

2008 National Youth Shadow Report

Progress Made on the 2001 UNGASS
Declaration of Commitment on HIV/AIDS



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Preface¹

In just two years, the world will evaluate ten years of work toward “Universal Access by 2010” to HIV and AIDS prevention, care and treatment. While progress has been made in several areas of the AIDS response, the targets laid out so ambitiously for youth in the 2001 Declaration of Commitment on HIV/AIDS (DoC) will be unmet by drastic margins; indeed, 7 years later, few governments even bother to collect data specifically on youth.

Globally, 1.7 billion young people aged 10-24 make up one quarter of the world’s population. Approximately 40% of all new HIV infections occur among young people between 15-24 years of age,² and there are 5.4 million young people living with HIV.³ Young people are the face of HIV. We are at higher risk of HIV infection because we lack access to the crucial information, education, and services to protect ourselves. However, our needs are often ignored when data is collected and strategies on HIV and AIDS are drafted, policies developed, and budgets allocated. Successful programs often lose funding as interests shift toward other, less controversial topics, or young leaders “age out” and others with similar potential are not empowered. This is especially tragic, because we, as young people, are statistically more likely than adults to adopt and maintain safe behaviors.⁴

Ignoring us in policies, programs, and resource allocation is a main contributing reason to the further spread of the HIV epidemic. Our particular vulnerability to HIV infection draws attention to societal inequities that few want to speak of, let alone address, such as sexual violence, injecting drug use, same-sex relationships, and sex work. Evidence clearly displays that the longer governments, stakeholders and health care providers continue to ignore the unpleasant realities faced by many young people, the more our peers and siblings will be infected with HIV.

In June 2001, heads of State and government representatives convened for the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). At the first UNGASS on HIV/AIDS, 189 countries signed the Declaration of Commitments (DoC) as a pledge to halt and begin to reverse the spread of the AIDS epidemic through international, regional and country-level partnerships and with the support of civil society. Progress is measured through intermittent reviews.

Despite DoC commitments to work in full partnership with youth, governments still treat us as beneficiaries of programmes and services rather than crucial stakeholders and key actors in achieving the DoC targets and goals.⁵ The impact of this exclusionary attitude will manifest shortly in a lack of leadership and an even greater shortage of health care workers. As we come of age to adulthood, we must be trained and empowered today as a cadre of young leaders.

The DoC states that by 2005, at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 will have access to the information, education, skills and services to protect themselves from HIV infection. **However, as of 2007, only 40% of young men**

Notably, the DoC recognizes young people’s higher risk to HIV infection and established time-bound targets for action:

- (Paragraph 37) By 2003, ensure the development and implementation of multi-sectoral national strategies and financing plans for combating HIV/AIDS that (...) involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people (...)
- (Paragraph 47) By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal: to reduce, by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent.
 - To reduce, by 2010, HIV prevalence among young men and women aged 15-24 globally.
 - To intensify efforts to achieve these targets as well as to challenge gender stereotypes, attitudes, and inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys.
- (Paragraph 53) By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV/AIDS education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, in full partnership with young persons, parents, families, educators and health-care providers.
 - Expanding good-quality, youth-friendly information and sexual health education and counseling services;
 - Strengthening reproductive and sexual health programs; and
 - Involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programs.

¹ Adapted from GYCA and Global Youth Partners, “Our Voice, Our Future: Young People Report on Progress Made on the UNGASS Declaration of Commitment on HIV/AIDS.” UNFPA, 2005. <http://www.youthaidscoalition.org/resources.html>

² UNAIDS (2007) AIDS epidemic update: Core slides: Global Summary of the HIV and AIDS epidemic. UNAIDS, Geneva. http://www.unaids.org/en/KnowledgeCentre/HIVData/Epidemiology/epi_slides.asp

³ UNAIDS (2007) AIDS Epidemic Update

⁴ UNICEF/UNAIDS/WHO (2004) Young People and HIV/AIDS, Opportunity in Crisis. UNICEF, UNAIDS & WHO, 2004.

and 36% of young women had accurate HIV knowledge on transmission and prevention.⁶

The needs of young people are not homogenous or universal. Young people are mothers, students and sex workers. They are injection drug users and prison inmates. Young people have varying sexualities, lifestyles and definitions of the family. Young people living with HIV are studying, working, having sex and planning families. Young advocates are best positioned to design policies and programs that are most relevant and effective at addressing our varying needs.

