Summary

Zimbabwe Human Development Report 2003

Redirecting our responses to HIV and AIDS

"Towards reducing vulnerability - the ultimate war for survival"

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
ASO	AIDS Service Organisation
CBO	Community Based Organisations
ESAP	Economic Structural Adjustment Programme
HBC	Home-Based Care
HDI	Human Development Index
HIV	Human Immune Deficiency Virus
IEC	Information, Education and Communication
MDGs	Millennium Development Goals
MERP	Millennium Economic Recovery Programme
MOHCW	Ministry of Health and Child Welfare
MSMEs	Micro, Small and Medium Enterprises
MTCT	Mother to Child Transmission
MTP1	Medium Term Plan 1
MTP2	Medium Term Plan 2
NAC	National AIDS Council
NACP	National AIDS Control Programme
NATF	National AIDS Trust Fund
NERP	National Economic Revival Programme
NGO	Non-Governmental Organization
NPRS	National Poverty Reduction Strategy
PLWHA	People Living With HIV and AIDS
PPTCT	Prevention of Parent to Child Transmission
SHAPE	Sustainability, Hope, Action and Prevention Education (SHAPE Zimbabwe)
SHD	Sustainable Human Development
STD	Sexually Transmitted Diseases
STIs	Sexually Transmitted Diseases
STP	Short Term Plan
SWOT	Strength, Weaknesses, Opportunities & Threats
TASO	The AIDS Support Organisation
TB	Tuberculosis
TCPL	Total Consumption Poverty Line
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV andAIDS
USA	United States of America
USD	United States Dollar
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation
ZAN	Zimbabwe AIDS Network
ZBCA	Zimbabwe Business Council on AIDS
ZHDR	Zimbabwe Human Development Report
ZIMPREST	Zimbabwe Programme for Economic and Social Transformation
ZRP	Zimbabwe Republic Police

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The Research Team

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The Steering Committee

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Throughout the graphic illustrations, the green animation stands for the HIV and AIDS challenge. The front cover is illustrating that with effective coordination of the scaled up multi-sectoral national response to HIV and AIDS, it is possible to defeat the epidemic and uplift the nation of Zimbabwe to development

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Foreword

The current Zimbabwe Human Development Report is the fourth publication in a series which started with Poverty (1998), Globalization (1999) and Governance (2000). The theme for the Zimbabwe Human Development Report 2003[1] on "HIV and AIDS" is most befitting. Southern Africa, Zimbabwe included, is the epicenter of the epidemic. The report comes in to challenge the nation on the need to address the epidemic from a developmental perspective in addition to the current largely biomedical response. In this respect, the Report explores extensively the link between HIV, AIDS and development dynamics (both level and pattern of development). The Report concludes that "reducing socio-economic vulnerability in the population at large is paramount to effective combating of the HIV and AIDS epidemic".

The methodology of Human Development Reports the world over is to collect secondary information and supplement it with primary information as far as possible to produce a coherent report to inform the policy formulation process. Thus, National Human Development Reports are similarly designed to support national governments and their development partners in their efforts to achieve sustainable human development. The Reports also seek to strengthen national capacity for analyzing development dynamics and coming up with effective strategies to address identified challenges. To that end, the current Zimbabwe Human Development Report on HIV and AIDS, relies heavily on key research already done in various sectors of the country. Primary research was carried out largely to verify already existing information.

It is hoped that this Report will help in the scaling up of the national strategies in Zimbabwe to combat the HIV and AIDS epidemic. The ZHDR is, generally, an advocacy tool to remind the nation of its development priorities as well as to alert the nation on emerging development challenges. As such, the Report is supposed to be an effective tool for mobilizing the nation to ensure effective implementation of development programmes at all levels.

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[1] This report is the product of collaborative effort by a team of local experts and advisors. The report is an independent publication jointly commissioned by UNDP, UNICEF, the Government of Zimbabwe, the Institute of Development Studies at the University of Zimbabwe and Civil Society through the Poverty Reduction Forum.

Overview and Context of HIV, AIDS and Human Development

The central/core message of the Zimbabwe Human Development (ZHDR) 2003 is 'the challenge of breaking the cycle of HIV infection using the broadened multisectoral developmental response approach'.

The developed and developing worlds have for a long time recognized the link between development and health. Interestingly this knowledge took a long time to be acknowledged and applied in the control of the HIV and AIDS epidemic. This is partly because of an overwhelmingly biomedical approach to the epidemic and partly because research failed to establish a clear link between development and HIV and AIDS. The Zimbabwe Human Development Report (ZHDR) 2003 argues that the devastating impact of the epidemic which is at its worst in the Southern Africa sub-region, is benchmarked against a historical context of widespread socio-economic vulnerability (lack of development) of the population over many decades. Thus the report has its central or core message as *"the challenge of breaking the cycle of HIV infection using the broadened multisectoral developmental response approach"*. The report postulates that, in view of the strong linkages between development and vulnerability, the current multisectoral response, which is largely biomedical in content, is necessary but far from being sufficient for combating and reversing the spread of HIV and AIDS in Zimbabwe in particular and Southern Africa in general. This postulation is premised on a number of acknowledgements by individual nations as well as international organizations including the African Union and the United Nations. The UN declaration on HIV and AIDS acknowledges the complex interaction between poverty, underdevelopment and HIV and AIDS as highlighted below:

"…recognizing that poverty, underdevelopment and illiteracy are amongst the principal contributing factors to the spread of HIV/AIDS, and noting with grave concern that HIV/AIDS is compounding poverty and is now reversing or impeding development in many countries and should therefore be addressed in an integrated manner".

In its National Strategic Framework for the HIV and AIDS response, Zimbabwe acknowledges that, since the identification of the first HIV and AIDS case in 1985, the response to the disease has been largely driven by the Health sector. However, it has become very evident that even the current multisectoral response in Zimbabwe is still largely biomedical.

Development levels and patterns affect the dynamics of how the HIV and AIDS epidemic thrives in a particular environment as well as what is feasible in terms of the response to the epidemic.

The current development paradigms are around Sustainable Human Development (SHD). SHD seeks to improve human lives through expanding the range of things a person could do and be i.e. a person's functionings and capabilities to function which include being healthy and well nourished, being knowledgeable and being able to participate in the life of the community. Development is about people's well-being and expansion of material output (economic growth) is a means to achieving this people's well-being, not an end in itself.

One of the reasons why development has lagged behind as a key response to the HIV and AIDS epidemic is the narrow interpretation on human development and the use of macroeconomic indicators in studying the relationships. Unfortunately, there has been a tendency to confine SHD strategies and ideas within the parameters of the Human Development Index (HDI) which include income, health and knowledge, thus, negating other equally important dimensions such as participation, civil and political freedoms from the current HDI measurement.

The challenge of combating the HIV and AIDS epidemic exposes this methodological weakness even more. This is because some of the major factors currently fuelling the epidemic have to do with power relations, empowerment and participation issues. While HDIs are presented as usual in this report and do make a very significant contribution to the report's messages, the report goes far beyond the HDI's three measurement dimensions in arguing for the multisectoral developmental response to the HIV and AIDS epidemic.

In the context of the standard approaches to human development, it is clear that the key indicators of human development in Zimbabwe have been declining steadily over the past 10 years. In the 80's, on average, the economy grew at around 3-4%, tending towards stagnation. Hence, the Economic Structural Adjustment Programme (ESAP) was adopted in 1991 as an effort to boost the country's economic performance at a time when the country still enjoyed wide international support. Despite the seemingly timely intervention in the economy under ESAP, the decade of the 1990s generally saw a decline in economic growth and a persistence of the structural problems of high poverty and inequality. Droughts and the non-realization of the objectives of the ESAP were associated with the economic decline in the 1990s. Similarly, Zimbabwe's social indicators which were impressive in the 1980's, progressively declined to current unacceptable levels.

Overlaying the HIV and AIDS epidemic on Zimbabwe's development course in the past two decades shows a close relationship between the evolution of the epidemic and deterioration of human development in its broad sense. HIV infection has increased dramatically from the low levels of the late 80's when development was reasonably strong to over 30% in 2002. This coincidence is clear evidence of development gone wrong. Life expectancy has dropped from 61 in 1990 to 43 years in 2003. While the children of mothers with no education experienced an under five mortality rate of 119 per 1 000, those of women with higher than secondary school education experienced a mortality rate as low as 21 per 1 000 indicating that education remains an important developmental indicator. Maternal mortality figures were estimated to be 283 deaths per 100 000 live births during 1984 -1994 rising sharply to 695 per 100 000 live births during 1995 – 1999. All these negative trends are closely associated with HIV and AIDS.

However, Zimbabwe's literacy levels for 15 – 24 year olds rose from 95% to 98% between 1992 and 1999. Over the years, there have been significant improvements in the quality of teaching personnel in the primary education sector. The proportion of trained teachers increased to from 52% in 1990 to 88% in 2000. However, there are strong indications of stress in the education sector as a result of HIV and AIDS mortality and morbidity of both staff, pupils and parents as well as due to brain drain. This is compounded by an ever increasing number of orphans and vulnerable children. Inevitably the quality of education is being negatively affected.

The declining economy is, consequently experiencing unprecedented levels of informalization or underground economic activities, as the vulnerable population tries to devise survival strategies. The informal sector income is largely unsustainable and entails behaviours that are generally risky under the HIV and AIDS epidemic mode. This is borne by the observation that life expectancy declined most in Midlands, Matabeleland South and Matabeleland North, provinces noted for informal sector income benefits accruing from informal cross border trading and gold panning.

The proportion of the population below the Total Consumption Poverty Line (TCPL) was estimated at 74% in 1995 and 2002 estimates are that it had risen to 80% making poverty a major cause of vulnerability thus fuelling HIV and AIDS and vice versa.

Rural areas, in general, and women, in particular, have been more hard hit by the socio-economic hardships.

The status of women in Zimbabwe, though being continuously addressed, still remains low. For example school enrolment remains lower than that of males in both secondary and tertiary institutions of learning. Few women have senior positions in public and private sector. This is partly because the issues of gender inequality go beyond empowerment to encompass issues of social justice, culture and discrimination. Thus women have remained extremely vulnerable to HIV and AIDS both from the point of view of acquisition of infection as well as of care. The sex distribution of HIV infection is heavily biased towards females. Although the sex ratio between males and females is about 1:1, HIV prevalence among young women below the age of 20 is reported to be five times higher than their male counterparts. This suggests the persistence of gender inequality and inequity in development. The girl child in particular, due to cultural and traditional beliefs, has been a victim of sexual violence on the one hand and economic vulnerability on the other, at a time when the HIV and AIDS epidemic is raging.

Even though data on the state of the environment is not easy to come by, there is general agreement that Zimbabwe's state of the environment continues to deteriorate in both rural and urban areas. Overcrowding in rural areas has led to severe land degradation, while the newly resettled areas are experiencing severe deforestation as people clear new land for farming or simply to sell firewood as a means of survival. Activities of major mining firms have not been sensitive to environmental concerns either. Similarly, small-scale gold and diamond panning, a common practice in various parts of the country, has contributed to the siltation of major surface water bodies. Rapid urbanization has denied proper urban planning and provision of services. Thus, pollution of water sources has increased tremendously in the past few years. All these further enhance the vulnerability of the Zimbabwean population to HIV and AIDS.

