Zimbabwe[1]

Children are our future and when we lose them we are virtually losing the future.[cxi]

The fight against HIV/AIDS can only be successful in a democratic context.[cxii]

9.1. Introduction

Zimbabwe is currently experiencing one of the worst HIV/AIDS epidemics in the region, only second to Botswana. At the same time, Zimbabwe is experiencing a serious humanitarian crisis which has several complex and interlinked challenges in addition to HIV/AIDS, such as poverty, food shortages largely associated with recurrent droughts and floods, an overburdened health system, the deteriorating economy and high levels of inflation, brain drain and unemployment. For instance, a SADC Food, Agriculture and Natural Resources Vulnerability Assessment Committee reported that the number of people in Zimbabwe requiring food aid rose from 6.7 million in 2001 to 7.2 million in 2002 (amounting to 62% of the population) and that national grain production in 2001/2002 was 65% less than average production for the past five years (SADC, 2002). This humanitarian crisis is occurring within a fast deteriorating socio-economic context where perennial poverty undermines the ability of the country to adopt and sustain HIV/AIDS intervention and economic developmental programmes – a vicious cycle demanding a two-edged planning and implementation approach. The extent to which Zimbabwe will be able to break this cycle of suffering will depend on the development planning approaches taken and the degree to which such plans are effectively implemented. Clearly, what is required is effective mainstreaming of HIV/AIDS into all humanitarian programmes and development planning. Yet, as this chapter will demonstrate, development planning in Zimbabwe has largely become a fire-fighting exercise aimed at addressing the most immediate problems exerting the most threatening political pressure.

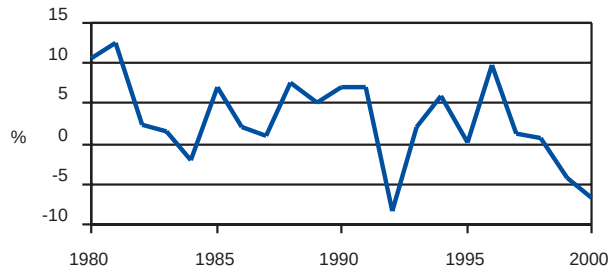
9.2. Overview of development trends since 1980

Zimbabwe has very limited systematic national data on most indicators of interest that are meant to inform this overview of development trends in the country. For instance, Zimbabwe does not have information even on national HIV prevalence levels since there is no system in place for the production of such estimates. Different institutions also use different estimates for the same indicators within the same period of time. Furthermore, within the current economic and political context certain indicators have become politically sensitive and there is politicisation of particular estimates. An effort has been made to draw most of the data reflected in this section from national documents. This has been complemented by data from other sources besides government documents in order to come up with some semblance of trends (see Appendix 2 for the Country Profile of Zimbabwe and relevant references).

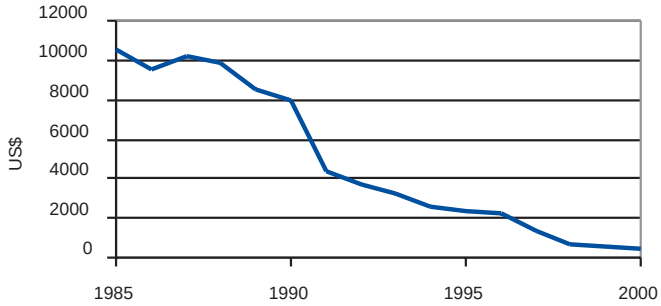
Demographic trends

In the 1980s and early 1990s, the population of Zimbabwe increased rapidly from an estimated 7.5 million in 1982 to 10.4 million in 1992. This correlates with a population growth rate of 3.1% during this period. During the mid-1990s, however, the population growth rate slowed down and by the turn of the century there was even evidence that the population started to decline. Whereas in 1997 the total population had increased to 11.8 million, by 2002 it had declined to 11.6 million people. Between 1992 and 2002, the average population growth rate was 1.1% (Central Statistical Office, 2003a). The increase in Zimbabwe's population during the 1980s was largely due to improved health status combined with high fertility rates. The subsequent reduced growth rate is the result of a combination of declining fertility and increasing mortality largely due to HIV/AIDS. For instance, fertility declined from a total fertility rate of just below seven (6.9) children in 1984 to four children in 2002 (CSO, 1994 and 2003a). This has largely been attributed to the increasing use of contraceptives. For example, while in 1984 about 27% of married women aged between 15-49 years used contraceptives, this

Graph 9.1. GDP growth (%) in Zimbabwe, 1980-2000



Graph 9.2. GNI per capita in Zimbabwe, 1985-2000



proportion increased to 36% in 1988, 42% in 1994 and about 50% in 1999.

The population is fairly gender balanced with women comprising 51% of the population in 1982 and 1992. This proportion increased slightly to 52% in 1997. Zimbabwe is still predominantly a rural country, although the proportion of the population living in urban areas has increased significantly during the past 15 years. For instance, in 1982 one in four Zimbabweans (26%) lived in urban areas, compared to one in three (34%) in 1997. This is comparable to the average for sub-Saharan Africa.[cxiii] In absolute numbers, it means that the urban population has more than doubled from an estimated 1.9 million in 1982 to 4 million in 1997. With a projected annual urban growth rate of 2.8% between 2000 and 2015, urbanisation in Zimbabwe is expected to be below the average of 3.5% for Africa as a whole (UN-Habitat, 2003).

Economic performance and structure of the economy

As Graph 9.1 shows, economic growth in Zimbabwe has fluctuated sharply during the past two decades. This growth is greatly influenced by the variations in agricultural output, which has been affected by recurrent droughts and floods. For instance, the 1991/92 drought resulted in a steep decline in the growth rate from 7.1% in 1991 to a negative rate of 8.4% in 1992. Subsequently, the economy showed some improvement reaching a GDP growth rate of 5.8% in 1994, after which it fell again to 0.2% in 1995. Again, this was largely due to the 1995 drought. In 1996, positive growth of about 9.7% was recorded. This increase was attributed to the good agricultural output, which increased by about 19.4%, and also good performance in tourism and the manufacturing sector, which grew by 6.8% and 4.8% respectively (Government of Zimbabwe, 2001). However, from 1997 a declining trend has set in, with the economic growth rate reaching a low of -6.8% in 2000. During this period, national savings have been slashed in half from 18.2% of GDP in 1996 to less than nine percent of GDP in 2000. Between 1995 and 2000, investment has fallen by about 62%. Spiralling inflation has aggravated Zimbabwe's economic crisis. In October 2002, inflation rates were estimated at about 139.9% and by December 2002 year-on-year inflation had reached 198.9%. Six months later, in June 2003, the rate of inflation had reached a record of 364.5%, only to increase even further to 455% in October 2003 (Central Statistical Office, 2003b; The Herald, 2 October 2003).

Poverty and inequality

Zimbabwe is experiencing acute poverty. During the 1990s, at least one in three Zimbabweans (36%) were living on less than US$1 a day and almost two out of three Zimbabweans (64.2%) were living on less than US$2 a day. By the end of 2002, an estimated three out of four (74%) people were expected to live on less than US$2 a day (Central Statistical Office, 2003a). Unemployment has also increased phenomenally over the years, from 18% in 1982 to 60% by 1999. The decline in living standards is further evident in the trends reflecting GNI per capita, which has dropped from US$10,523 in 1985 to US$395 in 2000 (see Graph 9.2).

Although historically government efforts have been geared towards the reversal of inequalities, income inequality in the country is particularly high, although trends cannot be discerned from the data available. In 1990, Zimbabwe's Gini coefficient was 0.57 compared to 0.45 for sub-Saharan Africa. UNCTAD has classified Zimbabwe as a highly unequal society in which the richest 20% of the population receive 60% of national income (quoted in UNDP, 1998). It is very likely that these disparities will increase as the current economic crisis deepens.

Human development

During the first two decades of Zimbabwe's independence, significant improvements have been recorded across a range of development indicators. For instance, the proportion of the population with access to safe water has increased from 80% in 1992 to 83% in 1997. During the same period, the proportion of the population with access to sanitation has increased from 68% to 72%. Unfortunately, comparable data from the decade preceding 1992 is unavailable.

Zimbabwe now boasts one of the highest literacy rates in sub-Saharan Africa. There have been notable improvements over time, from 62% in 1982 to 80% in 1990, eventually reaching 88% in 1999. During this period, literacy rates among men are consistently higher than among women, although the gender gap is slowly closing. In 1982, adult literacy rates for men and women were 70% and 56% respectively. By 1999, the respective rates for men and women were 92% and 84%. Yet, more recently a slight decline has been recorded in primary school enrolment, from 89% in 1992 to 88% in 1997. This decrease applies equally to boys and to girls. Interestingly, a slightly higher proportion of girls attend primary school compared to boys (88% and 87% respectively). In contrast, secondary school enrolment has increased from 67% in 1992 to 71% in 1997. Whereas gender disparities are much starker at secondary school level compared to primary school level, with 65% of girls and 77% of boys reportedly attending secondary school in 1997, the five years preceding 1997 have seen a significant increase in the proportion of girls going to secondary school. In 1992, only 59% of girls attended secondary school, compared to 76% of boys in the relevant age group.