Methodology

With only two years left to achieve the UNGASS goals and targets, young people are actively participating in the tracking and reporting of UNGASS commitments. In 2008, these young people have produced 10 UNGASS Youth Shadow Reports to present at the UNGASS, in its seven-year review. Young researchers from Egypt, Jamaica, Viet Nam, Nepal, India, Kenya, Zimbabwe, Senegal, Nigeria and the United States of America tracked and monitored progress on the UNGASS commitments to young people in their own countries and made recommendations for moving forward. Their research, findings and analysis will set the tone for needs and priorities that must be taken into account during the high level meetings. On 10-11 June 2008, 30 young leaders will advocate to decision-makers by sharing knowledge of their country's national response and identifying major gaps and barriers to success.

Since 2005 GYCA has facilitated the production of 34 UNGASS National Youth Shadow Reports.⁷ GYCA members from 17 countries volunteered to research and produce shadow reports, and assembled national teams of young people from various networks to take part. For several of researchers, this report was the first of such an undertaking. Seven reports address findings at the community level, and will be available shortly on GYCA's website. Researchers used a range of methods to conduct their research and collect relevant information. They gathered inputs from young people, including young people living with HIV (YPLHIV) in their countries through focus group discussions, in-depth interviews and workshops.

Young people were asked to make recommendations for strategies to ensure that their country would meet the UNGASS targets for young people. This qualitative information was supplemented by reviews of national policies, laws and documents, as well as academic literature. Young people also consulted representatives from national and local governments and national AIDS programs when available, as well as various stakeholders such as service providers, representatives from NGOs, international and bilateral organizations. The final reports were reviewed and edited by GYCA staff, preserving original content, tone, and perspectives as much as possible.

A guide was developed by young people with the technical assistance of adult allies to assist youth researchers in gathering information and reporting on their country's progress.⁸ A number of questions, based on the indicators suggested by the UNAIDS National AIDS Programs - A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programs for young people,⁹ were suggested to guide their research. Data collection and analysis focused on four main areas:

- 1) Political Commitment
- 2) Financial Commitment
- 3) Access to Information Services
- 4) Youth Participation

Country's progress on collecting youth-specific, disaggregated data was also evaluated. This report details the findings of the young researchers, and their recommendations and vision for the way to move forward.

⁶ UNGASS (2008). Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to Millenium Development Goal.

⁷ The first twelve reports were compiled into GYCA & GYP's "Our Voice, Our Future", UNFPA 2005. In 2006, six independent reports were produced, and in 2008, this report is one of 17- 10 national reports and 7 community level reports.

⁸ The research guide is available upon request, and is loosely based on UNDESA's 2004 "Making Commitments Matter: A toolkit for young people to evaluate national youth policy."

⁹ UNAIDS (2004) National AIDS Programs - A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programs for young people.

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About the Global Youth Coalition on HIV/AIDS (GYCA)

GYCA is a youth-led global network of over 4,000 young leaders and adult allies fighting the spread of HIV and AIDS in over 150 countries worldwide. GYCA, supported by UNFPA and UNAIDS, was established in 2004 and is based in New York and Accra, Ghana. GYCA empowers young leaders with the knowledge, skills, opportunities and resources they need to be effective agents of change in their communities. For more information please visit <http://www.youthaidscoalition.org>, or write to info@youthaidscoalition.org.