Conclusions, Challenges and Recommendations

To reverse the current trends in HIV and AIDS it is critical that the relationship between the epidemic and human development be acknowledged at all levels and that the principles of sustainable human development be a major focus and priority of the country's policies and programmes. Looking at HIV and AIDS from the development perspective clearly defines the vulnerability of the general population as well as specific sub-populations and sectors. This will widen the scope for a multi-sectoral intervention that will become more than just the mainstreaming of the standard HIV and AIDS health sector interventions in all sectors.

Clearly the colonial policy environment inadvertently produced fertile ground for the spread of HIV and AIDS. But the post-colonial policy framework, in attempting to redress the template, had some key elements of the transformation falling on policy blind spots, thereby further increasing vulnerability. The situation has been worsened by the current withdrawal of international support.

The current levels of HIV and AIDS are a manifestation of the past and current developmental shortfalls that have resulted in social reorganization favouring risky social behaviour and making people economically and morally unable to deal with care and support related issues. Overall, females are disproportionately

Clearly the colonial policy environment inadvertently produced fertile ground for the spread of HIV and AIDS.

affected, bearing a huge burden of infection, care and support but with minimal resources and societal recognition and support.

In view of these relationships between development, HIV and AIDS, the challenge then is to create a new template that reduces vulnerability, while at the same time, consolidating the positive policies already in place. This requires that a deliberate choice be made to widen further the national response to the HIV and AIDS epidemic and to implement more of the developmental response to complement the current still largely biomedical response. This choice is very easy to make, yet not making it can be very costly to the nation. It is critical that grassroot people are empowered through effective decentralized structures and mechanisms to combat the epidemic. Addressing the culturally imbedded plight of women and children remains the greatest challenge in any action we take to combat the HIV and AIDS epidemic.

The challenge then is to create a new template that reduces vulnerability, while at the same time, consolidating the positive policies already in place.

Policy is the Main Tool for Reducing Vulnerability and, hence, the HIV New Infection Cycle

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To stem the tide of infections and mitigate the impact of the epidemic there is need to immediately practically widen the multisectoral national response to the HIV and AIDS epidemic to purposely bias it in favour of human development, without compromising the progress made so far on the biomedical side of the response. Secondly the country should make a deliberate choice to "generate a new development template" that focuses on the reduction of poverty and vulnerability i.e. a practical commitment to pursuing sustainable human development (SHD). This choice should foster the will to design and implement a broad based national poverty reduction strategy (NPRS) as a priority in the *short-to-medium term.* Implementing such a strategy calls for establishment of a conducive socio-economic policy environment for growth and development, ensuring success of the agrarian reform, supporting indeginisation, and developing specific policies and strategies for empowerment and protection of children, youths women, the elderly and disabled, orphans PLWA and the affected.

The above is the responsibility of government at policy, technical and implementation level. At the broad participation level, both in the design and implementation stage, it is the rest of the nation's responsibility (civil society, private sector, communities and non-governmental organizations) to input effectively into the broad participatory processes of development such as the Millennium Development Goals (MDGs), Poverty Assessments, NPRS, National Budgetary, Macroeconomic Frameworks, Agrarian Reform and other important national development processes.

The Template: Revisiting the Fundamentals: The Origins of Vulnerability

The ZHDR 2003, argues that the general vulnerability experienced by the people of Zimbabwe, in particular, and Southern Africa, in general, is not a recent creation but a long process of social re-engineering which took place over a century of colonialism. Colonial and postcolonial political and economic governance created an ideal template for HIV transmission by deliberately or otherwise creating and

deepening poverty and inequality. Thus, both societal factors and individual factors sustaining the epidemic are directly linked to development.

For predominantly economic reasons, to create a working class, the colonial regime in the then Rhodesia passed laws that took away land, livestock, access to irrigation water, young men's labour and lucrative sources of livelihood from the black majority. In simple terms, systematic and systemic impoverishment created dependence on the colonial master. This deprivation introduced new and deepened existing inequalities between men and women laying the foundation for the current patterns of HIV infection and AIDS. Emerging survivalist social formations and value systems in the wake of this poverty have rendered people susceptible and vulnerable to HIV infection.

To ensure sustainability of the labour base and political acquiescence, the colonial social re-engineering transformed local institutions and their ethos through imposing laws, practices and new value systems which corrupted and destroyed the then existing social institutions. The black African family was a key target, and changing family relations within it was central to this social project. By independence, Zimbabweans had accepted the resultant social changes as *"our culture"* so that the post independence governance system found it difficult to tamper with these entrenched practices, norms and institutions.

To ensure sustainability of the labour base and political acquiescence, the colonial social re-engineering transformed local institutions and their ethos through imposing laws, practices and new value systems which corrupted and destroyed the then existing social institutions.

One of the major socio-cultural changes that entrenched vulnerability was the dualisation of homes. Working men were forced to move between their urban homes where they stayed most of the year to the rural home during holidays and weekends, thus creating an efficient transmission route for sexually transmitted diseases (STIs) and lately HIV. Dualisation of sexual life was deliberately encouraged through establishment of compounds in which beer drinking and prostitutes were deliberately provided as antidotes for desires to be with one's family.

One of the major socio-cultural changes that entrenched vulnerability was the dualisation of homes.

Deliberately or otherwise the culturally driven divisions of labour and affection between men and women were worsened by the social engineering project. The separation of spouses led to the feminisation of rural areas as well as the feminisation of poverty. In addition to farming on poor soils, women became the sole farmers but without decision making powers to dispose of the produce from the plots and to spend money without consulting their absentee husbands. Thus, women maintained men's stakes in the rural economy. In addition to their dispossession, rural areas became a depository for spent-out male labour discarded from the workplace in the absence of a comprehensive social security scheme for blacks.

In an effort to reverse the colonial template, the post-independence government adopted re-distributive policies, such as minimum wage policy, expansion of access to education and healthcare and land redistribution and resettlement programme. However, with de-restriction of mobility which came with independence, the enclaves attracted more people (male and female) from the impoverished rural hinterlands in search of employment and a better life. The droughts of the 1980s and 1990s merely intensified migration. Urban migration led to overcrowding in the urban areas, which had not been designed for large populations.

While land resettlement aimed at empowering people, women remained the majority of small scale farmers but with no control over the returns of their own labour. Hence in 1997, for example, 153 women reportedly committed suicide in Gokwe

over the disposal of cotton money. The downside of resettlement was that it further weakened kinship ties as people moved and lived apart from their kin. In the process, social institutions of censorship were weakened, and people lost opportunities for sex education and socially controlled courtship. Women's need for cash and the limited opportunities they have for earning enough to look after themselves renders them vulnerable to risky behaviour. This also makes it difficult for women to protect themselves against HIV and AIDS. The burden of care continued to remain solely that of the woman. Once a man loses his job for any reason including discharge on medical grounds related to HIV and AIDS, he goes to rural areas to his wife and children.

Thus, ESAP deepened insecurities, making people more susceptible and vulnerable to HIV infection and AIDS. By far, the most devastating effect of ESAP with regards HIV and AIDS was making the state an "umpire" and limiting its roles as a service provider.

Economic stagnation and the tendency towards decline in the late 80's led the government to adopt the Economic Structural Adjustment Programme. The program called for the removal of subsidies on social services and basic commodities; currency devaluation; price decontrols; and labour and commodity market deregulation among others. The net effects of these policies was a skyrocketing cost of living, as indicated by rising inflation, declining real wages, job losses leading to unprecedented levels of poverty and desperation. The gap between the rich and the poor widened**.** Thus, ESAP deepened insecurities, making people more susceptible and vulnerable to HIV infection and AIDS. By far, the most devastating effect of ESAP with regards HIV and AIDS was making the state an "umpire" and limiting its roles as a service provider**.**

Realising that ESAP was not a solution but fuelled vulnerability, the government developed home-grown strategies to address the imbalances. The government thus replaced the ESAP program of 1991-5 with a home-grown reform program entitled the *Zimbabwe Program for Economic and Social Transformation (ZIMPREST)* in April 1998. This was soon followed by yet another attempt to address the declining economic performance, the *Millennium Economic Recovery Program (MERP)* which was launched in 2001 as a short-term 18 month economic recovery program.

While the home grown economic reform efforts are commendable, the consolidation of vulnerability and insecurity generated by their non-delivery continues to put the population under pressure and stress, leading to the adoption of a variety of risky survival strategies. Among these survival strategies is high mobility in search of sustenance within the country, in the region (Tanzania, Malawi, Namibia, Zambia, South Africa, Botswana and Mozambique) and abroad. For instance, professionals look for better paying jobs elsewhere (brain drain), the poor search for food, menial jobs and also engage in itinerant trade, including cross border trade. In the process, people lack transport, food, accommodation, and ablutions etc. For women, the patron-client relations might also include multiple partner survival strategies and transactional sex.

Multiple partnership is generally accepted for men but not women due to entrenched social acceptance of polygamy

The impact of colonial and postcolonial economic policies on gender inequality have been highlighted above. In addition to these, the pre-existing cultural beliefs and practices prejudicing women persisted, while masculinities favouring multiple partnerships were consolidated despite commendable efforts at policy level to address gender issues. Multiple partnership is generally accepted for men but not for women due to entrenched social acceptance of polygamy. Women are driven to ensure they please men sexually and in so doing some practices make them more vulnerable to HIV. Similarly women have continued to be regarded as the natural care givers. Not surprisingly most care facilitators in home based care

programmes are women. Young women and girls are particularly vulnerable in view of the cultural belief that having sex with a virgin will cleanse bad omen or cure STIs including HIV and AIDS. All these factors have significant impact on ability to take up prevention technologies e.g. condoms by women.

Combating and reversing the spread of the HIV and AIDS epidemic is *"The Ultimate War for the Survival"* for this nation.

Empowering women is essential for reducing vulnerability and is a critical component of the culture re-building process

Conclusion, Challenges and Recommendations

Combating and reversing the spread of the HIV and AIDS epidemic is *"The Ultimate War for the Survival"* for this nation.

There is no doubt that when HIV and AIDS was first identified in Zimbabwe in 1985, it found "fertile ground" in the form of a social environment conducive for its rapid spread. This social environment was generated by a historical template characterized by rapid social and economic change, changing morals, high mobility, gender inequalities, widespread and deepening poverty, thus, constituting numerous vulnerability factors on the population at large. Individual responses to these conditions made people highly susceptible to HIV infection. In addition, the HIV and AIDS problem initially fell on a policy blind spot under the rubric of denial and the silence about HIV and AIDS in policy discourse.