The teacher to pupil ratio increased from one to 35 in 1990 to one to 41 in 1999, after which it reportedly fell again to one to 37 in 2000. Similar trends are noticeable in the health sector, where the number of physicians per 100,000 people declined from 15 in 1980 to 13 in 1995. While there are no up to date figures, it is assumed that this proportion has further declined given the recent exodus of professionals out of Zimbabwe.

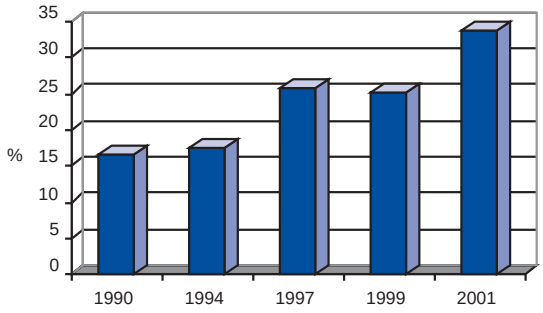
Not surprisingly, mixed trends are noticeable in relation to life expectancy during the past two decades. While a Zimbabwean born in 1982 had an average life expectancy of 58 years, a person born eight years later had an estimated life span of 62 years. The life expectancy of women was generally higher than that of men, reaching 62 years and 58 years respectively in 1990. Yet, in the early 1990s this positive trend is reversing largely as a result of the HIV/AIDS epidemic. According to national sources, life expectancy in Zimbabwe declined to 54 years in 1997, after which it fell even further to 40 years in 2001 (Population Reference Bureau, 2001). This life expectancy is about 29 years lower than what it would have been without HIV/AIDS. Adult mortality is still expected to rise as the increasing number of people already infected with HIV develop HIV/AIDS-related illnesses and die. This situation is exacerbated by the fact that ARV treatment is not readily available in Zimbabwe.

HIV/AIDS

Since the first HIV/AIDS case was identified in 1985 in Zimbabwe, infection rates have increased at an alarming rate. As noted before, national data on HIV prevalence rates are very scanty and are drawn from sub-samples. Yet, a brief assessment of these different estimates gives a good indication of national HIV/AIDS trends.

Within Zimbabwe, data supports a north-to-south spread of HIV infection. For example, in 1985 3% of blood donors in the northern part of the country, in the city of Harare, were HIV-positive, compared to

Graph 9.3. HIV prevalence rates in Zimbabwe, 1990-2001



less than one percent in the south of the country, in the city of Bulawayo. While data from ante-natal attendees at surveillance sites across the country suggested that infection rates ranged from 7.5% to 20.3% in 1990, these rates increased to between 18.7% and 32% in 1994/5. In 1996, the median HIV prevalence rate in Masvingo, Chiredzi and Beitbridge had reached 47%. There was not a single province in Zimbabwe which was spared from the epidemic as of 1995 (Ministry of Health and Child Welfare, 1996).

At national level, data from sentinel surveillance surveys show that within a time span of 15 years HIV prevalence increased from less than one percent in 1983 to 22% in 1996, meaning that over one in five adult Zimbabweans was infected with HIV in that year. This rate increased by about 32% in only one year, increasing to 29% in 1997. At the end of 2001, it was estimated that one in three adults (33.7%) is living with HIV/AIDS – representing an increase of more than 200% compared to 1990 (see Graph 9.3).[cxiv] Just over half of those adults are women (52%). It is estimated that approximately 35% of women attending antenatal clinics have tested positive for HIV in 2001 (Ministry of Health and Child Welfare, 2003a). It is particularly disconcerting that 28% of pregnant young women aged 15-19 years have tested positive. In fact, infection rates among young women in this particular age group were reported to be at least five times higher than those among their male counterparts since 1987 (Ministry of Health and Child Welfare, 2003b; NACP/Ministry of Health, 1998; UNAIDS, UNICEF and WHO, 2002).

Although information on other sexually transmitted infections (STIs) is mainly anecdotal, rates of infection are also known to be high. For instance, HIV infection rates among male STD patients from Murewa, Karoi, Mutoko and Bindura districts ranged from 7% in 1987 to 70% in 1994. Whereas over one million STIs were reported in 1989, this had declined to 826,261 in 1997. While figures prior 1989 are not available, it has been noted that the number of STDs increased from 1985 and peaked around 1989 (Ministry of Health, undated).

Given the high HIV prevalence rate and the continued high rates of infection, mortality has significantly increased across all age groups, thereby eroding the gains that have been made in the area of health and human development since Zimbabwe's independence. For example, infant mortality rates per 1,000 births initially declined from over 100 in 1980 to 66 in 1992. By 1997, this had increased again to 80 per 1,000. Given that at least 30% of children born to HIV-infected mothers get the virus and die within the first five years of life, mortality of the under fives increased from 26 to 36 out of 1,000 between 1992 and 1997 (Central Statistical Office, 1998). The Ministry of Health and Child Welfare (2003b) and UN agencies have estimated that about 60-70% of deaths among children younger than five years old are attributable to HIV/AIDS (see UNAIDS, UNICEF and WHO, 2002).

While the cumulative number of AIDS cases was considered to be 110,000 in 1995, it is estimated that about 2.3 million people in Zimbabwe are currently living with HIV/AIDS. Already, AIDS claims at least 2,500 lives a week (note that other sources estimate the number of AIDS deaths per week to range from 4,000-6,000) and has left more than 780,000 children orphaned (UNAIDS, 2002).

Conclusion

This brief overview of development trends in Zimbabwe has highlighted a number of important

improvements, particularly in the areas of health, education, access to basic services and the realisation of gender equality. Yet, it has also pointed to some critical development challenges that continue to leave their mark on Zimbabwe and its people, not least of which are the high and increasing levels of poverty, unemployment and income inequality and the erratic, if not poor, performance of the economy. Added to this is the devastating HIV/AIDS epidemic, which seems to spread largely unabated. The high levels of polarisation characterising the political terrain make it particularly difficult to address these complex and interlinked challenges with the resolve and collaboration required.

9.3. The core determinants and key consequences of HIV infection in Zimbabwe

This section draws on the interviews that were conducted with 21 key informants from different organisational backgrounds in Zimbabwe (see Appendix 3 for a list of persons and organisations interviewed). It reflects the feedback given by the respondents in relation to the core determinants that enhance vulnerability to HIV infection and the key consequences of HIV/AIDS in Zimbabwe as identified in Chapter 4. In light of the political situation in the country and to protect the identity of respondents, quotes are usually not attributed to specific individuals.

Core determinants

The respondents identified underlying factors to the spread of HIV in Zimbabwe at two levels: individual risk behaviour and contextual factors. Some respondents emphasised the loss of traditional values, the "collapse of the moral fibre" and the "moral decadence" characterising today's sexual behaviour, particularly of the youth of Zimbabwe. A politician argued:

> There has been an erosion of sexual values from a traditional perspective due to the infiltration of Western cultures into our cultural framework. It looks like the media has changed young people's orientation and thinking. In our days at 15 we would swim with girls and nothing happened. Now things have changed drastically. The problem is that most parents are too busy that they can't afford to spend time with their children …

Others, however, pointed to traditional practices, such as wife inheritance and polygamy, and to traditional cultural values condoning sexual promiscuity by men as contributing factors to the spread of HIV in Zimbabwe.

The most important environmental factors underlying the exposure to HIV infection that many respondents highlighted were the perennial poverty and lack of food, unemployment, gender inequality, migration, lack of access to basic services and denial. Often, these factors were understood to be interrelated. For example, a number of respondents suggested that poverty compels people to migrate to urban areas, leaving behind their spouses and families, which ultimately contributes to the breakdown of families.

Poverty and lack of food security were frequently mentioned in one breath. Respondents maintained that poverty exposed women especially to HIV infection and that women's vulnerability to HIV infection is further enhanced by the fact that sexual negotiation is stifled by unequal gender relationships. A representative from a civil society organisation articulated the link between poverty and gender inequality as follows:

> Chief among them [the factors facilitating the spread of HIV in Zimbabwe] is poverty and gender imbalance, two factors which invariably lead to sexual abuse. This has often resulted in young girls and women marketing sex for income. Further, due to poverty, these same people cannot access treatment and eventually die from otherwise preventable diseases. School children who travel to and from school on a daily basis have been put at greater risk. The temptation to get into relationships with commuter omnibus drivers and conductors in exchange for free rides becomes very great. In addition to that, some of them take recourse to sugar-daddies. Food scarcity and, where the food is available, imbalanced diets exacerbate the problem.