Portrait of Zimbabwe in Numbers	
Total Adult Population (15-49)	12,000,000 ¹⁰
Estimated total population living with HIV	1,320,739 ¹¹
Estimated adult population (15-49) living with HIV	1,085,671
HIV prevalence among adults (15-49)	9%- 15.6% ¹² *
Population of young people	5,100,000 ¹³
Percentage of young people living with HIV (15-24)	13.1% ¹⁴ (not disaggregated by age or gender)
Literacy among young people (15-24)	98% M, 98% F ¹⁵
Percentage of schools that provided life skills-based HIV education in the last academic year	100% ¹⁶
Percentage of young women and men aged 15-24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	45.6% M, 43.7% F ¹⁷
Percentage of young women and men aged 15-24 years who had sexual intercourse before the age of 15.	4.5% M, 5.3% F ¹⁸
Percentage of women and men (15-49 years) who have been tested and received their HIV results in the 12 months prior to survey conducted in 2006.	6.6% M and 6.6% F ¹⁹
Percentage of adults and children with advanced HIV infection receiving ART.	38% ²⁰
Government expenditure on HIV and AIDS	US \$86,256,000 ²¹
Number of physicians per 100, 000	16 ²²

*Please note that the report Zimbabwe submitted to UNAIDS in 2008 contains statistical errors such as the percentage given for the adult HIV prevalence(15.6%)

I. Introduction

HIV and Young People in Zimbabwe

In Zimbabwe roughly one person becomes infected every three minutes.²³ The country lies within the Southern African region with the highest HIV prevalence rates in the world. According to UNAIDS (2005), an estimated 11.4 million people are living with HIV in nine countries of Southern Africa, one of which is Zimbabwe. This means that almost 30% of all people living with

¹⁰ Zimbabwe UNGASS 2008 Country Report

http://data.unaids.org/pub/Report/2008/zimbabwe_2008_country_progress_report_en.pdf

¹¹ Zimbabwe UNGASS 2008 Country report

¹² Zimbabwe UNGASS 2008 Country report's data seem to be inaccurate. The given number of adults living with HIV is 9% of the total adult population, not 15.6% as claimed in the report submitted to UNAIDS. The 15.6% figure is most likely accurate, with the number of adults living with HIV an underestimation.

¹³ Population Reference Bureau (2006) Zimbabwe. <http://www.prb.org/Countries/zimbabwe.aspx>

¹⁴ Zimbabwe UNGASS 2008 Country report (data from National Survey of HIV and Syphilis Prevalence Among Women Attending Antenatal Clinics in Zimbabwe, 2006)

¹⁵ UNICEF, http://www.unicef.org/infobycountry/zimbabwe_statistics.html

¹⁶ Zimbabwe UNGASS 2008 Country Report (data from Ministry of Education Sports and Culture. Department of Policy and Planning)

¹⁷ Zimbabwe UNGASS 2008 Country Report (data from Zimbabwean Demographic Health Survey (DHS) 2005/2006))

¹⁸ Zimbabwe UNGASS 2008 Country Report (data from ZDHS2005/2006)

¹⁹ Zimbabwe UNGASS 2008 Country Report ((data from Ministry of Health and Child Welfare Programme)

²⁰ Zimbabwe UNGASS 2008 Country Progress Report (data from Ministry of Health and Child Welfare Programme)

²¹ Zimbabwe UNGASS 2008 Country Progress Report (data from Government of Zimbabwe, Ministry of Finance, Budget Estimates for 2007)

²² UNDP. Human Development Report (2007/2008) <http://hdrstats.undp.org/indicators/58.html>

²³ World Health Organisation (2005), 'Zimbabwe country profile for HIV/AIDS treatment scale up, http://www.who.int/hiv/HIVCP_ZWE.pdf

HIV globally reside in an area inhabited by only 2% of the world's population. In Zimbabwe, more than half of all new infections occur among young people, especially girls.²⁴