The key challenge is to design and implement a *"new development template"*, consistent with vulnerability and risk reduction, as a critical pre-condition to combating the HIV and AIDS epidemic. Overall, we must all be committed to creating *"non-fertile ground"* for the epidemic at all levels, from policy-making, implementation, development and behaviour change at the individual level. There is need to re-visit "our culture" and tirelessly endeavour to re-build a new and sustainable culture for our nation to survive. The situation of women deserves special attention as we embark on the process of re-building a sustainable culture as a people, given the current realities of life. Culture re-building will no doubt take a long time, but it is better to start now than never.

To tackle general vulnerability there is need to design and implement a broad based national poverty reduction strategy (NPRS). Equally important is the need to tackle the gender and culture nexus which is also central to the spread of the HIV and AIDS epidemic. There is thus need to rebuilding a gender sensitive culture for sustainable development. This calls for acknowledgement and acceptance of the fact that what we are currently calling "our culture" is, in fact, a generally perverted, re-engineered culture which was historically designed to serve the needs of a specific colonial mode of production. This stance can be taken with *immediate effect.* Empowering women is essential for reducing vulnerability and is a critical component of the culture re-building process and entails involving them in national, sectoral, community and family level policy and decision making as well as through attitude change and role modeling. Joint responsibilities in care and support, empowering women to have control over sexual life, and combating violence against women will ensure the moulding of a template that reduces or removes the current fertility for HIV transmission. The above is the responsibility of political and economic governance (i.e. government at policy level), with technical support from all institutions in the country in particular the private sector, government ministries, non-governmental organizations and communities. The role of the international community cannot be overemphasized.

Epidemiology of HIV and AIDS and Transmission Dynamics

Table 3.1: Routes of HIV Transmission in Zimbabwe

Transmission route	Percent contribution to HIV transmission	
	Zimbabwe*	Angola**
Heterosexual intercourse	92%	76%
Mother to child	7%	14%
Other (blood transfusion, sharing needles or syringes)	1%	9%
Bi-Homosexual		1%

*Source: *National HIV/AIDS Strategic Framework 2000-2004, Republic of Zimbabwe; 1999. **UNDP. The Development Challenge in Sub-Saharan Africa.*

In Zimbabwe and Africa in general, 99% of HIV infection is transmitted heterosexually, considering that vertical transmission is in itself a result of sexual transmission to the mothers. Thus, it is particularly important to understand who is infecting who and why in order to understand the underlying factors. While the epidemic is considered generalized, evidence is provided in the ZHDR 2003 that shows there is not one epidemic but many. It varies sectorally and demographically, and is driven by sector specific sex networks, and, therefore, demands different developmental interventions. In this context a sex network is a complex web of sexual relationships which bring many sexual partners of a diverse background, status, behaviours and other attributes into direct (or immediate) and indirect (or remote) sexual contact

Prevalence has remained persistently highest in commercial farming and mining areas, followed by border posts, growth points, urban and rural areas.

Since the first HIV and AIDS case was identified in Zimbabwe in 1985, HIV infection rates have progressively increased to the adult prevalence of 33.7% in 2002, the third highest in the world. Apparently significant differences exist in HIV prevalence in different locations. Prevalence has remained persistently highest in commercial farming and mining areas, followed by border posts, growth points, urban and rural areas. The origins of some of the vulnerabilities in these areas has been described above. Commercial farming and mining areas, border posts and growth points are areas that best illustrate development vulnerabilities in the population**.** In Masvingo province, for example, the highest prevalence was recorded in Chiredzi, a commercial farming area with the largest sugar estates in the country. On the other hand, Midlands Province has experienced an unprecedented upsurge of gold panning in recent years, with large numbers of young adults flocking into the province.

Intergenerational sex explains the higher HIV prevalence among young women compared to their male counterparts.

There is overwhelming evidence from Zimbabwe and elsewhere showing that women are particularly susceptible and vulnerable to HIV infection. Infection rates are much higher in women than men, with up to five times higher infection rates among young women than their counterparts. Similarly, married women are at great risk of getting infected. Intergenerational sex explains the higher HIV prevalence among young women compared to their male counterparts. For economic and social reasons, young women often have two types of partners: one an older boyfriend who has accumulated assets and is able to provide money and gifts, the other slightly younger, being cultivated as a potential husband. Thus,

young women with low rates of infection are having sex with older men with higher rates of HIV infection. Typical of gender inequality in education, women, especially those in rural areas, are still disadvantaged with respect to understanding key issues about HIV transmission and AIDS.

Factors influencing the rate of Mother-To- Child–Transmission (MTCT) include advanced disease, malnutrition and extended breastfeeding duration. These factors are, in turn, driven by lack of resources including Anti Retroviral drugs (ARVs) to manage HIV, shortage of food and lack of resources for formula feeding. In short, poverty is a major determinant of the outcome of vertical transmission of HIV. Furthermore, incorrect beliefs stemming from culture, and ignorance about HIV and AIDS have increased the incidence of child abuse. The abuse is mostly driven by the belief that sex with children will cure HIV and AIDS or slow disease progression.

The HIV and AIDS epidemic in Zimbabwe is considered to be generalized. However a critical analysis indicates that despite the generalised spread, there are sector specific factors that make some sectors more vulnerable than others.

Sentinel surveillance data shows that HIV prevalence has remained steadily higher in farming communities than in the general population. Research has established links between prevalence of Sexually Transmitted Infections (STIs), migration and season. It has further shown that condom uptake fluctuated with income and labour seasons and that STIs followed more or less the same trend. The current land reform programme aims to address the economic imbalances enshrined in the colonial economic governance. However, it also brings with it increased population movement, and social disruption, a reincarnation of the immediate post independence scenario described above. This increases the vulnerability of the population and threatens to derail the programme in the long run.

Vulnerability of the education sector arises from the social and economic conditions of teachers, and that the majority of people in the sector are young children and youths. In their respective communities, teachers are considered to have relatively high incomes and are also generally regarded as educated and knowledgeable. These enhance their social status and tend to significantly raise their level of risk to HIV infection. With their relatively privileged socio-economic position, additional pressure is put on them to have multiple relationships because they are attractive clients in transactional sex. Because the majority of teachers are stationed in rural areas, they also are highly mobile since they have to travel frequently to urban areas in order to join their spouses, to collect their salaries, to get entertainment and for shopping.

For students, economic deprivation leads to risky sexual behaviour.

For students, economic deprivation leads to risky sexual behaviour. Lack of accommodation is a problem in secondary and tertiary institutions in the face of increasing enrolments and student population in an environment of shrinking resources. On the other hand, parents are unable to meet the daily needs of their children in school, including what is considered fashionable. Thus students resort to transactional sex, often unprotected, for accommodation. Female students have noted that some men pay huge amounts for un-condomised penetrative sex. Similarly, omnibus crews and taxi drivers give schoolgirls free rides to and from school and buy the girls food from fast food shops.

Deployment of nursing staff without due consideration of the working locations of

their spouses was cited as an important determinant of risky behaviour**.** This contravenes the provisions in guiding principle 5 of the AIDS policy that seeks to uphold marital integrity and sustainability. The health delivery service has been severely affected by HIV and AIDS and brain drain. Medical staff (e.g. nurses) and field workers are particularly at risk. The former because of their position in society and because of the deployment system that does not consider the family. The latter because they spend substantial amount of time on field duty away from their families, but with huge sums that are given as allowances and not accountable to the family.

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Four main factors make the public sector highly vulnerable. These are deployment system (dualisation of homes), mobility, poverty (or relative poverty) and type of service. The deployment system has not been sensitive to the family resulting in families being split up for long periods. Some services require that staff be regularly on the move. These include staff in road construction departments, parks and wildlife etc. The employees often receive substantial travel and subsistence allowances, making them relatively wealthy in the midst of poverty, especially in rural areas. Young pension clerks have been cited as being highly vulnerable as they attend to desperate clients such as young *widows*. The clerks are not only seduced by the widows for fast tracking pension claims, but are themselves also attracted by the pension benefits of these women. Customs and immigration officials at border posts are at high risk because they are often without their families, have access to money through bribes and are targets for sexual persuasion by cross border traders as they try to avoid paying duty.

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Armies are very mobile and, often, military barracks are found in outlying areas that are poor so that the barracks are a high-income area, thereby nurturing transactional sex

According to a UNAIDS sero-survey undertaken in 1997, Zimbabwe and Cameroon militaries were found to have 3 to 4 times higher HIV prevalence rates compared to the rest of the civilian population. Typical of the military world wide, young and socially inexperienced people are recruited and trained to be fearless and aggressive. The youthful soldiers carry this approach in civilian life and into their private sexual interactions. Armies are very mobile and, often, military barracks are found in outlying areas that are poor so that the barracks are a high-income area, thereby nurturing transactional sex. In the camps, there is limited married staff accommodation, perhaps taking up about 5% and single quarter barracks holding about 20%; the rest then seek alternative accommodation with the local council, residing with the civilian population.

Overcrowding, shortage of food and other facilities in the prisons drive the sex networks

Several reports indicate that HIV infection is very high in prisons. Around 1996, 72% of deaths among prisoners were reported to be AIDS related. This is due to among other reasons, the overcrowding in single-sex living conditions, which promote casual or non-consensual homosexual relationships mostly involving anal sex. The sexual acts occur in an environment where use of condoms is not officially acknowledged nor accepted. Prisoners in Zimbabwe have no conjugal rights. Due to lack of adequate transport, men and women are transported together and anecdotal information suggests that frantic sex between male and female prisoners occurs in the overcrowded truck- en route to courts. This has also been reported in South Africa.

The MSME is a target for economic empowerment and revival. Although there are no data on the extent of HIV infection, the sector is highly vulnerable due to the nature of the business. Often the business requires extensive travel and bargaining in search for cheap materials. This often results in the establishment of sexual relationships aimed at facilitating trade. The informal mining sector has

expanded rapidly over the years, and more so in the latter part of the decade as the economic situation has drastically deteriorated. Mostly young men and women have converged on rich alluvial and reef gold deposits that abound in Zimbabwe. They spend long periods of time panning for gold and, inevitably, dwellings are built and sexual partnerships inevitably developed in situations where there are virtually no services.

The major vulnerability factors are mobility and poverty

The role of truck drivers in fuelling transmission of HIV has been extensively studied early in the epidemic. The studies have shown that prevalence of HIV is higher among truck drivers than the general population. In Zimbabwe, there is indirect evidence from observations that HIV prevalence was higher in roadside trading centers along major highways. The major vulnerability factors are mobility and poverty. Truck drivers spend long periods of time away from their families, and are exposed to poor women in roadside trade centres and border towns. Transactional sex is common with women, especially cross border traders (MSME) seeking free transport for their goods. This is an example of intersectoral sex networking that fuels the epidemic.

Conclusion, Challenges and Recommendations

Ample evidence exists that shows that the HIV epidemic profile is directly linked to the vulnerability of the population. Furthermore, despite the epidemic being generalized, there are sector specific vulnerabilities that warrant sector specific responses. By far the major factors are poverty, mobility, gender inequality and social value systems. The role of these factors in influencing sexual behaviour has been discussed above. The sectoral impacts, a manifestation of sex networks, are discussed below. Understanding the sectoral dynamics of transmission and impact thus becomes a key requirement for the mounting of an effective developmental response.

