



ZIMBABWE

No Bright Future

Government Failures, Human Rights Abuses and Squandered Progress in the Fight against AIDS in Zimbabwe

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WATCH



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Glossary of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretro Viral
BEAM	Basic Education Assistance Module
CIO	Central Intelligence Organization
DfID	Department for International Development
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
MoHCW	Ministry of Health and Child Welfare
MPSLSW	Ministry of Public Service Labor and Social Welfare
NACP	National AIDS Co-ordination Program
NAC	National AIDS Council
NATF	National AIDS Trust Fund
NGO	Non-governmental Organization
OVC	Orphans and Vulnerable Children
PASS	Poverty Assessment Study Survey
PEPFAR	Presidents Emergency Plan For AIDS Relief
PLWHA	People living with HIV/AIDS
PMTCT	Preventing Mother-To-Child Transmission
POSA	Public Order and Security Act

PVO	Private Voluntary Organization
STI	Sexually Transmitted Infections
UNGASS	United Nations General Assembly Special Session
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
ZANU-PF	Zimbabwe African National Union Patriotic Front
ZIMVAC	Zimbabwe Vulnerability Assessment Committee

I. Summary

My husband left when I fell sick. He now stays with another wife. Before my husband left I was on medical aid and then he left and I had nothing. My husband doesn't pay any maintenance and he took my property away. We were together for 13 years ... My relative who I stay with doesn't know that I am HIV positive. There are three other families in the same household and the others suspect that I am HIV positive and they aren't comfortable with me. If they knew they would chase me. I don't work. I do some embroidery but business isn't going well. I have had to sell some of my clothes to meet expenses. I just manage to pay the rent. We only have one meal a day in the evening. It's tough. Sometimes you just think that maybe if you die, things will get better. I have to find transport to get my ARVs and when I don't have the money I walk to get the ARVs. I am so stressed. I nearly committed suicide because things are so tough. There's no bright future because when you don't know what you are going to eat tomorrow, there's no future.

—Cecilia M., 40, living with HIV/AIDS

Zimbabwe has been widely hailed as a success story in the fight against AIDS since reporting in October 2005 a decline in HIV prevalence among adults from 25% in 2001 to 20% in 2004. In the face of the devastating impact of HIV/AIDS on the country, a declining economy, growing international isolation, decreased funding from international donors for HIV/AIDS prevention and treatment, and a disintegrating public health sector, Zimbabwe's achievement was indeed significant.

Despite the positive news, however, the HIV/AIDS epidemic in Zimbabwe remains a serious crisis with some three hundred and fifty thousand of the 1.6 million people carrying the virus in immediate need of life-saving antiretroviral (ARV) drugs and another six hundred thousand in need of care and support. With an HIV prevalence rate of 20%, Zimbabwe still has one of the highest prevalence rates in the world. Of greatest concern is that the progress gained so far could be undermined by Zimbabwean government policies and practices that violate the rights of people living with HIV/AIDS (PLWHA) and those most at risk of infection. These violations threaten their rights to health, information, work, equal protection before the law and nondiscrimination.

Zimbabwe's health and social welfare policies have resulted in the denial of access to healthcare for tens of thousands of Zimbabweans living with HIV/AIDS in immediate need of HIV/AIDS-related treatment.

Thousands of PLWHA are unable to access HIV/AIDS-related treatment and care services because they cannot afford the high costs of user fees for health services. The government has established a system of exemptions or waivers for health user fees to assist in equitable access to health care for the poor and vulnerable. However, lack of information on the criteria and availability of the exemptions, combined with a failure to have an enforceable and standardized assessment process by which all social welfare officers administer the exemptions, leads to their subjective and ultimately arbitrary application. The result is unnecessary obstacles for vulnerable and poor PLWHA who urgently need access to healthcare, leaving them at risk of fatal deterioration in their health.

A lack of public information on antiretroviral therapy (ART) policies also restricts access to treatment for thousands of people in desperate need of life-saving antiretroviral drugs. Failure to provide sufficient information to public sector physicians, AIDS service organizations and networks of PLWHA on national standards for ART, and specifically on the necessity and role of CD4 tests (a marker of immune system function) in the eligibility criteria for ART, has led to thousands of people being turned away unnecessarily from access to ART.