In 2002, President Robert Mugabe declared HIV and AIDS a national emergency. Notably, by 2007, Zimbabwe reported a decline in overall HIV prevalence in the adult population ages 15-49 from an estimated 24.6% in 2003 to an estimated 9-15.6%.²⁵ Nonetheless, the average life expectancy for women, who are particularly affected by Zimbabwe's AIDS epidemic, is 34 years old - the lowest anywhere in the world.²⁶ HIV prevalence of young women below the age of 20 was reported to be five times higher than their male counterparts.²⁷ Surveys have found that women as young as 12 years are engaging in sex work with very mobile populations who are statistically more likely to be infected with HIV in country with a generalized epidemic.²⁸

With increasing political conflict and economic decline, Zimbabwe has become isolated from the international aid community.²⁹ Zimbabwe is currently experiencing historic civil unrest due to a power struggle between two rival political candidates for President. The rate of hyperinflation as of March 2008 was 355,000%;³⁰ with global food and energy costs soaring, and opposition voters experiencing brutal intimidation by the incumbent President Robert Mugabe. Over 4 million Zimbabweans have fled to neighboring countries as refugees, and HIV is just one of the dire concerns for a people facing starvation, violence, unemployment, and disease. The international community has isolated Zimbabwe due to violent government repression of citizens, and allegations of a fraudulent election. Conflict exacerbates the causes of high rates of HIV infection in the region— sexual violence, low rates of condom use, multiple sexual partnerships, gender inequality, and low coverage of health services amongst others.

Young people account for most new HIV infections in Zimbabwe, and an estimated 13% of young people ages 15-24 years are living with HIV, one of the highest in the world.³¹ The situation is compounded by a lack of translation of knowledge on how to prevent HIV infection into action.³² According to the National Behaviour Change Strategy (NCBS) what needs to be addressed are issues related to perceptions of one's level of risk of infection, sex between older men and younger women, and multiple sexual partners that expose young people to HIV.³³

Methodology

The report was researched through a literature review at local resource centers and online research. Documents that were reviewed include government reports, key policies, United Nations reports, strategic plans of key sector ministries among others.

Key Findings and Recommendations

- There is still a serious lack of disaggregated data on young people by age, gender, subpopulation and location. Young people should be involved in the data collection process as

²⁴ UNICEF (2008) 'Humanitarian Action Report: Zimbabwe.'

www.unicef.org/har08/files/har08_Zimbabwe_countrychapter.pdf

²⁵ Ministry of Health and Child Welfare, Zimbabwe National HIV Estimates (2007), see 2008 UNGASS Zimbabwe http://data.unaids.org/pub/Report/2008/zimbabwe_2008_country_progress_report_en.pdf

²⁶ World Health Organisation (2006), 'The World Health Report 2006'

²⁷ DHS Survey, (2006-2007) <http://www.measuredhs.com/pubs/pdf/HF19/HF19.pdf>

²⁸ Zimbabwe UNGASS 2008 Country report

²⁹ AVERT (2008) 'HIV and AIDS in Zimbabwe.' <http://www.avert.org/aids-zimbabwe.htm>

³⁰ Economist (May 16, 2008) Billionaires' Woe: Hyperinflation in Zimbabwe.

http://www.economist.com/displaystory.cfm?story_id=11378439

³¹ National AIDS Council et al (2004) The HIV and AIDS Epidemic in Zimbabwe: Background Projections, Impacts and Future Response, National AIDS Council, Ministry of Health and USAID, Harare, Zimbabwe

³² National AIDS Council et al (2004)

³³ National AIDS Council (2006) et al Zimbabwe National HIV and AIDS Strategic Plan 2006-2010, National AIDS Council, Ministry of Health and UNAIDS

researchers and contributors to collect accurate and representative data that conveys their realities.