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The greatest challenge to strategists and implementers is how to break the sex networks that are driving the epidemic. There is need for identification and recognition of sector specific fundamentals of sex networking and design sector specific responses that address these factors. What is required now is to devise strategies that are not only pro-poor but should generate new value systems that ensure establishment of social institutions that control sexual behaviour in communities, to replace those destroyed by the colonial and post colonial social engineering. Gender inequity and inequality can be further reduced in order to reduce vulnerability of women in general. This is critical if the youths, our window of hope and the future of this nation, is maintained HIV free.

There is need for sector specific interventions to break the drivers of the epidemic in the sectors

Because most of the vulnerabilities are related to the template, it is critical that there is continuous review of cultural beliefs and practices and enforcement of legal instruments. This is to continuously review human resource needs, salaries and working conditions. This can be effected through education on the role of dualisation of homes on HIV transmission, revisiting deployment policies and the cultural issues of polygamy, inheritance and sexuality, including intergenerational sex. Ensuring the deployment of employees with their families is a feasible response that would reinforce the education on dualisation of homes. Reducing the duration of field duty and the allowances while increasing salaries is another response that could significantly reduce the risk of field workers. There is need for sector specific interventions to break the drivers of the epidemic in the sectors.

AGRICULTURAL SECTOR

i. Train extension workers in HIV and AIDS
ii. Integrate HIV and AIDS into agricultural curricula
iii. Mainstream agriculture in education curricula
iv. Provide agricultural finance to farmers
v. Research into and disseminate less labour intensive agricultural technologies

EDUCATION SECTOR

i. Ensure high quality education in all schools and provide "schools-only" transport
ii. Provide school accommodation in rural secondary schools
iii. Provide accommodation for tertiary students
iv. Tertiary institutions to provide food to students

PRIVATE SECTOR

i. Continuously conduct vulnerability assessments to direct HIV and AIDS policies
ii. Expand and enforce HIV and AIDS programmes in the workplace
iii. Enforce insolvency laws that protect workers

TRANSPORT SECTOR

i. Provide decent and affordable accommodation for truckers and cross border traders
ii. Provide exclusive transport for students
iii. Intensify HIV and AIDS information dissemination to travellers
iv. Shorten process of goods clearance at border points
v. Organise cross border traders for bulk trading
vi. Provide short distance cross border transport for small traders
vii. Expand IEC at all strategic points
viii. Train local authority employees to deliver HIV and AIDS messages to travellers

TOURISM SUB-SECTOR

i. Organise cross border traders for bulk trading
ii. Intensify IEC messages
iii. Provide condoms in all hotels

MICRO, SMALL TO MEDIUM ENTERPRISES SECTOR

i. Provide financial and technical support for MSMEs
ii. Organise MSMEs for bulk production and marketing of their products

MINING SUB-SECTOR

i. Provide comprehensive social services in mines
ii. Design and implement comprehensive HIV and AIDS programs in mines
iii. Organise small scale miners for support and services
iv. Support indigenisation in the mining sector

PUBLIC SECTOR

i. Provide decent and affordable accommodation in border towns

UNIFORMED FORCES

i. Use military discipline to enforce safe sex
ii. Provide adequate family accommodation in barracks.

PRISON SECTOR

i. Increase community service for petty crime
ii. Improve living conditions in prisons
iii. Pre-and-post counselling and HIV testing of prisoners
iv. Improve health services in the prisons
v. Improve transport services in the prison sector

HIV and AIDS Impacts: Development put under Threat

The epidemic cuts across all socio-economic groups

The impact of HIV and AIDS is first experienced at individual, household and family levels and gradually more widely in the community. The epidemic cuts across all socio-economic groups and because it affects primarily the productive age groups, its increasing impact is seen in the rising numbers of orphans, the elderly and children living on the streets. The epidemic is decimating the limited pool of skilled workers and managers and already eroding the faltering economy. The impact of AIDS is also being felt at unskilled labour level, as absenteeism increases due to deaths, illness or attendance at funerals. Even more distressing is the poverty and gender dimension of this impact. This chapter therefore describes the sectoral impacts of HIV and AIDS in a bid to highlight difficulties and incapacities experienced by different sectors. It is hoped that a sectoral analysis of impacts will highlight some of the possible mitigatory strategies.

Most of the orphans are cared for by grandparents who, in most instances have no income of their own and have severe limitations on the number of orphans they can look after

About 2.3 million Zimbabweans were already living with HIV and AIDS by the end of 2001. Of these, two million were adults aged between 15-49, with the adult prevalence of 33.7%. There were 240 000 Zimbabwean children (ages 0-14) living with HIV and AIDS. The adult and child mortality from AIDS is estimated at 200 000 and the cumulative number of related deaths, using conservative assumptions, will reach 1.3 million by 2005. Projections show that Zimbabwe's population would have grown from 11.8 million in 1992 to 16.6 million in 2010 and growth rate would have remained around 2.5%, but due to HIV and AIDS a 23% reduction in population growth between 1992-2010 is anticipated. The male and female population is also expected to decline by 22 and 24 percent respectively over the same period, according to the same projection showing the differential impact of the epidemic. AIDS has distorted the population pyramid by removing productive and reproductive adults and leaving children and the elderly, increasing an already high dependency ratio from 48% to 60%. It is projected that in Zimbabwe, Zambia and South Africa, 20-30% of all children younger than 15 years may be orphaned by 2010, (FHI, 2003)

As early as 1992, studies were already showing statistics of at least 10% AIDS-orphaned children within study areas and nearly one in five households taking in orphans as part of their families. Today there are nearly one million living orphans. Most of the orphans are cared for by grandparents who, in most instances have no income of their own and have severe limitations on the number of orphans they can look after. Such a scenario evidently, has grave implications on care for the orphans and integrity of social systems.

Thus, the social fabric of the extended family is showing signs of erosion and the close bonds that hold family members together are disappearing.

HIV and AIDS is beginning to have an effect on the value systems of the family as traditional norms and customs are breaking down. Thus, the social fabric of the extended family is showing signs of erosion and the close bonds that hold family members together are disappearing**.** Traditional roles, duties and responsibilities of family members also become blurred, as AIDS places additional demands and pressures on orphans, particularly economic uncertainty, stigmatisation and emotional insecurity. The death of adults and subsequent loss of family income leads children, especially girls being withdrawn from school to substitute adult labour, and increases the number of child headed households. Youth are being deprived of life and sex education, which is instrumental in establishing a code of conduct between men and women, husbands and wives. Some traditional customs, for example burial rites and ceremonies have been adjusted both in terms of time and money spent to cope with economic pressures resulting from HIV and AIDS. AIDS is stigmatizing therefore renders people societally invalid because they have to be cared for and this is humiliating and not easy for any adult. Despite the enactment of legal instruments to protect HIV and AIDS infected people against discrimination, there have been reports of people losing employment and accommodation upon the discovery by their employers and landlords that they were HIV positive.

With the job losses which come with an HIV diagnosis, or the death of the breadwinners, many households experience reduced viability. This is worsened by the chronic ill health of the surviving spouse which leads to a loss of savings, including the sale of property and livestock as resources get spent on medical and funeral expenses. This invariably leaves surviving children and other dependants in poverty. Women are usually sent to their paternal homes when they are diagnosed with HIV.

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HIV and AIDS have had a negative impact on rural development. In Zimbabwe sick persons are sent to rural homes. Women take up the responsibility of caring for the sick negating the time investment into agricultural activities, often their sole source of livelihood. In cases where the husband dies, the widow has to work for longer hours during the day to make up for the loss of income. One of the consequences of this coping mechanism however is that children are left unattended, their meals are poorly and hastily prepared and the widows' own health and diet deteriorates as a result of exhaustion and less food intake. Furthermore reduction in crop variety and switching to less labour-intensive crops alters the diet in favour of malnutrition.

It is undeniable that HIV and AIDS have a negative impact on the realisation of children's rights in Zimbabwe. The alarming rate of mortality from AIDS and its resultant growing number of orphans, inflation rate and high levels of unemployment has increased the dependency ratio in Zimbabwe. Poverty and economic hardships intensify the vulnerability of children. Most children affected by AIDS are easily identified in the communities because of their poor status and their involvement in

several arduous economic activities to supplement the income of the household. A large number become carers of their sick parents and eventually heads of house holds when the parents die. The vulnerability results in poor socialisation and psychological aberration leading to delinquent and criminal behaviour in these children. Some of these children may themselves be infected with HIV and therefore need care, often not available due to an ailing health care delivery system, and also because more often than not the parents are also sick.

Children between the ages of 5 and 14 are deemed to represent a window of hope because they are the least likely to be infected with HIV. Education before they reach the peak vulnerable years will protect them.

Children between the ages of 5 and 14 are deemed to represent a window of hope because they are the least likely to be infected with HIV. Education on HIV and AIDS before they reach the peak vulnerable years will protect them. It is highly regarded and believed within children's developmental organisations that education, empowerment and promotion of children's rights is key to HIV and AIDS prevention. Reducing children's vulnerability to HIV means improving the economic situation of their families. School offers children new knowledge and life skills, and keeping children in schools allows them to continue to acquire knowledge and skills that will help them escape from the spiral of poverty and HIV and AIDS and become the future productive workforce for their countries. The youth ages 15 to 24 are also viewed as a second window of hope owing to the fact that most of them in this age group are not yet infected despite being a high-risk group. Focusing on young people is therefore likely to be the most effective approach in confronting the epidemic, particularly in high prevalence countries. A good education system is viewed as a key means of HIV prevention.

The increase in home-based care due to AIDS places an enormous burden on the elderly, especially women. In developing countries, like Zimbabwe, where the welfare system has limited resources and is under extreme pressure, the elderly find themselves doing care work under extreme conditions of poverty, stigma, lack of support, abuse resulting from witchcraft accusations and other challenges faced in old age. There is growing evidence that older people are at high risk of being infected with the HIV virus in the process of caring for their sick children or grandchildren.

The misconception that people with disabilities never engage in sexual activities and therefore are HIV/AIDS free can put them at greater risk of contracting the disease than other people, as unprotected sex with a person with a disability is considered safe.

Traditional misconceptions and the exclusion of people with disabilities from the programmes fighting HIV and AIDS has led to a situation where many people with disabilities believe that HIV and AIDS cannot affect them, and where so-called able-bodied people believe that sex with people with disabilities is safe sex, because of the delusion that people with disabilities do not have a sex life. This of course is not true as people with disabilities have the same reproductive rights and sexual desires as the rest of the population. The misconception that people with disabilities never engage in sexual activities and therefore are HIV and AIDS free can put them at greater risk of contracting the disease than other people, as unprotected sex with a person with a disability is considered safe.