Reference was also made to the lack of access to basic services, particularly the collapse of the health system, and to the high cost of drugs as factors underlying the spread of HIV/AIDS.

Respondents further noted that the families were being split due to migration necessitated by the need to get jobs. In turn, most migrants fail to get decent accommodation and end up living in crowded accommodation that compromises privacy. The land resettlement programme was particularly mentioned by most respondents as enhancing the

spread of HIV/AIDS. It was argued that land resettlement areas are poorly serviced and have limited opportunities for income generation. As such, a context is created in which commercial sex is likely to flourish whilst the provision of information and the treatment of STDs are greatly compromised. A politician made the following observation:

> Land reform is a top issue here. What do you think happens when young men and women are quarantined in the bushes without condoms? I would like to say land reform has been characteristically lawless, unplanned and haphazard. Again in the resettlement areas there are no health infrastructures and facilities. There are no toilets or clinics and how would one expect people to survive under those conditions?

A few respondents regarded the lack of services and infrastructure in the land resettlement areas as a temporary setback. As a government official argued: "Resettlement without social services, in the short run, undermines prevention and mitigation efforts." Others, however, were less inclined to consider these drawbacks of a temporary nature.

A large number of respondents emphasised denial of the existence and the severity of HIV/AIDS as a contributing factor to the spread of the epidemic. The Government of Zimbabwe was seen to have been slow in recognising the seriousness of the situation and in articulating its response in the initial stages of the epidemic. Some respondents remained critical of what they perceived as a lack of commitment and political will to address HIV/AIDS:

> For too long government denied HIV/AIDS as a reality and when they finally admitted, it was very late. The admission again is still incomplete even now because there is a tendency to distance ourselves from the disease. Government officials prefer to cite cases of HIV/AIDS in other countries instead of making references to their own constituencies. Citations usually go something like: "in Uganda, so many people have died of AIDS". It's a pity these guys know the statistics of other countries more than their own.

Denial was mentioned not only by representatives from civil society, but also by government officials and politicians, including government Ministers, as shown in the following two quotes:

> One of the important factors is state denial which continues even up to this date despite all the deaths recorded so far. Efforts have been made by prominent government officials to conceal their HIV status and this has only worked to reinforce the stigma. Cause of death for top officials is not made public. During their long battle with the disease, there is no talk about their health. When they finally die, media reports only mention that they died after "a short illness". What the public is given for consumption is the end of the story without an elaboration of how the death came about.

> Chief among the factors has been denial in government and in the general public. In fact, government left everything to the individual initially, only to come in very late in the fight. It took us rather long to come to the full realisation that we are up against a terrible monster.

A few respondents expressed their concern about the lack of disclosure and the fact that HIV status cannot be divulged even to sexual partners. While lack of disclosure is in part necessitated by insurance companies which discriminate against those infected with HIV, the result is the continued stigmatisation of HIV/AIDS which in turn undermines prevention efforts. It further shows the extent to which HIV/AIDS-related discrimination has become institutionalised.

Certain core determinants, like income inequality, weak social cohesion, unequal political power and lack of political voice, and social instability and conflict, were not readily identified by respondents. This omission does not necessarily mean that these factors are irrelevant to the situation in Zimbabwe. Instead, it may reflect that there are very obvious overriding and pervasive concerns that affect people on a daily basis and preoccupy their minds. Some of these determinants, however, did emerge more implicitly in the interviews. For instance, politicisation of development programmes was cited as a key impediment to successful programme implementation. Politicisation here means that people's access to programmes and services is determined by their political affiliation. The omission may also partly reflect limited freedom of speech on political matters and/or complacency.

Key consequences

Respondents acknowledged a range of devastating effects of HIV/AIDS. Most commonly mentioned

were increased mortality and the consequent reduction in life expectancy, a rise in the number of orphans and child-headed households, increasing levels of poverty and a loss of productivity due to high levels of morbidity and mortality among the labour force. Some respondents added that the loss of productivity has implications for the national economy and undermines economic growth.

Regular reference was made to the fact that HIV/AIDS results in more poverty both at national and at household level, where domestic resources continuously get diverted to health services and funerals. It was further noted that HIV/AIDS-induced poverty exposes the most vulnerable groups, women and children, yet again to the risk of HIV infection, thereby entrenching a vicious cycle. The reduction in agricultural productivity was seen to aggravate household poverty and lack of food security as it increases the prevalence of malnutrition. Malnutrition, in turn, has a synergistic relationship with HIV/AIDS, indeed with disease in general. It was highlighted that lack of food security serves to undermine treatment and care of people living with HIV/AIDS, largely because people find it difficult to take tablets without food.

In addition, it was noted that HIV/AIDS has contributed to the general collapse of public services, more particularly of the health sector. The Minister of Health noted that at least 70% of hospital beds are occupied by patients with HIV/AIDS-related illnesses. Another respondent made reference to the implications of losing trained personnel in the education sector due to HIV/AIDS:

> … at Doma (pseudonym) Teachers College we lose about 10 lecturers per year and about 120 students per cohort. The reversal of developmental gains erodes investments made in education. It's something like we are investing in the grave! About 3.5% to 5% of our teachers are dying and these are the most productive people who are dying.

In general, respondents were clearly aware that the HIV/AIDS epidemic is eroding the country's most valuable resources: its people, who fulfil crucial roles as parents, breadwinners, workers, farmers, professionals and so on.

A few respondents made mention of the added burden on women to care for an increasing number of dependents. More specifically, the shift to Home Based Care was criticised by some as aggravating gender inequality, particularly where it involves, in the words of one of the respondents, "turning women into nurses without resources".

Stigma and discrimination were also highlighted as critical consequences of HIV/AIDS. A person living with HIV/AIDS noted that this has detrimental implications for efforts to curb the spread of HIV:

> Our society believes that AIDS is a culmination of one's history in sexual perversion. Subsequently, sufferers resort to a dangerous complex of denial which in turn leads to further infection and physical degeneration.

Some respondents mentioned that HIV/AIDS erodes social support systems as members of the extended family succumb to HIV/AIDS. In addition, it was noted that most people still suspect witchcraft whenever someone dies and that often relatives or neighbours blame each other for such witchcraft, which fuels distrust and weakens social cohesion.

The fact that HIV/AIDS has the potential to widen income inequalities, aggravate the risk of social instability, conflict and violence, or undermine the local revenue base did not emerge during the course of the interviews. Given that the first two factors were also not mentioned as potential drivers of the epidemic, this omission is probably not surprising. Again, this is not to suggest that these key consequences of HIV/AIDS do not hold relevance for Zimbabwe.

9.4. Development planning and HIV/AIDS in Zimbabwe

This section aims to review to what extent current development plans in Zimbabwe, consciously or unwittingly, enhance or diminish an environment of vulnerability to HIV infection and address the key consequences of the HIV/AIDS epidemic. First, some observations are made regarding the nature of development planning in Zimbabwe since independence in 1980. In light of the current economic and political crisis, it is evident that Zimbabwe currently does not operate on the basis of medium-term development plans. Rather, short-term economic stabilisation plans have become the hallmark of development planning in Zimbabwe. After reviewing the link between HIV/AIDS and the short-term plans that have been adopted to get Zimbabwe out of the current crisis, this section concludes with some observations on stakeholder participation and on the alignment and implementation of these plans.

Development planning in Zimbabwe in historical context

After independence in 1980, development planning in Zimbabwe can be characterised as a determined state effort to redress the colonial legacy of inequality. The country was characterised by imbalances in many aspects of development between the white minority and the black majority: in education, health and economic opportunities. The Government set out to redress these imbalances with the Growth with Equity Policy of 1981, followed by the Zimbabwe Transitional National Development Plan (1982-1985) and Zimbabwe's first five-year National Development Plan (1986-1990). The overarching development plan entailed national objectives and targets, which had to be operationalised and implemented through sector plans. Line ministries received a budgetary allocation from the Ministry of Finance for this purpose. This became the chief mode of planning for the 1980-2000 period.

The first development planning frameworks were based on a socialist ideology and the broader development strategy was of an allocative nature, favouring a redirection of resources towards the social services sector during the first decade of independence. Priority was given to health and education, which were considered, first, as a basic human right and, secondly, as an investment that stimulates national development. Subsidisation and price controls were the main tools to achieve equity.