- Zimbabwe is the first country in Southern Africa to achieve a decline in rates of HIV infection. Condom use has increased among young people and incidence of new infections has declined.³⁴
- Zimbabwe is far from universal access to antiretroviral therapy (ART), 38% of PLHIV (ages 15-49) accessing ART.³⁵ However, access is increasing with limited funding from external donors. At the end of 2007, an estimated 102, 566 people in urgent need of ART.
- Voluntary testing and counseling requires parental consent until 16 years. Laws around parental consent greatly decrease the chances of young people seeking health care due to fear of stigma, violence and discrimination at times even within their households.
- There are a higher number of orphans in proportion to its population than any other country in the world. Most of these cases are a result of parents dying from AIDS.³⁶ Policies must include the needs of young people who are caretakers.
- Teachers do not prioritize sex education. Students reported that because sex education is not evaluated on standardized exams that teachers neglect to include lessons.

Key UNGASS Indicators that Affect Youth

In the 2008 UNGASS country report, Zimbabwe did not collect data on all the key UNGASS indicators targeting young people and instead focused mainly on children and adults in general. Because young people make up such a large percentage of new HIV infections in Zimbabwe, it is crucial that the government track trends and behaviours among young 15-24 year old men and women specifically in order to understand what type of action is appropriate and how much funding to invest. There is no data on condom use amongst young people. Zimbabwe also failed to report on the critical indicator that looks at the percentage of most- at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. This is of particular concern since many young women as young as 12 years old engage in transactional sex. In the future, the government and other partners need to invest in research that examines these vulnerable populations.

³⁴ Population Service International (2007) 'Zimbabwe first region to see HIV decline.'
www.psi.org/resources/pubs/zimbabwe-hiv.pdf

³⁵ Zimbabwe UNGASS 2008 Country Progress Report

³⁶ Association of Zimbabwe Journalists (19th November 2006), 'Zim has Highest Orphan Rate: UN Official', accessed from AVERT (see above)

II. Political Commitment

The Zimbabwean government has proven its commitment through a succession of initiatives and National HIV and AIDS Strategic Plans (ZNASP) since 1987. Its main purpose is to support HIV prevention efforts and care for those with HIV. However, the lack of real policies addressing young people and HIV is a contributing factor to the high rates of HIV amongst 15-24 year olds. As part of a national testing campaign, 10 parliamentarians agreed to take a public test along with a number of celebrities taking public tests on soap operas to combat the exceedingly low rate of people accessing HIV testing nationwide.³⁷

The National Youth Policy lays out as one of its key objectives to reduce the spread of STIs and HIV among youth. However, the Ministry of Education does not allow condoms in schools with a policy that restricts lessons to abstinence-only education,³⁸ an approach that has been scientifically proven to be ineffective compared to comprehensive education including condoms, partner reduction, behavior change and life skills.

The Zimbabwe National Behaviour Change Strategy (2006-2010)³⁹ mentions the word young people 36 times but in all these instances participation of young people in the development of policies or programmes are not explicitly mentioned. In fact, the policy is largely prescriptive assessing various behaviour change strategies where youth are mostly viewed as targets rather than involved stakeholders. The National Youth Policy⁴⁰ highlights HIV as one of the major challenges faced by youth. The policy evidently looks at varied developmental issues that affect young people and is thus not comprehensive in relation to the unique challenges related to the HIV and AIDS and the role that young people should play. One survey respondent, a student intern at the National AIDS Council pointed out that the policy seems to be 'more of a desk overview' and not 'a policy with recommendations and detailed structures for implementers to adopt'.⁴¹

The National AIDS Council (NAC) has spearheaded the formation Young People's Network on HIV and AIDS which is a multisectoral platform that brings young people together to advise the National Partnership Forum on HIV and AIDS issues particular to youth.

A National Partnership Forum composed of the general public, civil society, private sector, United Nations (UN) and the donor community was established to enhance coordination.

Recommendations

What seems to be a major gap in Zimbabwean policy formulation is the lack of youth participation in policy design, implementation and evaluation. Given the high prevalence rates among youth, clearly current interventions are not adequate. Evidence shows that policies and programs with designed involvement of young people are more relevant and successful at reaching this age group. Furthermore, many young Zimbabweans are already active in the AIDS response and are implementing effective interventions at the community level. They must have access to capacity building opportunities and funding in order to ensure that there is an adequate cadre of new leaders to handle the increasing burden of AIDS on the country. However, the Zimbabwe National Youth Policy does not emphasize the importance of youth participation adequately, and young people continue to be largely overlooked.