Agriculture is the backbone of the Zimbabwean economy. Thus the negative impact of HIV and AIDS on this sector is of great concern. Evidence is accumulating that HIV and AIDS is affecting both commercial and subsistence agricultural productivity in Zimbabwe as the workforce is affected by illness, death and absence due to illness and attending funerals. Kwaramba (1997) and Zimbabwe Farmers Union (2000) reported a 50% reduction in smallholder production.

HIV and AIDS pose serious threats not only to nutrition, but also to food security in general. Studies of HIV and AIDS affected households have shown a fall in the

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average income (52% to 67%). Smallholder agriculture impact studies revealed a decline in cultivated acreage for the year 1997/98 due to reasons related to HIV and AIDS, loss of essential human skill, general shortage of labour, lack of essential resources, draught power (livestock being sold to buy drugs, take care of the sick or in the upkeep of their surviving dependants) and farm implements. The food security crisis in Zimbabwe these previous years, besides being attributed to droughts, has through study findings, also been attributed to HIV and AIDS, because of its widespread impact in the agricultural sector.

The Education Sector has not been spared either by the HIV and AIDS epidemic especially because it caters for the young people. An estimated 30% of learners is likely to be infected during or soon after completing their school career, and most of them are likely to die of AIDS-related illnesses before they turn 40 years of age (Mupawaenda and Murimba, 2002). While the impact on society is disastrous, and the level of wastage in economic terms staggering considering the investment made, the impacts are likely to be felt by the education system itself much earlier on. The loss of teachers, learners, growing number of orphans and children with special needs, high stress and anxiety levels, fatalism and other psycho-social problems are already responsible for system inefficiencies. This factor has an impact that far exceeds that attributable to any other causes. As all stakeholders increasingly become aware that they are labouring in vain, the resultant frustration could induce further inefficiency.

Evidence is available in Zimbabwe that primary school enrolments have been declining since 1996 to 1998. This is attributed to a number of factors, including HIV and AIDS and the impact of Structural Adjustment Programmes. With regards to HIV and AIDS, a significant proportion of children will not reach school going age because they die (due to vertical HIV transmission) in infancy and childhood. Some are orphaned and unable to pay fees and meet other school requisites; others caring for sick parents. Infected and affected pupils exhibit erratic school attendance and are less likely to concentrate in class, and thereby tending to have lower attainment in school. With parents and providers succumbing to the disease, many children especially girls have had to quit school owing to lack of school fees. This is believed to be a major reason for the high dropout rates both in primary and secondary schools.

The impact of HIV and AIDS in this sector manifests in teachers' absence from duty due to ill health or attending funerals. This affects the quality of education. Furthermore, the presence of a sick or dying teacher induces stress among teachers and learners alike. The process of replacement of sick or late teachers often takes a long time and it is a very costly process to the responsible Ministry of Education.

HIV and AIDS affects the health sector by increasing ill health and death among service providers at all levels, and also by increasing demand on service provision as more people become sick. Ratios of about 1 nurse to 20 hospitalised patients were reported in three district hospitals yet the WHO recommended ration is 1:10. The situation has been made worse by the mass exodus of nursing staff to other countries in recent years due to the worsening economic situation. The MOHCW estimates that the health sector needs 1400 nurses and 2500 more doctors to be effective. The rising number of HIV and AIDS cases has had a number of serious consequences for health care expenditures. First health care expenditure is increasing rapidly as a proportion of total government spending, leaving fewer resources for non-medical spending. Secondary care of HIV and

AIDS patients has been consuming an increasing share of the total national health budget, leaving fewer resources for other health needs.

HIV and AIDS induced morbidity has increased, and hospitals are failing to cope with the increased number of patients. HIV and AIDS infected patients occupy 50 to 80% of all beds in hospitals, resulting in an acute shortage of drugs. HIV and AIDS have also led to an epidemic of tuberculosis, the leading cause of death in AIDS patients in Sub-Saharan Africa. The shortage of foreign currency in the country has made it difficult for procurement of drugs. Some patients who unfortunately could have had a good chance of survival die as a result.

Those on home based care have to contend with lack of skills and other resources. Many people are dying at home with minimal support to ease there suffering and stressing the carers.

Because of the immense burden and challenges facing the health delivery system, there has been a deliberate shift to home-based care and hospices for the terminally ill patients. Those patients who are released to hospices and nursing homes have to deal with the same drug and equipment shortages. Those on home-based care have to contend with lack of skills and other resources. Many people are dying at home with minimal support to ease their suffering and stress on their carers.

The Public Service is a major employer in most countries, with a specific mandate to provide quality service through a responsive, skilled and professional workplace that will meet the expectations of the public it serves. The public service provides security, collection of revenue, maintenance of law and order. HIV and AIDS in the public sector has become known to worsen inefficiencies coupled with increased spending due to absenteeism, occupational benefits and other numerous costs. Records from the Public Service Commission show that the period from 1 January 2000 to 30 September 2003, 46 employees died, 29 were retired on medical grounds, whilst 200 were granted indefinite sick leave and 100 others attended funerals in the same period. The total amount of leave days between the same period was 1694.

The debilitation of the security forces due to HIV and AIDS compromises national security.

Uniformed forces form the basis of a country's defence and constitute the underpinning of stability both within states and between them. The debilitation of the security forces due to HIV and AIDS compromises national security. Worldwide evidence shows that military personnel are considered a high-risk group for both infection and transmission due specifically to their age group and their deployment policies. In countries where the virus has been present for more than ten years, armed forces report HIV and AIDS infection rates figures between 40 and 80%. It was also shown in a comparative study which covered Botswana, Kenya, Malawi, Tanzania, Uganda, Zambia and Zimbabwe that 75% of soldiers were dying from AIDS within one year of discharge.

The capacity of the ZRP to deliver its mandate of maintaining law and order in the country is being severely undermined by HIV and AIDS as members succumb to the disease

The capacity of the Zimbabwe Republic Police (ZRP) to deliver its mandate of maintaining law and order in the country is being severely undermined by HIV and AIDS as members succumb to the disease. Statistics from the force revealed that during the year 2000 up to September 2003, approximated 1356 officers died, 1241 of which were male. Morbidity is on the increase amongst the experienced and skilled personnel, and replacement of this staff is reported to be an uphill task. The authorities are resorting to re-introduction of the six months training programme for officers in place of the previously employed one-year training. The depletion of manpower has compromised the delivery of service by the force, thereby putting at stake the security of communities in greater need of protection from the increasing criminal elements due to poverty and a lot of delinquents who have been orphaned by AIDS.

A study carried out in 2003 showed massive overcrowding in Zimbabwe's prisons, and results from another study (1999-2001) had earlier on revealed that up to 1050 AIDS-related deaths had occurred in the prisons, the deaths averaging 330 people annually.

The effect of HIV and AIDS on business in the MSMEs is in the form of absenteeism and death, leading to loss of skills. Absenteeism and reduced productivity are reportedly on the increase due to protracted illness of workers and funeral attendance. In MSMEs, the impact of HIV and AIDS is much more visible because the business owner/entrepreneur is often the skills base, so when she/he dies the enterprise folds up.

Evidence in Zimbabwe, suggests that illness and mortality are on the increase and the loss of employees was projected to increase threefold by 2003. The loss in work time and increases in staff turnover in the country is concentrated in the 30-45 year age group, resulting in a shift to younger and less experienced workers, leading to an increase in staff replacement costs.

The Medical aid insurance schemes have not also been spared from the impact of HIV and AIDS

The life insurance sector has high vulnerability levels owing to its high level of skills and increased claims. Sources of savings and investment like insurance and private savings schemes have been adversely affected before adequate accumulation of contributions. Indirect costs to companies include increase in life assurance and pension fund claims as well as increased demands on medical schemes.

The Mining sector is characterized by a high level of migration, overcrowding, alcoholism, purchasing of commercial sex, sexually transmitted diseases, lung diseases and TB related to increased HIV risk. The economic depression in Zimbabwe has seen the closure of many mines living the population unemployed and redundant. This redundancy has resulted in vulnerability due to sex networking for survival.

Since the Transport sector plays an important role in a country's socio-economic development, the impact of the HIV and AIDS pandemic on this sector has far-reaching implications. The sector is particularly prone to HIV and AIDS due to the personnel's high mobility, which exposes them to opportunities for sexual activities with different partners and so increase risk of infection. Border towns, entry and exit points for cross-border commercial truck drivers and cross-border traders are also high HIV and AIDS risk areas owing to high mobility and transactional sex occurring in these areas.

Overall, HIV and AIDS has negatively affected life expectancy, infant mortality rates, child mortality rates and crude death rates.

An analysis for the ZHDR, 2003 showed that in Zimbabwe, Human Development has declined by 12% from 0.507 in 1995 to 0.444 in 2000. Overall, HIV and AIDS has negatively affected life expectancy, infant mortality rates, child mortality rates and crude death rates. The scourge has also impacted negatively on health, education, as well as a host of other critical public and private sectors whose well-being is instrumental to socio-economic development of Zimbabwe.

Conclusions, Challenges and Recommendations

In the light of the impacts and implications of HIV and AIDS on the demographic, economic, social and developmental aspects of general human development, the recommendations below have been made to ensure a sustainable response mechanism to the scourge.

a) Mainstreaming HIV and AIDS in all sectors-training of workers in public, private and informal sector in HIV and AIDS, as well as integrating HIV and AIDS issues into all schools, technical and academic colleges' curricula.
b) Investment in treatment of opportunistic infections and Antiretrovirals - a higher investment on ARVs would lower expenditures on funerals, companies could retain more of their trained and skilled staff though infected, and fewer children would also be orphaned as more parents live to take care of their families.
c) Provision of support and care for vulnerable children, particularly orphans - girl children need to be encouraged to stay in schools, and also need to be protected from abuse emanating from their vulnerability. There is need to immediately provide care, counselling and support to the infected and affected students and teachers, and to link the pupils to social welfare and health services.
d) Continuous review of salaries and working conditions - vulnerability to HIV and AIDS is shown in the report to be exacerbated by the harsh economic climate. There is need for companies and organisations to continuously review human resource needs, salaries and working conditions as well as provision of care and support to staff and their families in cases of being infected or affected by HIV and AIDS
e) Ensuring that Tourism Benefits Local Communities' Development - so as to avoid transactional sex rampant in border towns due to poverty
f) Provision of financial and technical support and information to MSMEs - so as to reduce mobility and to improve availability of services and materials.
g) Provision of Continued Support for Prisoners - need to provide sex education, control of STIs, care and counselling support adequate health services to inmates. Ex-prisoners also need support for successful re-integration into society

Responses: A Living Challenge

Globally the response to HIV and AIDS seems to follow the same pattern: denial, complacency or a laissez faire attitude, followed by panic, and finally acceptance

Globally the response to HIV and AIDS seems to follow the same pattern: denial, complacency or a *laissez faire* attitude, followed by panic, and finally acceptance. Time spent on each stage depends on a complex mix of culture, access to scientific knowledge and politics. It is also clear the current HIV and AIDS crisis is a result of 'backlash of complacency'. In other words those countries that stayed too long in the complacency stage are likely to have a worse epidemic than those whose complacency stage was shorter.