As the overview of development trends has highlighted, health and education levels significantly improved after 1980. However, national resources could not cope with the vastly expanding social services sector, largely because of low investments and low and unpredictable economic growth (Government of Zimbabwe, 1991). The development plans aimed at redressing imbalances in the economy subsequently precipitated economic decline, high unemployment rates and increasing poverty. In an effort to curb these developments, the Government adopted an externally prescribed stabilisation programme. The main objective of the Economic Structural Adjustment Programme (ESAP)[cxv] was to redirect resources away from the social sectors to the productive sector. The cost of social services was transferred back into the hands of individuals. Clearly, the adoption of the ESAP signalled a fundamental change in state ideology as reflected in the shift from a regulated economy to a market economy. Development plans became externally financed, which gave the financiers significant power to demand certain achievements and conditions. Most of these goals were not met as the economic situation continued to worsen. Initially, the social sector was not included in the ESAP. It was appended when it became apparent that people were suffering from even harder economic times. The ESAP was only partially implemented. While efforts were made to liberalise the economy, less was done to reduce government spending which contributed to increasing inflation. Poverty and food shortages continued to increase, in part due to recurrent droughts and floods. Coupled with the rampant spread of HIV and the emergent consequences of the epidemic, these trends formed the ingredients of a serious humanitarian crisis.

In April 1996, the Government replaced the ESAP with a 'home-grown' reform package, the Zimbabwe Programme for Economic and Social Transformation (ZIMPREST) (Government of Zimbabwe, 1998). Like its predecessors, ZIMPREST was a five-year development plan expected to run from 1996-2000. Unlike ESAP, ZIMPREST balanced its attention between the productive and social sectors. However, the launch of ZIMPREST was not until 1998. This was largely because external financiers did not support it and there were no resources to fund the plan. The escalating economic crisis compelled the Government to let go of medium-term national development plans and adopt short-term recovery programmes concentrating largely on stabilising the economy and stimulating economic growth. Thus, in 2001 the Government launched the Millennium Economic Recovery Programme (MERP) as an 18-month economic recovery programme (Government of Zimbabwe, 2001). Again, due to lack of resources which was exacerbated by the withdrawal of the international donor community, the MERP was rendered ineffective and in February 2003 the Government launched yet another home-grown 12-month stabilisation programme, the National Economic Revival Programme (NERP): Measures to Address the Current Challenges (Government of Zimbabwe, 2003). The NERP has been informed by the Tripartite Negotiation Forum (TNF), which has broadened economic policy decision making to include the Government, the private sector and labour. As such, it has been met with more optimism by donors, the private sector and other stakeholders than its precursors.

It follows that Zimbabwe does not currently have a strategic development plan per se, but a short-term economic stabilisation plan. By the same token,

long-term sector plans have been suspended and have been replaced by short-term plans in accordance with the NERP. The following development plans form the basis of the discussion here of the possible links between development planning and HIV/AIDS in Zimbabwe:

- The National Economic Revival Programme (NERP);
- The National HIV/AIDS Strategic Framework;
- The 2003 Revival Action Plan: Ministry of Health and Child Welfare;
- The Plan of Action for the Ministry of Education, Sports and Culture as a Production Unit of the Confidence Building, Culture and Entertainment Sectoral Committee of the NERP.

It is obvious that these short-term plans, with the exception of the National HIV/AIDS Strategic Framework, are devoid of the long-term development goals characteristic of customary development planning frameworks. As such, it seems reasonable to expect that the extent to which these plans consciously and effectively address the identified core determinants and key consequences of HIV infection – which are generally associated with complex, systemic development challenges – would be rather minimal. On the other hand, however, the relatively short lifespan of these plans might also create an opportunity for HIV/AIDS to be integrated more explicitly and more effectively compared to long-term indicative planning frameworks. The following assessment will seek to determine which of these two propositions holds true for development planning in Zimbabwe.

The National Economic Revival Programme (NERP)

As noted earlier, the NERP is currently the overarching development plan from which sector plans are drawn. It was launched in February 2003 and has the following overall aims:

- To restore conditions necessary for full agricultural production;
- To reverse de-industrialisation;
- To increase capacity utilisation in the manufacturing sector; and,
- To resuscitate closed mines and companies (Government of Zimbabwe, 2003: i).

In accordance with these overall aims, the plan reflects the following objectives:

- To give full support to the primary sectors which include agriculture and mining;
- To boost the secondary sector of manufacturing;
- To give support to the small and medium enterprises (SMEs);
- To support the service sector, which includes finance and insurance, construction, transport and communication, education and health;
- To support the tourism industry while assuring guaranteed and sustainable supply of energy; and,
- To harness and efficiently utilise the country's human resources.

As noted earlier, in accordance with the aims and objectives outlined in the NERP the Ministry of Finance and Development sets budgetary limits for the implementation of the planned programmes by line ministries, currently described as production units. Therefore, this assessment will concentrate not only on the strategies set out in the NERP, but also on the extent to which the respective strategies are funded. This theme will be further elaborated on in the final subsection, which looks at issues related to the implementation of development planning frameworks. Where appropriate, reference will be made to the feedback from the key informants during the interviews.

Core determinants of HIV infection

In the area of prevention, the NERP places emphasis on individual behaviour change, especially of the working population. Interventions specifically aimed at changing individual behaviour include IEC, the provision of VCT services and condom promotion. HIV prevention is also to be achieved through the reduction of parent-to-child transmission, treatment of STIs, prevention of occupational exposure and post-exposure prophylaxis, and screening and provision of safe blood – all of which are related to the core determinant of access to basic services. Budgetary provision is made for STI treatment, while VCT services are provided jointly by the public and non-public sector, especially NGOs. Although VCT services are highly subsidised, in many parts of the country people do not have easy access to these services.

The NERP also deals with environmental factors which enhance vulnerability to HIV infection and contribute to the spread of HIV. However, it is obvious that the main emphasis in the NERP is on boosting Zimbabwe's key economic sectors, increasing production and reducing inflation. Cognisant of the negative and pervasive impact of poverty on individual wellbeing, particularly of women, youth and the disabled, the NERP makes

provision for a Social Protection Fund with an estimated Z$15.8 billion for 2003. In addition, there is a Health Assistance Fund to assist vulnerable groups. Attention to poverty reduction is also given through support for SMEs and income-generating projects and resources are set aside for this purpose. The Government has set up an Empowerment Fund targeted at income generating activities, which can be accessed through the relevant ministries (e.g. Youth Development, Gender and Employment Creation and Small and Medium Enterprises Development). Yet, given the levels of poverty and unemployment in the country, the need for such projects outstrips supply by far.

Land redistribution is specifically intended to reduce income inequalities once the resettled households begin to be productive. To ensure sustainable agricultural production and equitable income, however, these households require sufficient capital inputs. Again, funds are not adequate for this component.

While the long-term goal of land resettlement is to equalise the distribution of national income, in the short-term at least the migration of people into new areas is associated with reduced and less equitable access to public services and infrastructure. This point was also conveyed by a significant number of respondents, although they held different views on whether this was a temporary problem that could be overcome in the short-term or whether this concerned a more systemic drawback. Most new settlements do not have adequate services or public infrastructure such as schools, health facilities, good sanitation and safe water. It has been noted that farming areas tend to be conducive environments for the spread of HIV/AIDS for the following reasons: the farming population is young, tends to be sexually active and has cash to spare amidst boring environments; these areas foster a high gender mix with minimal kinship ties to monitor sexual behaviour; the high prevalence of STIs is accentuated by limited resources and access to treatment; the farm managers, extension workers and skilled artisans provide negative role models since they are promiscuous; unemployment, limited income and the resultant poverty force women to engage in commercial sex work; and, interventions against HIV/AIDS tend to be fragmented (Kwaramba, 2003). Thus, unless these core determinants of vulnerability to HIV infection are effectively addressed as part of the land reform programme, the expansion of the farming community in its current form might actually fuel the HIV/AIDS epidemic. On the other hand, through its explicit focus on access to land for women, the land reform programme can make a contribution to the reduction of gender inequality and enhancing the status of Zimbabwean women.

What is of concern, however, is the politicisation of access to resources, services and land that characterises present-day Zimbabwe. The fact that such access is determined on the basis of political affiliation defeats the aspiration of equitable development for all Zimbabweans, undermines social cohesion and serves to fuel conflict and social instability – all of which have been identified as core determinants of enhanced vulnerability to HIV infection.

With respect to political voice and empowerment, mention has already been made of the fact that unlike its predecessors, the NERP was the outcome of a wider consultation on economic matters involving the private sector and labour. Yet, there has virtually been no involvement of civil society, which is suffering the brunt of a deteriorating economy. In the interviews, some respondents pointed out that there is no functional political system to consult with people or hear their voices. It was also intimated that in the current political climate the expression of political voice is being undermined and that certain political voices are being suppressed:

> There have been a lot of impediments. Right now MPs cannot meet with their communities because of laws such as the Public Order and Security Act. In one shot, lack of democracy impedes involvement. The fight against HIV/AIDS can only be successful in a democratic context.