³⁷ See 2008 UNGASS Country report

³⁸ See 2008 UNGASS Country Report

³⁹ Government of Zimbabwe (2006) Zimbabwe National Behaviour Change Strategy, Government of Zimbabwe and National AIDS Council, Harare, Zimbabwe

⁴⁰ Government of Zimbabwe (2000) National Youth Policy, Government of Zimbabwe and the Ministry of Youth, Gender and Employment Creation, Harare, Zimbabwe

⁴¹ Interview with a Third Year University Student doing an internship with the National AIDS Council in Zimbabwe

While young people are mentioned in numerous policies, the Zimbabwean government must mainstream youth issues and youth participation into the work of ministries and agencies taking part in the national AIDS response. Policies so far have not been adequately implemented. The Zimbabwean Youth Council should be integrated into this process front and center with strategic assistance from the Zimbabwean Network of People Living with HIV/AIDS.

III. Financial Commitment

In the Zimbabwean situation, there is a severe lack of adequate resources to fully implement and review policies that have been put in place by various stakeholders and with the support of international agencies. The political and economic crisis that Zimbabwe is facing renders local financial resources insignificant due to a runaway inflation rate of over 355, 000 percent.⁴² The international resources made available to Zimbabwe have been so highly politicized to the point of discouraging donors to continue giving. In fact the Zimbabwe Human Development Report points out that the donor response to HIV and AIDS in Zimbabwe have been partial and selective; non-governmental programs often run parallel to government programmes because donors are not happy with the Zimbabwean government.⁴³

Before the political and economic crisis in Zimbabwe showed its early signs in early 2000, Zimbabwe and South Africa were the only countries in Southern Africa who were able to fulfill their commitment made at an historic HIV/AIDS Summit in Abuja in April 2001 to allocate 15 per cent of government expenditure to health.⁴⁴ In fact, the level of health expenditure in Zimbabwe had always ranked very high relative to its economic ranking based on its per capita income.

The situation has changed drastically over the years in a context of hyperinflation, balance of payment deficits, unplanned land reform which has resulted in the destruction of the agricultural sector, industry and exports. Public hospitals which used to be the envy of Southern Africa now have very few doctors and nurses and are unable to retain current health care workers due to low wages. To add to this the hospitals lack basic and essential medical supplies.

Young people bear a disproportionate burden of the country's political and economic woes, and are more likely to be unemployed, involved in political violence including sexual violence, and to increase their risk-taking behaviors in periods of uncertainty and deprivation.

Financial allocations to any key ministry are not clearly tracked or designated. The reserve bank in Zimbabwe engages in what has been referred to as "quasi-fiscal policies." The bank has been accused of printing more and more money whenever required by the government, fueling the soaring hyperinflation rates. Nonetheless, the government has continued to provide resources to the health sector and the HIV and AIDS response. The government introduced the National AIDS Trust Fund (NATF) a 3% levy collected from taxable income from all sectors to mitigate the impact of HIV and AIDS and is channeled to NAC by the Ministry of Finance.

In an efforts to streamline coordination between ministries and agencies that have in the past failed to communicate effectively and often duplicate each other's programs or compete for resources, the government has developed a strategic plan to better engage the private sector in the national response. In addition to the above mechanisms, the Ministry of Health and Child

⁴² Economist (May 16, 2008) Billionaires' Woe: Hyperinflation in Zimbabwe.
http://www.economist.com/displaystory.cfm?story_id=11378439

⁴³ Poverty Reduction Forum et al (2003) The Zimbabwe Human Development Report 2003: Redirecting Our Responses to HIV and AIDS, Harare, Zimbabwe

⁴⁴ H.G. Martin (2003) 'A Comprehensive Analysis of the Financing of HIV/AIDS Programmes in Botswana, Lesotho, Mozambique, South Africa and Zimbabwe' WK Kellogg Foundation, United Kingdom.