The denial/complacency/laissez faire stage- was attributable to a number of factors

1. HIV was first discovered among marginalized groups - gay men, drug addicts and ethnic minorities (Haitians in the USA) making 'mainstream society' think that it was an isolated illness.

2. In the Third World HIV spread through heterosexual sex in a context where people do not talk publicly about sex
3. The belief that a conclusion would soon be found due to advances in science.

The panic stage - is seen in HIV being declared as an emergency but the problem with panic is that it can create paralysis especially when people feel overwhelmed by the problem at hand. The acceptance stage - has seen governments and people accepting the reality of HIV and AIDS and taking steps to understand people's lived realities and doing something to end HIV and AIDS. This is marred, sometimes, by the donor push where externally conceived programs are used without taking cognizance of the local lived realities leading to different countries having similar programs.

Generally, Zimbabwe's national response has been described by many as slow, weak and selective. While strategically we have a multisectoral response, on the ground the approach is largely biomedical. That is, HIV and AIDS are seen a problem to be solved largely by the health sector. The HIV virus is seen as an asocial bug so that the focus is on its impact on the body and not what behaviours, social situations and socioeconomic circumstances lead to it entering the body in the first place and rectifying these. In addition, officially there are sectoral differences in the response. There is complacency in some sectors, panic or acceptance in others. Overall the approach is a one-size-fit-all approach with no regard for nationwide differences in vulnerability to HIV.

While strategically we have a multisectoral response, on the ground the approach is largely biomedical

Historically, the reaction was more to use all medical and scientific knowledge to stem the tide of HIV and AIDS. Hence the National Blood Transfusion Services was among the first to screen blood for HIV to prevent healthcare based infections. Later a 'health experts' advisory committee was formed to give advice on HIV and AIDS; followed by a 1 year Short Term Plan (STP) later criticized for being to short a period to effectively prevent HIV. The Medium Term Plan 1 (MTP1) from 1989 -1993 and MTP2 1994 -1999 replaced it. The two sought to prevent HIV and AIDS through an Information, Education and Communication (IEC) approach, Psycho-social care and support for the affected and infected and community care for the sick, surveillance of the virus, STI treatments and improving laboratory equipment for effective testing of the virus. Finally, biomedical (epidemiological, clinical and behavioural) research on HIV and AIDS received emphasis. Both MTPs lacked clarity and specificity on who did what, how and when. Although a National AIDS Control Program (NACP) had been put in place, evaluations done by a joint donor-government team in 1993 showed that it lacked personnel to implement its mandate and that HIV was still seen as a health sector problem. There was limited political support and leadership to the HIV and AIDS struggle. In addition despite the formation of the Zimbabwe AIDS Network (ZAN) in 1990 to coordinate the NGO response, some NGOs did not want to work with it. These issues still persist to date. Thus, effective coordination of the national response falls short of expectations while non-governmental initiatives largely continue uncoordinated and responsive to their donors.

The National AIDS Council (NAC) was formed in 1999. Its mandate is to coordinate all HIV and AIDS prevention, mitigation, care and support. It is largely locally funded. Its board is multisectoral including people living with AIDS (PLWAs). Since January 2000, an AIDS levy was instituted at 3% of individual income for people employed in the formal sector. Since then a National AIDS Trust Fund (NATF) has been created and it has accumulated millions of dollars (in USD)

some of which is yet to be used owing to low capacities of districts and ward structures that should be using this money. Historically, these structures participate in policy making but not in policy implementation and resource allocation. There have been unconfirmed reports of abuse/misuse of the fund at local level as a result. Because of the stigma of HIV and AIDS, people at the local level cannot target the fund to intended users nor do all intended users claim assistance from it.

Based on (Strength, Weaknesses, Opportunities and Threats) SWOT analysis of the country, the Strategic Framework for a national response (2000-2004) document was formulated to guide the national response. Among others it acknowledged that before 2000
the response was slow and fragmented and it did not cover the whole country. The framework decried the persistence of stigma which limits the effectiveness of programs. There is limited visibility of political and civil society leaders fighting against HIV and AIDS. Civil society organizations respond more to their funders and their programs are subject to funding cycles rather than problems on the ground. In terms of what drives the epidemic the document notes the increasing and deepening poverty and lukewarm responses to it and lack of comprehensive support for the informal sector thereby weakening people's responses to HIV and AIDS.

The government responded commendably through the AIDS levy

The document also decries donor dependency to which the government responded commendably through the AIDS levy although it is still surrounded with a lot of controversy on the ground. Furthermore the document highlights that HIV and AIDS are national problems which are textured by age and gender. Youths are generally more vulnerable, but female youths are five times more likely to be infected with the virus than their male counterparts because of physiological makeup and socio-economic inequality. These vulnerabilities also apply to older women. However, despite a comprehensive situation analysis, the document is silent on methodologies of implementing these strategic concerns nor does it say anything about possible impediments to the implementation of the strategy and how they could be overcome. For instance, the private-public partnership has been a pipe dream or a case of too little too late as will be discussed later. Relations with many western donors have changed drastically thereby threatening the already weak coordination efforts.

One of these is the question of confidentiality, which makes HIV technically a non-notifiable disease unlike other STIs.

The National AIDS Policy document notes that although HIV is largely sexually transmitted its spread belies complex socio-cultural practices, norms and beliefs. One of these is the question of confidentiality, which makes HIV technically a non-notifiable disease unlike other STIs. It notes the need for continued debate on this matter taking cognizance of the rights of patients/clients and health professionals. It notes too the need for all citizens, including children and prisoners to be informed about HIV and AIDS and STIs. However some of these issues remain a pipe dream.

The focus in the Information Education and Communication (IEC) strategy is on the ABC (Abstinence, Being faithful, Condom) use. This is a globally adopted strategy. Fieldwork reveals that this strategy is selectively understood on the ground. While abstinence is widely accepted by people of different ages and creeds, it leaves many questions unanswered. Implicitly in refers to abstinence from penetrative vaginal sex without mentioning the penetration of other orifices. Youths also expressed concern over the need to be sexually experienced which abstinence does not allow. Some youths also noted that abstinence is manipulated by young

women to attract marriageable young men while they have sex with older men for money and gifts. Being faithful is compromised by high mobility of people making partners to live away from each other for extended periods of time. As for the use of condoms a number of issues have to be dealt with namely: that condoms are associated with promiscuity and STIs, they are seen as indecent for married people making some married men in extramarital affairs risk their lives through unsafe sex, in sex for money/gifts relations the giver of gifts determines the use of condoms by the type of gift or amount of money s/he is willing to pay for sex, people erroneously use visual assessments of the person to determine whether the use of condoms is necessary or not and in established relations if the pattern was uncondomised sex it has been noted that initiating condom use is difficult. In short, in marriages condoms are rejected by both men and women. Lastly, there is the low image of free condoms distributed by many NGOs and government outlets. The IEC strategy spread through the media is urban biased because rural areas lack billboards, radio reception or batteries to receive radio and television messages, newspapers and magazines.

Assumptions of the Voluntary Testing and Counselling (VCTs) strategy are that if people know their status and are well counselled they are likely to want to protect themselves from (re)infection and in so doing protect others and curb the spread of HIV. However, it has been noted that there are very few VCTs in the country and their coverage is very selective. Anecdotal evidence has shown that people are reluctant to go for testing because of the fact that there is no cure for AIDS. Most of the VCTs are in urban centres yet the most badly hit areas are outlying areas such as border towns and mining and commercial farming areas. Demographically, towns are home to 30% of the population who are served by these urban-based VCTs. This remains inadequate. Urgent efforts should be made to increase rural people's access to these facilities. Furthermore, there are indications that the counselling sessions are at the moment one-off sessions, when ideally people need more thorough going counselling to help people go through the whole cycle of emotions associated with an HIV positive diagnosis.

Due to stigma, more work need s to be done to educate people on this program beyond expectant women so that there is adequate community support for the choices the women make to prevent their children from being infected.

The Prevention of Parent-to-Child-Transmission (PPTCT) of HIV program is currently running on drugs donated by manufacturers of Nevirapine. The program has been rolled out rather slowly on account of staff shortages and high staff turnovers. Due to stigma, more work needs to be done to educate people on this program beyond expectant women so that there is adequate community support for the choices the women make to prevent their children from being infected. Experiences from some mission hospitals show that community awareness campaigns help to destigmatise HIV.

There have been other responses including the state of emergency declaration according to which antiretroviral (ARVs) can be imported at low tariffs until December 2008 when the declaration expires. On the legal front, there have been laws such as the Sexual Offenses Act which criminalizes 'wilful transmission' of HIV and the recruitment of children into commercial sex among others. However, this particular law has been criticized for being reactive rather than proactive, it does not prevent infection but punishes the person who infects or exposes one to infection. In any case, given the stigma of HIV and its confidentiality, it is hard for individuals in consensual sexual relationships to sue for wilful transmission because this assumes that they can get evidence that their partners were aware of their status.

In the private sectors emphasis has been placed on condom use and distribution. In some estates commercial sex workers were used as peer educators, but this isolated married women and girls because husbands/ fathers feared that their wives and daughters were going to be recruited into prostitution.

The media has been a vehicle for communication HIV and AIDS's rampage hence the media is a strategic ally in the fight against HIV and AIDS.

The Private sector response has been varied depending on perceptions of threat from the epidemic. The transport sector (haulage companies and the railways) and commercial farmers (companies and individual farmers) were among the first to respond because the threat of the HIV virus was arguably worse in those sectors for a variety of factors. In the private sectors emphasis has been placed on condom use and distribution. In some estates commercial sex workers were used as peer educators, but this isolated married women and girls because husbands/ fathers feared that their wives and daughters were going to be recruited into prostitution. Studies also show that married women who engage in cross border trade also used sex with long distance truck drivers for free passage of their goods and that despite the talk of condoms drivers did not use condoms with these women as condoms were said to reduce the status of married women. For all other sectors, the Zimbabwe Business Council on AIDS (ZBCA) was formed in conjunction with NAC belatedly at the end of 2002 with a call on all business to analyze the impact of AIDS on their industries.

The media has been a vehicle for communication of HIV and AIDS's rampage hence the media is a strategic ally in the fight against HIV and AIDS. However, journalists do not shy away from sensationalism to sell their products and HIV and AIDS has not been spared. By referring to AIDS deaths as deaths due to 'short illnesses' or cancer the media has perpetuated HIV and AIDS stigma. In addition some media organizations have reported on AIDS in a manner that seeks to 'out' or shame the sick or dead. HIV positive diagnoses have been used in political smear campaigns reported in all spectra of the media. HIV stigma is perpetuated.