Key consequences of HIV/AIDS

Few key consequences of HIV/AIDS are highlighted in the NERP and where mitigation strategies are developed, these are only partially implemented due to limited resources.

To reduce AIDS-related morbidity and mortality, the NERP has set aside funds to purchase medicines for the treatment of opportunistic infections, including anti-retroviral drugs. Several billions of Zimbabwean dollars have been allocated to purchase ARVs, which would be introduced in phases. However, as the Minister noted, the Ministry of Health has not yet been able to buy the drugs due to lack of foreign currency. An official from the

National AIDS Council indicated that these drugs are imported at parallel market rates of US$ 1 to Z$ 5,300 or more, which makes it unaffordable for the Government. Thus, regardless of the budgetary allocation, in reality people living with HIV/AIDS still have little to no access to appropriate treatment due to the unavailability of these drugs in the public health sector and the exorbitant costs of treatment.

In recognition of the fact that HIV/AIDS enhances poverty, the NERP makes provision for an AIDS levy. The AIDS levy is a 3% income tax which is collected on a monthly basis for the support of HIV/AIDS activities. The AIDS fund is administered through local communities. Again, though, the resources are insufficient to address existing (and increasing) need. Also, there is a general complaint that the AIDS levy is not administered well. While the AIDS levy together with the abovementioned Social Protection Fund and Health Assistance Fund are commendable efforts to mitigate the impact of HIV/AIDS on poor households, there is minimal publicity. As a result, there is limited knowledge of the existence of such funds to the extent that most vulnerable groups remain unassisted.

The NERP also recognises the need to shield orphans and other disadvantaged children from the effects of poverty induced by HIV/AIDS and other economic hardships. The AIDS levy is one way in which such support is provided. Through the NERP, the Government of Zimbabwe partly finances a fund called Basic Education Assistance Module (BEAM), together with the National AIDS Council and the private sector. BEAM is a community-managed support programme which makes it more responsive to the needs of the most disadvantaged children. BEAM also ensures the supply of basic teaching/learning resources to schools. The Minister of Education, Sports and Culture noted that support for the BEAM fund had doubled from Z$300 million to over Z$600 million in 2003. Approximately 418,000 children had benefited from BEAM by July of 2001. This figure is estimated to have doubled in 2002, thus representing about 20% of the entire primary and secondary school population (Mupawaenda and Murimba, 2003).

The NERP only addresses the abovementioned three key consequences of HIV/AIDS: adult mortality, HIV/AIDS-induced poverty and orphans. The other twelve key consequences outlined in Chapter 4 are not explicitly addressed. Yet, this does not mean that these factors have no relevance for the NERP or, vice versa, that the NERP is irrelevant to these potential consequences of HIV/AIDS. For instance, the public sector is negatively affected by HIV/AIDS-related morbidity and mortality. At the same time, deteriorating salaries propel professional and skilled workers to seek their fortunes elsewhere, in other sectors and even in other countries. Also, given the precarious economic situation there is a real risk that job security of workers infected with HIV/AIDS is threatened, particularly where the deteriorating economy compels companies to retrench workers. Furthermore, stigma and discrimination flourish in the absence of programmes specifically designed to address these issues, whilst persistent denial enhances the two.

Also, as some respondents noted, user fees are inhibiting access to essential public services and particularly to life-enhancing and life-prolonging treatment for PLWHA. Concern was also expressed for the nature of HBC programmes, which essentially mean that the burden of care is placed on women without adequate support or resources to fulfil this task. In the absence of such support, it is not only the HIV/AIDS epidemic that aggravates gender inequality; it is further exacerbated by the 'unfunded mandate' imparted on women by the state.

To conclude, this assessment has sought to demonstrate that there is a certain amount of correlation between the objectives of the NERP and the core determinants of HIV infection.

However, it has also indicated that this correlation is at times ambiguous. Given the emphasis on economic stabilisation and increased productivity in the NERP, it is perhaps not surprising that this is the case. Also, the fact that the NERP is a short-term plan may explain why less attention is given to certain (more systemic) core determinants of HIV infection and to consequences of HIV/AIDS that are yet to make themselves felt. The assessment of possible links between HIV/AIDS and the NERP is summarised in Table 9.1. Because the annual sector plans are directly derived from the NERP, some aspects of subsequent assessments may already have been mentioned here. In that case, an attempt will be made to avoid repetition.

The National HIV/AIDS Strategic Framework

The National HIV/AIDS Strategic Framework is currently the only medium-term development planning framework that has not been suspended or replaced by short-term plans. It does not have

Table 9.1. Possible links between HIV/AIDS and the NERP			
	Objective	**Explicit**	**Possible impacts or links**
1.1	Change in individual (sexual) behaviour	Yes	Recognises the need for IEC, VCT, condom promotion & prevention/treatment of STIs and allocates resources to such programmes, although possibly not sufficient.
1.2	Poverty reduction (ensuring a minimum standard of living and food security)	Yes	Support for Social Protection Fund and Health Assistance Fund. Yet, need is much greater than these funds can satisfy; also lack of awareness about these funds. Support for SMEs + income-generating projects, with resources set aside for this purpose. Again, scale of these initiatives is small compared to need. Food security is further enhanced by involvement of private sector and duty free importation of basic food commodities.
1.3	Access to decent employment or alternative forms of income	Yes	Employment is enhanced through support for SMEs and income generating activities. Yet, not necessarily sustainable employment creation and also not widespread enough to deal with the high level of unemployment in the country.
1.4	Reduction of income inequalities	Yes	Through the land reform programme. Yet, can only be realised if newly settled households become productive, for which they require capital and other forms of support that is currently not made available.
1.5	Reduction of gender inequalities and enhancing status of women	Yes	Through the land reform programme, which is considered gender sensitive. Also recognition that women, like youth and disabled persons, are particularly marginalised by the current economic crisis, yet no explicit focus on women in terms of support for income generation or employment creation.
1.6	Equitable access to quality basic services	No	Not explicitly stated in the document which is geared towards the productive sector. Yet, access to services and land on the basis of political affiliation undermines this objective. Insufficient resources to ensure equitable access to services such as VCT across the country. User fees further limit access.
1.7	Support for social mobilisation and social cohesion	No	Political instability and politicisation of distribution of resources has increased tension between groups, thereby undermining social cohesion.
1.8	Support for political voice and equal political power	No	The NERP based on consultation between government, private sector and labour. Yet, no involvement of civil society and no system to facilitate such involvement. Political tension still limits political voice.
1.9	Minimisation of social instability and conflict/violence	No	Political instability has tended to increase social instability characterised by erratic conflicts. Where access to services and land is politicised, tension and the potential for conflict between groups have increased.
1.10	Appropriate support during migration and displacement	No	Limited access to basic services and infrastructure, like health, education, sanitation and clean water in resettlement areas.
2.1	Reduction of AIDS-related mortality	Yes	Allocation for the provision of drugs to treat opportunistic infections, including ARVs. Yet, lack of foreign currency means drugs cannot be purchased. Food insecurity + increasing poverty expedite progression to AIDS and eventual death.
2.2	Patient adherence	No	Lack of food security undermines adherence.
2.3	HIV/AIDS-induced poverty reduction	Yes	Introduction of the AIDS levy, yet concerns about administration of the levy and whether it is sufficient to meet the needs.
2.4	Reduction of income inequalities (aggravated by HIV/AIDS)	No	Income of affected households deteriorates as breadwinners succumb to HIV/AIDS and household resources including livestock and agricultural implements get sold to support the sick and to pay for funerals.
2.5	Reduction of gender inequalities & enhancing the status of women (threatened by HIV/AIDS)	No	Unlikely as women carry the burden of care for sick relatives and orphans. Girls drop out of school to care for sick parents or siblings. HBC programmes not adequate in providing the necessary resources and support to women, thereby shifting the burden of care onto the shoulders of women.
2.6	Appropriate support for AIDS orphans	Yes	Programmes and measures to support orphans are in place (e.g. BEAM and AIDS levy), but resources are limited.
2.7	Equitable access to essential public services (eroded by HIV/AIDS)	No	In a context where access to services is generally difficult due to inflation, poverty and unavailability of drugs, vulnerable households and PLWHA may be even more disadvantaged.
2.8	Effective/enhanced public sector capacity (eroded by HIV/AIDS)	No	Public sector is losing staff due to HIV/AIDS and brain drain. Due to financial instability, the public sector cannot retain qualified staff who leave because of deteriorating salaries.
2.9	Job security & job flexibility for infected/affected employees	No	Economic crisis fuels retrenchments. In the absence of anti-discrimination legislation, workers with HIV/AIDS may be particularly vulnerable.
2.10	Ensuring sufficient & qualified labour supply (eroded by HIV/AIDS)	No	The NERP does not focus on the creation or protection of sustainable employment, which probably explains why it does not focus on how HIV/AIDS erodes labour supply and the national skills base.
2.11	Financial stability & local revenue generation (threatened by HIV/AIDS)	No	The stabilisation of the economy and of spiralling inflation is central to the NERP, yet no attention to how HIV/AIDS erodes public sector resources and local revenue.
2.12	Support for social support systems & social cohesion (eroded by HIV/AIDS)	No	Possibly through support for the principle of home based care, yet in the absence of well-funded and supported HBC programmes social systems are likely to be further eroded.
2.13	Support for political voice & equal political power (PLWHA, etc)	No	Economic decision-making at best seen as a process involving government, private sector and labour. Civil society in general and PLWHA or affected households in particular are not consulted or involved in this process.
2.14	Reduction of AIDS-related stigma & discrimination	No	In the absence of programmes aimed at reducing stigma and discrimination, these will perpetuate and political denial will reinforce stigma.
2.15	Reduction of HIV/AIDS-related social instability & conflict	No	Present-day Zimbabwe is a highly conflictual society and the denial and stigma associated with HIV/AIDS may serve to aggravate this situation.