The repressive political environment in Zimbabwe has prevented activism and debate on HIV/AIDS and human rights among civil society and PLWHA. NGOs working on HIV/AIDS report that they face difficulties advocating for the human rights of PLWHA and the political and economic aspects of the pandemic because government officials and members of the government's Central Intelligence Organization (CIO) regularly intimidate and harass them when they try to do so. Restrictive legislation has also curtailed the ability of NGOs, including those working on HIV/AIDS to work freely around the country.

Tens of thousands of PLWHA continue to suffer from the catastrophic consequences of the government's program of mass evictions and demolitions (Operation Murambatsvina) which has disrupted their lives and access to HIV/AIDS treatment, care and support.

Further, the government's economically ruinous policies towards informal traders and the informal economy have increased the risk of infection for thousands while further imperiling the lives of those already infected with HIV. Economic restrictions on informal trading put in place by national government authorities, pose a significant obstacle to the ability of PLWHA to earn a livelihood and afford HIV/AIDS -related treatment and care. These restrictions have also narrowed the livelihood strategies of a significant part of the population which relies upon the informal sector most, such as

women and other poor and marginalized individuals. As a result of these policies and discrimination against women in the workforce generally, women in particular are left with few choices and often engage in high risk behaviors and strategies such as “survival sex” which put them at greater risk of HIV infection. The report also documents the plight of women who bear the brunt of the epidemic and are often economically insecure. Women continue to face overlapping abuses of their human rights including domestic violence, discriminatory legislation and violations of property and inheritance rights which leave them vulnerable to HIV infection or unable to alleviate the consequences of living with HIV/AIDS.

The report also examines the role of the international donor community, which has significantly pulled back direct assistance to Zimbabwe since 2000. Given the enormity of the HIV/AIDS epidemic in Zimbabwe, a substantial increase in donor funding is crucial. Increased funds from the British and US governments, and from the Global Fund against HIV/AIDS, Malaria and Tuberculosis, are now imminent. It is imperative that the international donor community not allow well founded concerns about the state of democracy in Zimbabwe to block the provision of much needed assistance for HIV/AIDS programs in the country. At the same time international donors should continue to call on the government of Zimbabwe to respect human rights and provide an environment that is conducive to effectively addressing the crisis.

The 2001 U.N. General Assembly Special Session (UNGASS) declaration of commitment on HIV/AIDS recognized that the realization of human rights is essential to reducing vulnerability to HIV/AIDS and that protecting human rights empowers people living with HIV/AIDS.

The government of Zimbabwe risks a reversal in the progress achieved thus far in the fight against HIV/AIDS unless it takes serious steps to address violations of human rights and creates an environment that is conducive to free expression and activism on human rights and HIV/AIDS. Human Rights Watch calls on the government of Zimbabwe to meet its international obligations and respect the rights of its citizens including PLWHA to information, employment, freedom of expression, association and assembly, nondiscrimination, and health. It must show its commitment to fighting the HIV/AIDS pandemic by ensuring equitable and nondiscriminatory access to health care for all its citizens, reversing economic policies that have the effect of further impoverishing its poor and vulnerable citizens, ceasing policies that prevent and restrict advocacy on the part of people living with HIV/AIDS, and supporting the efforts of international and local organizations working with and providing treatment and care to PLWHA.

II. Recommendations

To the government of Zimbabwe

On access to health care and treatment for PLWHA:

- Ensure equitable and nondiscriminatory access to health services for all, including PLWHA;
- Ensure that health practitioners, NGOs (including organizations representing people living with HIV/AIDS) and other personnel working on HIV/AIDS are fully informed on the national guidelines for treatment of HIV/AIDS in particular requirements for CD4 testing and eligibility criteria for access to antiretroviral drugs and implement a monitoring mechanism that will ensure that the criteria are uniformly and properly applied;
- Clarify and standardize national guidelines for social welfare exemptions for health user fees. Ensure that social welfare offices have the financial and technical resources to properly evaluate candidates and fulfill obligations to pay medical expenditures to hospitals. Ensure that exemptions for CD4 tests are not arbitrarily restricted; and
- Ensure that all individuals testing positive for HIV are provided with information on: where to access medical care and counseling (including information on requirements for accessing antiretroviral therapy and medicine for opportunistic infections); criteria for social welfare exemptions for health user fees; the rights of individuals participating in clinical research trials; and, the broader rights of people living with HIV/AIDS to nondiscrimination.