Civil society's responses include all non-government initiated activities even though funding might come from government or donors. It also includes faith, sport, culture or locale based activities as well as professional NGOs. The NGOs have been doing a lot of work on HIV and AIDS although it has been observed that NGO responses have not been well coordinated**.** Several women's organizations have been involved in access to treatment activism' especially the widespread availability of the PPTCT program. A review of the ZAN directory shows that most NGOs are urban based and work in urban areas and their immediate environs. Some NGOs are run by entrepreneurs who are answerable to no one and do not include communities they work with in planning their work. There is also a problem of 'turfing' areas of work. Rural areas on the other and are dominated by faith based organization run on shoe string budgets, by volunteers pushed to HIV and AIDS work by faith. Studies show that many faith-based organizations (especially churches) are not keen on condom promotion. The faith-based response is driven by mission hospitals which among other things also run home based care programs, PPTCT programs and so on. This is undesirable in view of the fact that these areas are generally treated as shock absorbers of all economic problems in the country. That is even the urban-based sick, eventually retire to the poorly endowed rural areas to be cared for.

Traditional healers have also responded to HIV in many different ways including offering alternative healing. Practices of mass witch hunting which swept the country in 2000 are however dangerous and retrogressive for HIV and AIDS prevention as they leave people without livestock and therefore more vulnerable to the disease.

Community based responses have been driven largely by women as people living with HIV and AIDS or as affected individuals. They have done so by forming

Community based responses have been driven largely by women as people living with HIV and AIDS or as affected individuals

AIDS Service Organizations (ASOs), Home Based Care (HBC) groups, peer educator programs and so on. It was generally noted that many HBC programs ran into problems because they have to deal with burnout and work without requisite resources, equipment, professional support and remuneration. In addition, women are at the forefront as care givers for affected children and also volunteer in community orphan care initiatives where they exist.

There have been efforts to mobilize people living with HIV and AIDS to help destigmatise them along the same lines as The AIDS Support Organization (TASO) of Uganda and many others in the US and elsewhere. Many individuals came out and openly talked about their HIV and AIDS status in a bid to destigmatise HIV and AIDS. However, the network of people living with HIV and AIDS has met a number of snags and has had to reorganize. Meanwhile the stigma of HIV and AIDS marches on.

In terms of youth programs, a number of problems still persist namely the alienation of youths in the economy and politics leading them to while away time in substance abuse for boys and early sex for girls

In terms of youth programs, a number of problems still persist namely the alienation of youths in the economy and politics leading them to while away time in substance abuse for boys and early sex for girls. Out of school youth are particularly affected here. In-school youth on the other hand have been fortunate because many institutions have HIV and AIDS programs in their institutions. The University of Zimbabwe for instance has the Sustainability, Hope, Action and Prevention Education (SHAPE) program which works by emphasis behaviour change by looking at predisposing, enabling and reinforcing factors in behaviour change. It seeks to train university students in forms of recreation that exclude alcohol and sex such as sports and music production. The project has been criticized for being more oriented towards the affluent students because it plays music genres that are closer to these youths than the less affluent.

The international community has generally been at the forefront of the battle against HIV and AIDS through giving aid and conferences which have sought and obtained commitments of different international players to fight poverty, HIV and AIDS among other problems

The international community has generally been at the forefront of the battle against. However, it is not possible to combat HIV and AIDS without supporting the development agenda. In the case of Zimbabwe, funding for development *per se* has been withdrawn as protest against land reform and results of parliamentary and presidential elections. Without getting involved in the merits and demerits of this carrot and stick system, we can say that this has deepened the developmental challenges thereby fueling the HIV and AIDS pandemic. In the case of Zimbabwe, donors continue to view HIV and AIDS as a stand alone problem and hence channel funds to HIV and AIDS program run by NGOs and selected CBOs. The focus is still care, support and mitigation and not development.

Conclusions, Challenges and Recommendations

Redirecting the response

Although the best practices are not being used as prescriptions, they show that it is not only good policies that deliver a turn around in HIV and AIDS but acting immediately, using a multisectoral approach where all sectors (religions, government, the private sector, communities, NGOs and funding agencies) participate in formulating situation specific responses within the parameters of the national response strategies. The challenge is to design a broader national response reflecting a balance between the biomedical and development aspects of HIV and AIDS. Addressing socio-economic vulnerabilities becomes the cornerstone to combating the epidemic. In this respect, a systematic approach to addressing the gender and youth specific vulnerabilities remains a challenge for the national response. It is therefore recommended that we need to act swiftly to recommit ourselves to a more effective and well coordinated response by reactivating NAC's mandate and obliging all players to accept NAC's guidance and leadership. Interventions for vulnerable groups should be revisited with a view to removing age and gender based vulnerabilities and going beyond information and awareness.


Poverty
Reduction
Forum


IDS


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Statistical Annex

Table A1:Zimbabwe Human Development Index by Province, Sex and Urban Rural, 1995 and 2001

Table A1.1: Human Development Index 1995, Total

Province	Life expectancy at birth (years) 1995	Adult literacy rate (%) 1995	Average years of schooling (%) 1995	Mean income (PPP US$) 1995	Mean income (Z$) 1995	Life expectancy index 1995	Adult literacy index 1995
Bulawayo	52.4	95.4	7.2	1 485	3 252	0.457	0.954
Harare	51.6	96.0	8.1	2 106	4 613	0.443	0.960
Matabeleland South	53.8	81.8	5.3	798	1 747	0.480	0.818
Matabeleland North	53.1	78.6	4.9	689	1 508	0.468	0.786
Midlands	53.7	85.6	5.6	918	2 010	0.478	0.856
Mashonaland East	50.6	85.4	5.5	617	1 351	0.427	0.854
Mashonaland West	49.8	81.7	5.1	751	1 645	0.413	0.817
Manicaland	46.7	85.1	5.0	550	1 205	0.362	0.851
Masvingo	48.7	83.7	5.1	699	1 531	0.395	0.837
Mashonaland Central	48.5	75.0	4.9	841	1 841	0.392	0.750
Zimbabwe	**51.8**	**86.0**	**5.6**	**987**	**2 162**	**0.447**	**0.860**

Table A1.1: Human Development Index 1995, Total (continued)

Province	Average years of schooling index 1995	Education index 1995	Income index 1995	HDI value 1995
Bulawayo	0.449	0.785	0.450	0.564
Harare	0.504	0.808	0.509	0.587
Matabeleland South	0.329	0.655	0.347	0.494
Matabeleland North	0.306	0.626	0.322	0.472
Midlands	0.348	0.686	0.370	0.512
Mashonaland East	0.341	0.683	0.304	0.471
Mashonaland West	0.319	0.651	0.337	0.467
Manicaland	0.310	0.671	0.285	0.439
Masvingo	0.316	0.663	0.325	0.461
Mashonaland Central	0.308	0.603	0.355	0.450
Zimbabwe	**0.353**	**0.691**	**0.382**	**0.507**

Table A1.4: Human Development Index 2001, Total

Province	Life expectancy at birth (years) 2001	Adult literacy rate (%) 2001	Average years of schooling (%) 2001	Mean income (PPP US$) 2001	Mean income (Z$) 2001	Life expectancy index 2001	Adult literacy index 2001
Bulawayo	41.2	97.0	8.7	1421	192360	0.270	0.970
Harare	39.4	97.3	9.1	1519	205548	0.240	0.973
Matabeleland South	37.4	86.1	6.5	1240	167784	0.207	0.861
Matabeleland North	37.2	83.2	6.6	1121	151776	0.203	0.832
Midlands	36.7	87.9	6.9	811	109728	0.195	0.879
Mashonaland East	36.1	87.4	6.8	699	94536	0.185	0.874
Mashonaland West	36.7	86.6	7.1	633	85728	0.195	0.866
Manicaland	33.8	88.2	6.8	792	107172	0.147	0.882
Masvingo	35	84.4	6.7	802	108600	0.167	0.844
Mashonaland Central	35.1	80.2	6.6	861	116544	0.168	0.802
Zimbabwe	**38.2**	**88.1**	**7.2**	**948**	**128340**	**0.220**	**0.881**

Table A1.4: Human Development Index 2001, Total (continued)

Province	Average years of schooling index 2001	Education index 2001	Income index 2001	HDI value 2001
Bulawayo	0.542	0.827	0.443	0.513
Harare	0.571	0.839	0.454	0.511
Matabeleland South	0.405	0.709	0.420	0.445
Matabeleland North	0.413	0.692	0.403	0.433
Midlands	0.433	0.730	0.349	0.425
Mashonaland East	0.426	0.725	0.324	0.411
Mashonaland West	0.446	0.726	0.308	0.410
Manicaland	0.424	0.729	0.345	0.407
Masvingo	0.418	0.702	0.348	0.406
Mashonaland Central	0.411	0.672	0.359	0.400
Zimbabwe	**0.450**	**0.737**	**0.375**	**0.444**

Table A1.5: Human Development Index by Urban and Rural Areas, Zimbabwe 2001

	Life expectancy at birth (years)	Adult literacy rate (%)	Average years of schooling (%)	Mean income (PPP US$)	Mean income (Z$)	Life expectancy index	Adult literacy index
Zimbabwe Urban	40.6	96.6	8.7	1 283	173 616	0.260	0.966
Zimbabwe Rural	35.5	83.2	6.4	614	83 064	0.175	0.832

Table A1.5: Human Development Index by Urban and Rural Areas, Zimbabwe 2001 (continued)

	Average years of schooling index	Education index	Income index	HDI value
Zimbabwe Urban	0.543	0.825	0.426	0.504
Zimbabwe Rural	0.397	0.687	0.303	0.388

Table A2: Zimbabwe Human Poverty Index by Provinces 1995 and 2001

Table A2.1: Human Poverty by Provinces, Zimbabwe, 1995

Province	% in a cohort not surving to 40 years 1995 P1	Adult illiteracy rate % 1995 P2	Under weight children under five years % 1995 P32	Population without access to safe water % 1995 P31	Population without access to health care % 1995 P33	Living Standard Deprivation % 1995 P3	Human poverty index (HPI) value % 1995
Bulawayo	30	6.4	4.0	0.1	14.0	6.0	20.9
Harare	32	6.0	10.7	1.5	7.3	6.5	22.3
Matabeleland South	30	22.0	6.8	28.8	6.3	14.0	23.8
Matabeleland North	26	26.3	9.1	23.9	8.8	13.9	23.4
Midlands	29	18.5	11.0	31.4	9.9	17.4	22.9
Mashonaland East	31	20.1	16.3	41.4	7.0	21.6	25.2
Mashonaland West	33	24.6	17.6	22.6	11.2	17.1	26.5
Manicaland	26	24.8	11.7	30.0	9.3	17.0	23.2
Masvingo	21	24.2	23.2	31.8	3.1	19.4	21.7
Mashonaland Central	31	33.0	16.9	28.4	9.6	18.3	28.8
Zimbabwe Total	**31**	**19.6**	**13.3**	**23.4**	**8.8**	**15.2**	**23.9**