stated goals with specific targets, but rather has general objectives which are:

- To reduce the transmission of HIV and other sexually transmitted infections (STIs);
- To reduce personal and social impact of HIV/AIDS/STIs; and,
- To reduce the socio-economic consequences of the epidemic (NAC, 1999).

Core determinants of HIV infection

In relation to the first objective outlined above, the framework identifies three modes of HIV transmission that need to be targeted for prevention, namely sexual transmission, mother-to-child transmission and transmission through blood. Behaviour change is a central strategy in reducing sexual transmission of HIV. The framework emphasises abstinence, reduction of sexual partners, faithful monogamy and condom use, in addition to treatment of STIs.

The framework also concentrates on the economic and socio-cultural determinants of infection. Among the economic determinants, the framework highlights the unstable macro-economic environment, rising poverty, the weak informal sector and the lack of economic growth in the communal and resettlement areas. Reference is also made to declining public sector funding for education, health and social services, which translates into lack of access to quality public services. Moreover, gender inequalities in the provision of, and access to, public services like education, health and housing, are recognised as contributing to the enhanced vulnerability of women to HIV infection. The framework further specifically mentions increasing urbanisation which, in the absence of appropriate public services, leads to a decline "in living, health and moral standards". To address these determinants of vulnerability to HIV infection, the framework calls for mainstreaming of HIV/AIDS in economic planning and development programmes and in sectoral planning, which is where budgetary provision for HIV/AIDS prevention and care activities should be made.

Among the cultural determinants of the spread of HIV identified in the framework are "the dissolution of the extended family systems with the attendant loss of socializing and support groups" and "cultural and religious traditions and sensitivities which disempower certain population groups and perpetrate their vulnerabilities by modulating access to information, interpersonal skills, services, etc." The National HIV/AIDS Strategic Framework suggests that these retrogressive cultural values can be remedied by involving traditional and local leadership structures in HIV/AIDS programmes.

The framework further refers to the importance of involving the community into HIV/AIDS prevention and support efforts to foster community ownership of HIV/AIDS programmes. As such, it recognises the importance of community mobilisation for reducing the spread of HIV, although it is clear that the framework is specifically concerned with social mobilisation to prevent the spread of the epidemic, rather than community mobilisation as a broader development imperative.

The framework is silent on a number of core determinants of vulnerability to HIV infection. Apart from the reference to the weak informal sector, no attention is given to the need for decent employment or other sustainable ways of income generation for the people of Zimbabwe. Nor is income inequality mentioned as a key driver of the epidemic. The framework also does not address the link between HIV spread and social instability, conflict, migration and displacement and it remains silent on the issue of political voice and empowerment of marginalised groups.

Key consequences of HIV/AIDS

The second and third objectives of the National HIV/AIDS Strategic Framework are concerned with addressing the consequences of HIV/AIDS at personal, community and society level. Paramount is the need to provide sustained care and support for PLWHA and those affected by the epidemic. Within this context, the framework recognises the significance of an accessible, responsive and well resourced health delivery system, including the need to ensure that acceptable standards of health care are being adhered to. It also emphasises the need to strengthen the primary health care system and the importance of community participation in care and support activities. As such, it advocates for the need to develop a continuum of care from health care facilities down to the level of households.

Specific reference is made to the need to reduce HIV/AIDS-related stigma and to promote policies and legislation that safeguard the rights of those infected with, and affected by, HIV. Attention is also given to the need for clear orphan care and support strategies. In addition, the framework emphasises the importance of ensuring gender sensitivity in HIV/AIDS-related policies, plans and programmes. Finally, the framework is concerned with

strengthening a local grassroots response to the epidemic, which would be achieved by, among others, developing sector specific strategies.

It is worth mentioning that the National HIV/AIDS Strategic Framework is indicative of the overall policy direction on HIV/AIDS, rather than reflecting the detail of implementation. In other words, a number of key consequences of the HIV/AIDS epidemic are articulated as objectives that need to be addressed, without specifying how this can be done or which stakeholder should be involved. Where strategies are proposed, these are more of a supportive nature and relate specifically to the National AIDS Council (NAC). The proposed activities for the NAC include the provision of information on best practices, lobbying, encouraging relevant organisations to support mitigation efforts and overall coordination. The framework also includes a section on resource mobilisation for the implementation of HIV/AIDS programmes and refers to the need to involve the private sector and to ensure sector budgeting for HIV/AIDS.

Other key consequences of HIV/AIDS as identified in Chapter 4 are not explicitly mentioned or addressed. Thus, there is no focus on how HIV/AIDS is likely to enhance poverty and inequality, aggravate the burden of care on women and further entrench gender inequality (apart from the reference in passing to ensure gender sensitivity in relevant policies and plans). The framework also does not engage with the impacts of the epidemic on the public sector, its capacity to provide quality services or its financial resource base. The issue of job security and the impact of HIV/AIDS on labour in general are also not given attention and the framework is conspicuously silent on the need to support political voice of those directly affected by HIV/AIDS and the impacts of HIV/AIDS on social cohesion and social stability. Many of these omissions have also been observed in the preceding assessment of the NERP.

The 2003 Revival Action Plan, Ministry of Health and Child Welfare

The Ministry of Health adopted a ten-year Strategic Plan (1997-2007), which had as its overall objective to create conditions to improve the quality of health of Zimbabweans into the new millennium (Ministry of Health and Child Welfare, 1999). The Strategic Plan covered long term goals and a range of broader issues related to the health sector and the provision of health services. However, it is now dormant as it has been replaced by the 2003 Revival Action Plan of the Ministry of Health and Child Welfare (Ministry of Health and Child Welfare, 2003c), which was developed to fit in with the immediate goals and objectives of the NERP. This assessment focuses on the one year Revival Action Plan. The overall objectives of this plan are twofold, namely to spend the limited available resources on those diseases and conditions which cause the highest morbidity and mortality, and to create an enabling environment to address the health problems in Zimbabwe.

Although HIV/AIDS is nowadays considered a development problem, the Ministry of Health and Child Welfare continues to play a pivotal role in HIV/AIDS interventions. It has the largest budget allocation to deal with the different aspects of HIV/AIDS compared to any other line ministry. In both the 10-year Strategic Plan and its current substitute, the 2003 Revival Action Plan, HIV/AIDS is given top priority.

Core determinants of HIV infection

As far as addressing the core determinants of HIV infection is concerned, the Revival Action Plan deals only with two issues: changing individual sexual behaviour and food security. No attention is given to the remaining eight economic, social or political determinants of HIV infection.

Preventive measures to change sexual behaviour include the generic measures of abstinence, condom use, reduction of sexual partners, faithful monogamy and the treatment of STIs. These are also reflected in the National HIV/AIDS Strategic Framework. The Ministry has expanded the target population for prevention activities to include health workers, more specifically to prevent work-related exposure to HIV infection. To this end, the Ministry will train health workers on infection control while ensuring availability of protective clothing and safe disposal equipment. Awareness campaigns form an integral part of the proposed interventions.

While there is no programme directly targeted towards poverty reduction, the Revival Action Plan attempts to ensure food security through its nutrition programme. This programme includes a focus on vulnerable children, mainly of pre-school going age. However, although over Z$2 billion has been budgeted for this programme, implementation has been constrained due to the fact that no local company has been able to make the blend needed for the food supplement. Foreign currency is required to import the blend, yet this commodity is

currently in extremely short supply. During the interviews, the Minister of Health and Child Welfare noted that the Ministry would like to extend supplementary feeding to cover primary school children and the elderly, but that resources to support such an expansion were not available.