Welfare has provided leadership in coordinating the Global Fund grant (2006-2008) through the Country Coordinating Mechanism, which is co-chaired by the World Health Organization.⁴⁵

As of 2007, the Expanded Support on Health Programs (ESP) funded by a consortium of European bilateral agencies⁴⁶ committed over US \$60 million for prevention, care, treatment and mitigation of impact for two years. Through this initiative and with government support, 38% of adults needing treatment accessed ART.⁴⁷

Gaps and Recommendations

- As far as budget allocations specifically designated for young programming and interventions, there is no accessible data. The lack of data represents neglect in prioritizing government funds to Zimbabwean youth.
- One interviewee also pointed out that much of the major donor funds in HIV and AIDS such as the Expanded Support Programme and the Global Fund has a mechanism of granting funds for research only to established sub- recipients. Therefore, funding goes to large organizations that are successful in social marketing campaigns, but often fail to reach young people effectively, and are not necessarily interested in meaningfully involving young people. Such funds are usually inaccessible by youth-led or community-level interventions which may be newly established and may not have grant writing expertise, but could also be much more effective at reaching marginalized populations than large social marketing campaigns.
- The private sector in Zimbabwe lags behind in terms of engagement with young people.

IV. Access to information and services

General information on HIV and AIDS issues is widely available in Zimbabwe; however; the Government points out that knowledge of HIV and AIDS issues is not always comprehensive. Among young people, only 43.7% women (15-24 years) and 45.6% men (15-24 years) had comprehensive knowledge of primary ways of transmission and rejected major misconceptions.⁴⁸ This is less than half way toward the 2010 UNGASS target Zimbabwe committed to, of 95% of young people.

There are some NGOs conducting sex education programs in schools. However, the fact that HIV education is not assessed on exams resulted in teachers not taking the subject seriously and often using the time allocated to this for other subjects, according to some students.⁴⁹ For out-of school youth, activities such as peer education and media programs attempt to strengthen integration of the many young people not in school.⁵⁰

The number of stand-alone testing and counseling sites and health clinics offering testing has increased from 395 sites in 2005, 547 in 2006 to 649 at the end of 2007.⁵¹ Unfortunately, these numbers do not indicate whether testing sites are in rural or urban areas. While no data can be found on young people specifically, only 6.6% women and 6.6% men (15-49 years) had been tested and received their HIV results in the 12 months prior to survey conducted in 2006.⁵²

⁴⁵ National AIDS Council (2006) et al Zimbabwe National HIV and AIDS Strategic Plan 2006-2010, National AIDS Council, Ministry of Health and UNAIDS

⁴⁶ Namely CIDA, DFID, Norweign Aid, Irish AID and SIDA

⁴⁷ UNGASS 2008 Country Progress Report

⁴⁸ UNGASS 2008 Country Progress Report

⁴⁹ Based on a conversation with a high school Guidance and Counselling Teacher in Manicaland Province in a Secondary School in Zimbabwe

⁵⁰ UNGASS 2008 Country Progress Report

⁵¹ Interview with Lower Sixth Students at a Secondary School in Mashonaland East in Zimbabwe

⁵² UNGASS 2008 Country Progress Report

Zimbabwean guidelines require young people under 16 to obtain parental consent before getting tested.⁵³ Such laws serve as a major barrier for accessing testing, since young people rarely want their parents to know that they are having sex at a young age and may opt to continue having unprotected sex rather than disclose this information. Notably, young people interviewed indicated that the network of Population Services International (PSI) New Start Centres provided youth friendly and confidential voluntary counseling and testing services that young people can access.⁵⁴

Distribution of condoms by the public sector is done through the Zimbabwe National Family Planning Council (ZNFPC). ZNFPC distributed 980,560 female condoms and 55,567,000 male condoms in 2006 only. In the private social marketing sector, Population Services International (PSI) is responsible for condom distribution. PSI distributed 455,566 female condoms, which quadrupled to 1,806,760 by 2007. Male condom distribution increased from 7,593 930 in 2001 to 48,134,700 in 2007.⁵⁵ The figures indicate high availability of condoms in Zimbabwe for young people.