Table A2.2: Human Poverty Index by Provinces, Zimbabwe,2001

Province	% in a cohort not surving to 40 years 2001 P1	Adult illiteracy rate % 2001 P2	Under weight children under five years % 1999 P32	Population without access to safe water % 2001 P31	Population without access to health care % 2001 P33	Living Standard Deprivation % 2001 P3	Human poverty index (HPI) Value % 2001
Bulawayo	34	3.1	8.1	0.0	14.1	7.4	23.7
Harare	37	2.7	5.8	0.4	7.7	4.6	25.7
Matabeleland South	35	14.0	15.3	10.3	2.5	9.3	24.9
Matabeleland North	49	16.8	18.9	13.3	3.9	12.0	34.6
Midlands	40	12.1	9.9	14.6	5.6	10.0	28.1
Mashonaland East	41	12.6	15.2	11.4	5.3	10.7	28.9
Mashonaland West	47	13.4	16.7	7.4	4.5	9.5	32.9
Manicaland	43	11.8	16.3	12.0	3.8	10.7	30.2
Masvingo	27	15.6	11.3	20.4	2.5	11.4	20.3
Mashonaland Central	42	19.8	17.4	6.0	5.3	9.5	30.2
Zimbabwe Total	**41**	**12.0**	**13.0**	**10.4**	**5.1**	**9.5**	**28.8**

Table A2.2: Human Poverty Index by Provinces, Zimbabwe, 2001 (continued)

	% in a cohort not surving to 40 years 2001 P1	Adult illiteracy rate % 2001 P2	Under weight children under five years % 1999 P32	Population without access to safe water % 2001 P31	Population without access to health care % 2001 P33	Living Standard Deprivation % 2001 P3	Human poverty index (HPI) Value % 2001
Zimbabwe Urban	38	0.0	7.5	0.1	6.3	7.3	26.4
Zimbabwe Rural	44	16.9	15.6	15.0	4.1	8.8	31.1

Table A2.3: Percentage Change in Human Poverty Index Components by Provinces , Zimbabwe 1995 and 2001

Province	% in a cohort not surving to 40 years P1	Adult illiteracy rate % P2	Under weight children under five years % P32	Population without access to safe water % P31	Population without access to health care % P33	Living Standard Deprivation % P3	Human poverty index (HPI) Value %
Bulawayo	13	-52	103	-100	1	23	13
Harare	16	-54	-46	-77	6	-29	15
Matabeleland South	17	-37	125	-64	-60	-33	5
Matabeleland North	88	-36	108	-44	-56	-14	48
Midlands	38	-35	-10	-53	-44	-42	23
Mashonaland East	32	-37	-7	-72	-24	-51	15
Mashonaland West	42	-45	-5	-67	-60	-44	24
Manicaland	65	-52	39	-60	-60	-37	30
Masvingo	29	-36	-51	-36	-20	-41	-7
Mashonaland Central	35	-40	3	-79	-45	-48	5
Zimbabwe Total	**41**	**-39**	**-2**	**-55**	**-43**	**-37**	**21**

Table 4.1:Gender empowerment measure by provinces, Zimbabwe, 1995

Province	GEM (value) 1995	Mean income			
		females Z$ 1995	males (PPPUS$) 1995	females 1995	males 1995
Bulawayo	0.434	2 995	3 501	1 368	1 599
Harare	0.469	4 431	4 784	2 023	2 184
Matabeleland South	0.422	1 496	2 016	683	920
Matabeleland North	0.287	1 324	1 710	605	781
Midlands	0.441	1 868	2 156	853	985
Mashonaland East	0.405	1 280	1 431	585	654
Mashonaland West	0.453	1 532	1 758	699	803
Manicaland	0.381	1 064	1 356	486	619
Masvingo	0.383	1 366	1 710	624	781
Mashonaland Central	0.446	1 764	1 922	805	878
Zimbabwe	**0.429**	**2 012**	**2 316**	**919**	**1 058**

Table 4.1: Gender empowerment measure by provinces, Zimbabwe, 1995 (continued)

Province	Parliamentary Representation (% female) 1995	Administration and managerial positions 1995	Professional and technical positions 1995	Population 1995	Economically active 1992
Bulawayo	12.5	30.6	29.7	0.51	0.35
Harare	15.8	29.6	28.5	0.50	0.31
Matabeleland South	12.5	29.6	33.5	0.54	0.34
Matabeleland North	0.0	24.0	43.3	0.52	0.41
Midlands	12.5	27.6	46.7	0.53	0.44
Mashonaland East	8.3	31.5	47.2	0.54	0.45
Mashonaland West	16.7	23.8	34.4	0.52	0.35
Manicaland	7.1	26.9	47.9	0.53	0.44
Masvingo	7.1	28.2	46.8	0.54	0.43
Mashonaland Central	10.0	38.3	44.8	0.51	0.43
Zimbabwe	**10.8**	**29.7**	**40.8**	**0.52**	**0.39**

Table 4.1: Gender empowerment measure by provinces, Zimbabwe, 1995 (continued)

Province	Equally distributed indices			
	Parliamentary representation 1995	Administration and managerial positions 1995	Professional and technical positions 1995	Mean income 1995
Bulawayo	21.552	42.146	41.422	0.034
Harare	26.607	41.677	40.755	0.050
Matabeleland South	20.637	40.359	43.409	0.017
Matabeleland North	0.000	35.737	48.840	0.014
Midlands	20.933	38.919	49.586	0.020
Mashonaland East	14.270	41.914	49.621	0.013
Mashonaland West	27.100	35.527	44.576	0.016
Manicaland	12.546	38.267	49.786	0.011
Masvingo	12.344	39.130	49.542	0.015
Mashonaland Central	17.717	47.042	49.357	0.019
Zimbabwe	**18.681**	**41.091**	**47.954**	**0.022**

Table 4.1: Gender empowerment measure by provinces, Zimbabwe, 1995 (continued)

Province	Indexing Parliamentary representation 1995	Legislators, Senior Officials and Managers positions 1995	Professional and technical positions 1995
Bulawayo	0.431	0.843	0.828
Harare	0.532	0.834	0.815
Matabeleland South	0.413	0.807	0.868
Matabeleland North	0.000	0.715	0.977
Midlands	0.419	0.778	0.992
Mashonaland East	0.285	0.838	0.992
Mashonaland West	0.542	0.711	0.892
Manicaland	0.251	0.765	0.996
Masvingo	0.247	0.783	0.991
Mashonaland Central	0.354	0.941	0.987
Zimbabwe	0.374	0.822	0.959

Table 4.1: Gender empowerment measure by provinces, Zimbabwe, 1995 (continued)

Province	Female income index	Male income index	Combined female and male indexes	GEM rank 1995
Bulawayo	0.032	0.038	0.836	5
Harare	0.048	0.052	0.824	1
Matabeleland South	0.015	0.021	0.838	6
Matabeleland North	0.013	0.017	0.846	10
Midlands	0.019	0.022	0.885	4
Mashonaland East	0.012	0.014	0.915	7
Mashonaland West	0.015	0.018	0.801	2
Manicaland	0.010	0.013	0.881	9
Masvingo	0.013	0.017	0.887	8
Mashonaland Central	0.018	0.019	0.964	3
Zimbabwe	**0.021**	**0.024**	**0.890**	

Table 4.2: Gender empowerment measure by provinces, Zimbabwe, 2001

Province	GEM (value) 2001	Mean income			
		females Z$ 2001	males (PPPUS$) 2001	females 2001	males 2001
Bulawayo	0.465	150 214	238 417	1 110	1 762
Harare	0.478	138 792	272 575	1 026	2 014
Matabeleland South	0.453	175 036	159 729	1 293	1 180
Matabeleland North	..	171 406	130 715	1 266	966
Midlands	0.414	101 912	118 186	753	873
Mashonaland East	0.391	89 382	100 024	660	739
Mashonaland West	..	66 678	104 974	493	776
Manicaland	0.324	117 097	96 248	865	711
Masvingo	0.338	94 460	124 718	698	922
Mashonaland Central	0.359	126 266	106 454	933	787
Zimbabwe	**0.419**	**122 161**	**134 927**	**903**	**997**

Table 4.2: Gender empowerment measure by provinces, Zimbabwe, 2001 (continued)

Province	Parliamentary representation (% female) 2001	Legislators, Senior Officials and Managers 2001	Professional and technical positions 2001	Population 2001	Economically active 2001
Bulawayo	12.5	34.9	41.5	0.51	0.33
Harare	15.8	27.6	37.8	0.50	0.34
Matabeleland South	12.5	33.3	43.7	0.54	0.56
Matabeleland North	14.3	..	39.4	0.51	0.50
Midlands	12.5	25.0	31.9	0.52	0.51
Mashonaland East	8.3	27.3	39.3	0.52	0.52
Mashonaland West	16.7	..	20.7	0.50	0.43
Manicaland	7.1	17.4	31.6	0.53	0.53
Masvingo	7.1	20.0	34.3	0.54	0.56
Mashonaland Central	10.0	16.7	31.4	0.51	0.48
Zimbabwe	**11.7**	**27.0**	**34.8**	**0.52**	**0.48**

Table 4.2: Gender empowerment measure by provinces, Zimbabwe, 2001 (continued)

Province	Equally distributed indices		
	Parliamentary representation 2001	**Legislators, Senior Officials and Managers positions** 2001	**Professional and technical positions** 2001
Bulawayo	21.447	45.046	48.344
Harare	26.677	40.003	47.057
Matabeleland South	20.555	43.209	48.681
Matabeleland North	24.033	..	47.489
Midlands	21.334	36.877	42.923
Mashonaland East	14.780	38.952	47.297
Mashonaland West	27.689	..	32.726
Manicaland	12.678	27.754	42.348
Masvingo	12.460	30.615	44.035
Mashonaland Central	17.789	27.511	42.822
Zimbabwe	**20.046**	**38.736**	**44.845**

Table 4.2: Gender empowerment measure by provinces, Zimbabwe, 2001 (continued)

Province	Indexing	
	parliamentary representation 2001	**Legislators, Senior Officials and Managers positions** 2001
Bulawayo	0.429	0.901
Harare	0.534	0.800
Matabeleland South	0.411	0.864
Matabeleland North	0.481	..
Midlands	0.427	0.738
Mashonaland East	0.296	0.779
Mashonaland West	0.554	..
Manicaland	0.254	0.555
Masvingo	0.249	0.612
Mashonaland Central	0.356	0.550
Zimbabwe	**0.401**	**0.775**

Table 4.2: Gender empowerment measure by provinces, Zimbabwe, 2001 (continued)

Province	female income index 2001	male income index 2001	Combined female and male income index 2001	GEM rank 2001
Bulawayo	0.025	0.042	0.934	1
Harare	0.023	0.048	0.871	2
Matabeleland South	0.030	0.027	0.919	3
Matabeleland North	0.029	0.022	..	..
Midlands	0.016	0.019	0.798	4
Mashonaland East	0.014	0.016	0.862	5
Mashonaland West	0.010	0.017	..	..
Manicaland	0.019	0.015	0.701	8
Masvingo	0.015	0.021	0.746	7
Mashonaland Central	0.021	0.017	0.703	6
Zimbabwe	0.020	0.022	0.836	

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