Key consequences of HIV/AIDS

The Revival Action Plan also reflects quite a restricted focus on the potential impacts of HIV/AIDS. The only explicit intervention related to the key consequences of HIV/AIDS is concerned with the reduction of HIV/AIDS-related mortality. For this purpose, provision is made for the acquisition of drugs to treat opportunistic infections and ARVs, which would be phased in in the public health system. The Plan also makes provision for post-exposure prophylaxis for health workers. Again, the main obstacle to the implementation of these measures is the lack of foreign currency.

Other key consequences of HIV/AIDS are not addressed in the Revival Action Plan. It is obvious, though, that the epidemic puts serious strain on the health system. As mentioned earlier, the Minister estimates that about 70% of hospital beds are occupied by patients with AIDS-related diseases. Yet, the Plan does not engage with what this means for health service provision in general, nor does it reflect on the loss of health care workers due to HIV/AIDS. In addition, the health sector is losing qualified staff due to emigration. Undoubtedly, the level of vacancies and the high staff turnover are negatively affecting the efficiency and quality of health services.

In order to increase access to health services, there has been a shift to support a community home based care programme. However, this programme relies heavily on community volunteers whose sustained involvement is quite tenuous in a poverty stricken economy, unless such volunteers are given some form of remuneration. For instance, it was noted during the interviews that those involved in care do not have access to very basic necessities, such as protective clothing, soap and food. Yet, no budgetary provision has been made for some form of monetary remuneration, nor are other forms of support provided. In addition, it should be noted that community care is heavily dependent on women, which adds to the burden on women thereby enhancing gender inequality. In light of these flaws, the community home based care programme may end up relegating the care of patients to individuals and institutions that are ill-equipped for this task.

The Plan of Action for the Ministry of Education, Sports and Culture

Despite the fact that education was given priority in national development planning since independence, the Ministry of Education, Sports and Culture has not adopted a strategic planning framework. Instead, the Ministry used the Education Act as its guiding document. Strategies for change were articulated in circulars. The argument for using circulars instead of medium-term strategic plans was that it was administratively easier for the Ministry to change circulars whenever a change of strategy was deemed necessary. This partly reflects the laxity and fluidity of planning in the country. Thus, there is no explicit development planning framework for education in Zimbabwe. The Ministry is currently considered a production unit of the Confidence Building, Culture and Entertainment Sectoral Committee of the NERP and as such has an annual plan in accordance with the NERP. The plan has a number of objectives for the Ministry as a whole, some of which are specifically concerned with education:

- To build capacity to facilitate the effectiveness of the NERP;
- To increase access to education;
- To improve nutrition, health and safety in schools;
- To enhance patriotism through the national flag and the national anthem;
- To provide a legal framework to commercialise cultural activities and the arts;
- To undertake aggressive and vigorous development and promotion of arts and culture;
- To undertake aggressive and vigorous development and promotion of sport;
- To vocationalise the education curriculum; and,
- To promote behaviour change in the light of HIV/AIDS.

Core determinants of HIV infection

Like the Revival Action Plan of the Ministry of Health and Child Welfare, the Plan of Action for the Ministry of Education, Sports and Culture only partially covers the first two key determinants of vulnerability to HIV infection, namely behaviour change and poverty reduction. The Plan of Action aims to realise a change in sexual behaviour by strengthening life skills of school children and education staff.

With respect to poverty reduction, the Plan seeks to contribute to enhanced food security by running school supplementary programmes and establishing nutrition gardens at institutions of learning. In

Table 9.2. Explicit objectives in Zimbabwe's development planning frameworks				
	NERP	**NASF**	**RAP: health**	**PoA: education**
Core determinants of HIV infection				
1.1. Change in individual behaviour	++	++	++	++
1.2. Poverty reduction (minimum standard of living & food security)	++	+	+	++
1.3. Access to decent employment or alternative forms of income	+	-	-	+
1.4. Reduction of income inequalities	+	-	-	-
1.5. Reduction of gender inequalities & enhancing the status of women	+	+	-	-
1.6. Equitable access to quality basic public services	-	+	-	-
1.7. Support for social mobilisation & social cohesion	-	+	-	-
1.8. Support for political voice & equal political power	-	-	-	-
1.9. Minimisation of social instability & conflict / violence	-	-	-	-
1.10. Appropriate support in the context of migration/displacement	-	+	-	-
Key consequences of HIV/AIDS				
2.1. Reduction of AIDS-related adult/infant mortality	++	-	++	-
2.2. Patient adherence	-	-	-	-
2.3. Poverty reduction	+	-	-	-
2.4. Reduction of income inequalities	-	-	-	-
2.5. Reduction of gender inequalities & enhancing the status of women	-	+?	-	-
2.6. Appropriate support for AIDS orphans	+	+	-	+
2.7. Equitable access to essential public services	-	+?	-	-
2.8. Effective/enhanced public sector capacity	-	-	-	-
2.9. Job security & job flexibility for infected and affected employees	-	-	-	-
2.10. Ensuring sufficient & qualified/skilled labour supply	-	-	-	-
2.11. Financial stability & sustainable revenue generation	-	-	-	-
2.12. Support for social support systems & social cohesion	-	+	-	-
2.13. Support for political voice and equal political power, particularly for PLWHAs and affected households and individuals	-	-	-	-
2.14. Reduction of AIDS-related stigma and discrimination	-	+	-	-
2.15. Reduction of social instability & conflict	-	-	-	-
+ = to some extent or in part; ++ = to a greater extent; +? = possibly, but mostly indirectly				

addition, income generation projects in schools are intended to help reduce income-based poverty. The Plan further aims to contribute to poverty reduction by offering youth opportunities for vocational training. This has hitherto been ignored as a strategy to enable future adults to earn a living, as was reinforced by the Minister of Education, Sports and Culture during the interview:

> We only have 23% of our graduates with O-levels passing and the rest fail. … Such youngsters cannot even be apprentices. … The public service is elitist. They do not allow space for low academic achievers, which renders about 80% of our youth jobless. … We need our schools and curricula to be practical and provide skills. The world was not transformed by intellectuals, but by technicians.

Key consequences of HIV/AIDS

If little attention is given in the Plan of Action to the core determinants of vulnerability to HIV infection, there is even less focus on the key consequences of HIV/AIDS. The Plan only deals with one aspect, namely providing assistance to orphans. Such assistance mainly takes the form of a contribution to school fees through the BEAM (see the discussion of the NERP) and the AIDS levy.

As noted under the NERP and the Revival Action Plan for health, the fact that most determinants and consequences of HIV/AIDS are not recognised in the Plan of Action does not mean that these factors have no bearing on the education sector. What these possible links between HIV/AIDS and education planning are has been explored in Chapter 4.

Table 9.2 summarises the preceding discussion by highlighting whether the main development plans in Zimbabwe explicitly seek to respond to the various core determinants and key consequences of HIV infection. Table 9.2 illustrates clearly that relatively

little attention is given to these factors in the various planning frameworks. All four frameworks put significant emphasis on behaviour change and, to a greater or lesser extent, on poverty reduction and the need to ensure food security for the people of Zimbabwe. The NERP does address some of the economic determinants underpinning the spread of HIV, yet the political dimensions of vulnerability to HIV infection are ignored by all four frameworks. Even less attention is given to the various key consequences of the HIV/AIDS epidemic. To some extent, these omissions could be explained by the fact that the development plans discussed here generally have a relatively short life span and are chiefly concerned with 'quick fixes' to resolve the current economic and political crisis.

The planning process

Given that respondents generally identified a more comprehensive range of factors facilitating the spread of HIV in Zimbabwe and, similarly, of the impacts of HIV/AIDS compared to what is reflected in the key planning frameworks, it might be instructive to reflect on the planning process in Zimbabwe. As the brief historical overview of development planning has highlighted, planning in Zimbabwe is traditionally the domain of officials in the Ministry of Finance and Economic Development. During the past two decades, this Ministry has played the lead role in guiding the national planning process and stipulating budgetary ceilings to guide sector planning by line ministries. The one diversion occurred in the early 1990s, when the World Bank and the International Monetary Fund became instrumental in the formulation and monitoring of the ESAP. However, with the withdrawal of the donor community from Zimbabwe, the involvement of the World Bank and other donors in development planning has become minimal. More recently, since 2000, development planning has been informed by the involvement of two other stakeholders additional to the Government, namely the private sector and labour. These three parties have made an input into the NERP. Sector plans have subsequently been drawn up by the respective line ministries, which may or may not have engaged with other stakeholders in this process.

Parliament

During the interview phase, it was suggested that parliamentary involvement in the formulation of the key plans guiding the development of Zimbabwe has been insufficient. It was noted that there had been some workshops for parliament when the National HIV/AIDS Strategic Framework was developed, but other than that there was no clear role for parliamentarians in the formulation, implementation or monitoring of this framework. However, there had been some parliamentary involvement in sector planning through the relevant portfolio committees. It was suggested that such plans usually incorporate recommendations made by these committees.

