDs Project to attend the SANASO Regional Conference in Mbabane, Swaziland. This conference was to allow exchange among different organizations working in the AIDS sector in Southern Africa. The participants presented papers of their experience at the workshop. They were pleased that their presentations we well received.

87. ZIMBABWE 699-97-906 CONSULTANCY FOR AIDS AWARENESS BASELINE SURVEY CADEC MUTARE

Project Duration: 12/01/97-01/31/98
Project Location: Mutare, Diocese
Project Holder: CADEC Mutare
Direct Target Group: 10 health centers and the population they serve (131,000)
Total Project Cost: $3,790
Requested of CRS: $3,790
Unfunded Balance: -0-
Project Description:
This baseline survey will serve to demonstrate the impact that the Mutare AIDS project has had in terms of awareness of the population and behavior change. It will serve to advise the project on strengths, weaknesses and new areas which need to be addressed.

CATHOLIC RELIEF SERVICES

SOUTHERN AFRICA OVERSEAS DIRECTORY

ime difference: (summer/winter)

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Angola	Kara Greenblott/Senior Liaison Officer Vital-Office Manager	86 Avenida de Lenin Luanda, Angola	86 Avenida de Lenin Luanda, Angola	(244-2) 337897 Kara's cell phone (244-9) 506325	(244-2) 337897 alt. fax c/o Trocaire: 244-2-348319	crs.luanda@ebonet.net *HF radio comm. between the offices.* *Luanda cannot dial direct to CRS/HQ, has to call CRS/Shipping to be transferred to Baltimore*
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