Young people interviewed indicated that they prefer socially marketed branded condoms, which they perceive to be safer as compared to the free condoms distributed by government. They also indicated that the PSI condoms were affordable.

Recommendations

- Expand quality services to peri-urban, farming and rural communities of Zimbabwe. Post-test support services for people living with HIV (PLHIV) have also been developed but they still have an urban bias.⁵⁶
- Incorporate sex education curricula into standardized tests or otherwise evaluate sex education programs in school for quality and comprehensiveness.

V. Young People's Participation

A key strategic document by the National AIDS Council looks at where we are and where we are headed but does not talk about participation of young people, only the interventions targeted at young people.⁵⁷ There is no clear inclusion of youth at the national level. In fact, most of the data that has been collected through the ZNFPC is only project specific.⁵⁸

As a nation Zimbabwe is yet to refine and broaden youth messages so that they focus on the realities of youth sexuality and empower us for positive lifestyles and cater for all ages in both urban and rural areas. There is a need to involve youth in developing programmes concerning their sexuality because they best understand their own realities.⁵⁹

VI. Overall Recommendations for Action

- Revise, implement and evaluate the Zimbabwe National Youth Policy through full participation of young people with expertise in HIV/AIDS, and invest adequate political and economic

⁵³ Zimbabwe National Guidelines on Testing and Counselling (2005)

http://www.who.int/hiv/topics/vct/ZIM_HIVTesting%20Guidelines%20Oct2005.pdf

⁵⁴ Interview with a Third Year University Student doing an internship with the National AIDS Council in Zimbabwe

⁵⁵ UNGASS 2008 Country Progress Report

⁵⁶ Poverty Reduction Forum et al (2003) The Zimbabwe Human Development Report 2003: Redirecting Our Responses to HIV and AIDS, Harare, Zimbabwe

⁵⁷ National AIDS Council et al (2004) The HIV and AIDS Epidemic in Zimbabwe: Background Projections, Impacts and Future Response, National AIDS Council, Ministry of Health and USAID, Harare, Zimbabwe

⁵⁸ Interview with a Third Year University Student doing an internship with the National AIDS Council in Zimbabwe

⁵⁹ Poverty Reduction Forum et al (2003) The Zimbabwe Human Development Report 2003: Redirecting Our Responses to HIV and AIDS

support from government, intergovernmental and non-governmental institutions active in Zimbabwe.

- Collect data disaggregated by age, gender and subgroup, including 10-14 and 15-24 age groups.
- Ensure consistency and synergy between the Youth Policy with the National Population Policy, the National HIV/AIDS Policy, the Reproductive Health Policy and other complementary policies.
- Promote the National Behaviour Change Strategy 2006-2010 and the Zimbabwe National HIV and AIDS Strategic Plan 2006-2010 as a strategy to inform strategic and operational plans of various organizations that implement youth programmes.
- Allocate adequate resources to youth and HIV issues by the Ministry of Youth, Gender and Employment.
- The Zimbabwe AIDS Network and the Southern Africa HIV and AIDS Information Dissemination Service should provide technical assistance and capacity building trainings to youth organizations.
- The Zimbabwe National Youth Council should lead in the creation of a multi-sectoral platform for young people. A concerted and coordinated effort is required by government, non-government, and private institutions, churches, youth groups and community organizations to address youth issues in a comprehensive way.
- Governmental, non-governmental and intergovernmental sectors must cultivate opportunities for more political advocacy and capacity building for young people.
- The Ministry of Education must incorporate comprehensive and evidence-based sex education material into standardized curricula and tests.

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