Civil society organisations

Based on the interview findings, it appears that civil society is hardly involved in the planning process, let alone the implementation or monitoring of the development planning frameworks. As mentioned earlier, there is no mechanism or system to facilitate the involvement of communities and local organisations in the planning process. As one of the respondents observed:

> People and various organisations are not consulted. Even in cases where they are consulted, the final drafts only reflect what the authors wish to see done. In the end, one is forced to think that the initial consultation is just a cover up strategy.

Respondents pointed in particular to the level of suspicion between the Government and NGOs as an impediment to a consultative planning process. Whereas some argued that the Government failed to consult civil society organisations, others suggested that NGOs were chiefly to blame for this state of affairs and for failing "to break the political indifference". Quite a number of respondents representing different organisational contexts emphasised the need for an interface between the Government and civil society organisations on the development challenges facing Zimbabwe. They argued that the lack of such an interface breeds antagonism between the respective parties, a situation which in turn stifles the implementation of development plans.

NAC and organisations representing PLWHA

In contrast to the other development plans discussed in this chapter, the National HIV/AIDS Strategic Framework has been informed by relatively widespread participation from a variety of organisations representing PLWHA, including the NAC. However, representatives from these organisations noted that they had not been involved in the formulation of the NERP or other development plans. At best, their involvement has extended to the formulation of specific HIV/AIDS policies or programmes in line ministries. As one of the

respondents explained:

> AIDS is normally regarded as a health issue. This medical perspective has only tended to result in many efforts revolving around the Ministry of Health and Child Welfare. Government tends to perceive NGO activities as an appendage to those of the Ministry of Health and Child Welfare. We are largely called upon by the Ministry of Health and Child Welfare when they are discussing issues of HIV/AIDS. The multi-sectoral nature of the epidemic is not seriously considered.

Other respondents echoed the view that the lack of involvement of organisations with expertise in HIV/AIDS is because the Government does not sufficiently appreciate HIV/AIDS as a development issue that requires mainstreaming of HIV/AIDS into all aspects of development.

Alignment and implementation of development planning frameworks

Respondents differed quite strongly in their opinion whether the current development planning frameworks are sufficiently aligned, although there was more unanimity on the inadequate implementation of current development plans. It needs to be noted, though, that most respondents seemed to interpret the question about alignment of the development planning frameworks as being about the responsiveness of these frameworks to the needs of the country and its people, rather than the synchronisation of the various frameworks. As such, they tended to mention issues such as insufficient grassroots involvement in the planning process, turning people into "passive consumers" of government plans and interventions, and the political turmoil characterising the country. As one of the respondents said, when asked about the alignment of the key development planning frameworks in Zimbabwe:

> Those who make policies panel beat the policy documents into shape from their perspective. No wonder the policies are not people-oriented.

Given the fact that the 2003 Revival Action Plan and the Plan of Action for the Ministry of Education, Sports and Culture are directly derived from the NERP, it stands to reason that these plans show a significant amount of alignment with the goals and objectives of the NERP. This is not the case with the National HIV/AIDS Strategic Framework. In fact, the Director of the NAC has intimated the need for its revision so that it is consistent with the overarching planning framework (currently the NERP) and the annual cycle of development planning currently operating in the country.

At the beginning of this section, it was suggested that there might be more scope to integrate HIV/AIDS into short-term development plans rather than long-term indicative planning frameworks. This hypothesis would be proven if there was evidence of strong and explicit alignment between the National HIV/AIDS Strategic Framework and the other development plans discussed here. However, this does not really seem to be the case. Whereas a number of core determinants and key consequences of HIV infection are explicitly addressed in the NERP and associated sectoral plans, these do not necessarily correlate with the objectives outlined in the National HIV/AIDS Strategic Framework. As mentioned before, this is probably because development planning in Zimbabwe has largely become a fire-fighting exercise aimed at addressing the most immediate problems exerting the most threatening political pressure. Various respondents argued that HIV/AIDS is not considered one of those pressing political issues.

With respect to the implementation of the current development planning frameworks, most respondents agreed that implementation is at best poor, haphazard and uncoordinated. Some specifically mentioned that there is no clear implementation strategy and no strategy to monitor the implementation of proposed interventions. In a number of instances, this observation was specifically related to the National HIV/AIDS Strategic Framework. Reference was also made to the need to decentralise the implementation of the various development plans, yet given the current resource constraints facing Zimbabwe this was recognised as being extremely difficult.

The issue of inadequate resources emerged as a consistent theme during the course of the interviews, particularly from the side of government officials and politicians. In the absence of external funds, budgetary allocations were seen to be insufficient for a number of reasons. For one, Zimbabwe is faced with a humanitarian crisis manifested in lack of food security, increasing poverty and high levels of inflation. As noted, earlier, the number of people in need of government food aid increased from 6.7 million to 7.2 million within the past year. This comprises about 63% of the total

population. Thus, a very large proportion of the population requires government support for a wide range of issues, such as school fees and medical assistance. It is beyond the national budget to meet such a great level of demand. Secondly, and linked to the previous point, the Government itself has a high budget deficit, which undermines its ability to cope with the current crisis. Thirdly, parallel foreign exchange rates have compounded the erosion of public sector investments. Inherent in national budgets which are based on the official exchange rate is under-budgeting, since the actual procurement of imported goods and services depends on the parallel market.[cxvi] Finally, compounding the budgeting problem is the spiralling inflation, which increases the cost of goods and services within days.

Some, however, suggested that the issue is not just the lack of resources for implementation, but also the inappropriate targeting of resources. Given the political dynamics in the country, it is hardly surprising that some respondents believed that current priorities on expenditure in Zimbabwe are wrong.

9.5 Conclusion

Zimbabwe is faced with a development crisis characterised by high and increasing levels of poverty and unemployment, lack of food security, an unstable and deteriorating economy, spiralling inflation, political instability and a very severe HIV/AIDS epidemic. The current political and economic crisis has forced the Government to abandon long-term development planning and resort to annual plans in an attempt to rein in the most pressurising problems. As a result, these plans at best only partially address the long term, systemic development challenges that are usually the focus of development planning.

It is largely for this reason that the current development plans and frameworks do not adequately address the core determinants and key consequences of HIV/AIDS in Zimbabwe. The most comprehensive of the plans discussed in this chapter is the NERP, which is chiefly concerned with the economic determinants driving the spread of HIV (poverty, lack of income and income inequality) and with individual behaviour as a core determinant of HIV spread. There is consistent silence on the political determinants of vulnerability to HIV infection in all four documents discussed here. This issue also did not surface during the interviews with key informants, which could be indicative of a lack of appreciation of these factors and/or perhaps of the oppressive nature of the current political system, which does not foster independent political thinking. In contrast, whereas the planning documents are equally silent on the need to ensure adequate support during migration and displacement, this was clearly recognised by a large number of respondents as a contributing factor to the spread of HIV, with specific reference to the land resettlement programme. If the development plans ignore a significant number of core determinants of vulnerability to HIV infection, even less attention is given to the key consequences of HIV/AIDS. As such, one can conclude that HIV/AIDS is not sufficiently integrated into development planning in Zimbabwe.

In addition to the fact that development planning in Zimbabwe is currently operating on the basis of crisis mode, the nature of the planning process may also serve to explain these omissions. Historically, development planning in Zimbabwe has been a highly centralised process in which officials in the Ministry of Finance and Economic Development used to formulate an overarching development plan which provided sector ministries with budgetary ceilings. While the current economic stabilisation programme, the NERP, has been prepared with input from the private sector and labour, no official mechanisms are in place to facilitate the involvement of communities and civil society organisations in the planning process. The lack of such mechanisms further aggravates the current antagonism that characterises the relationship between the Government and civil society organisations.

It has also been suggested that HIV/AIDS is still largely understood as a health issue, despite the fact that in official discourse HIV/AIDS is referred to as a development issue. Respondents consulted during the course of this study pointed to the disproportionate responsibility allocated to the health sector to address the HIV/AIDS epidemic. This programmatic slippage into largely health-driven interventions may be an additional explanatory factor for the inadequate integration of HIV/AIDS into development planning.

Finally, this chapter has identified that a significant gap exists between the expressed intent and the actual implementation of development plans. The issue of resources is clearly critical here as the current economic crisis, particularly the lack of foreign currency, erodes budgetary allocations even

before these can be spent. It is beyond the scope of this assessment to review the nature and causes of the current economic and political crisis in Zimbabwe, or to comment on interventions pursued by the Government to try and curb the crisis. Undoubtedly, though, what has emerged from this assessment of Zimbabwe is that it is very difficult to separate development planning from its political context.