On the right to earn a livelihood:

- Respect the right to work of all people:
 - Clarify the procedures and requirements for obtaining a trading license, allocation of vending stalls, and expedite the process for obtaining a trading license. Ensure national standards for licenses and guarantee nondiscrimination against women and people living with HIV/AIDS in eligibility requirements for a trading license. Set up appropriate, participatory, non-formal forums for the discussion of informal trading

practices with representation by street vendors and hawkers, NGOs, local authorities, the police and others;

- Facilitate participation by vulnerable and marginalized populations, including women and people living with HIV/AIDS in the informal sector of the economy by setting reasonable and appropriate license fees; and
- Review legislation on informal trading activities and expand legal access to the use of appropriate and available space for vending in urban areas.

On women's rights:

- Legislate and enforce prohibitions against practices that place women at a disadvantage in society and increase their risk of HIV infection—such as domestic violence and discriminatory customary laws. Enact the Prevention of Domestic Violence and Protection of Victims of Domestic Violence Bill of 2005 without delay;
- Initiate legal and policy reforms that ensure that legislation and traditional practices are nondiscriminatory, gender-sensitive and empowering to women. To this end repeal or amend section 23 (3) (b) of the constitution which discriminates against women in the private sphere, and recognize women's matrimonial property rights under unregistered customary unions;
- Ensure that all protections afforded to women are strengthened and fully compliant with Zimbabwe's obligations under the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) and are implemented as a matter of urgency; and
- Undertake measures to combat violence and discrimination targeted at women living with HIV/AIDS.

On the participation of civil society and PLWHA in HIV/AIDS- related programs:

- Repeal or amend all legislation which inappropriately interferes with the work of local and international NGOs, including legislation governing the operation of NGOs and private voluntary organizations. Ensure that activists and NGOs working with and supporting PLWHA are free to carry out their work without fear of harassment, intimidation or arrest;
- Ensure the meaningful participation of PLWHA and civil society in the decision-making and monitoring process of all HIV/AIDS-related funding, policy, and programming. PLWHA and civil society should be included in monitoring the government's progress in the fulfillment of its commitments and obligations relating to HIV/AIDS. For example, in the monitoring and reporting of the 2006 Global Fund grant and the report to the United Nations General Assembly in 2008 on the establishment and progress towards national targets related to the 2006 High Level Meeting on AIDS; and
- Regularly conduct general HIV/AIDS awareness campaigns that provide comprehensive information on how HIV/AIDS is transmitted and how it can be prevented, to fight stigma and discrimination, with a particular emphasis on discrimination within the home and family. Where the rights of PLWHA have been violated there should be accessible and nondiscriminatory mechanisms to remedy their grievances.

To international donors, including the US and UK governments

- Continue to call on the government of Zimbabwe to respect human rights and provide an environment that is conducive to effectively addressing the crisis;
- Support those persons displaced by Operation Murambatsvina including providing support for income-generating and microfinance projects, to provide financial security to those affected by the evictions;
- Support women's grass roots rights organizations and community initiatives by providing them with funding and other forms of assistance for their work on women's rights and HIV/AIDS such as:

- Programs that raise general awareness on HIV/AIDS treatment and prevention, and fight stigma and discrimination;
 - Prevention interventions that provide comprehensive and accurate information and reduce the vulnerability of women to infection;
 - Strengthening legal protections on property inheritance and ownership for women, especially those living with HIV/AIDS; and
 - Promotion of advocacy work with both men and women in the community that challenge abusive and violent behavior.
- Work to ensure donor supported sites, provide all individuals testing HIV positive with information on:
 - Where to access medical care and counseling (including information on requirements for accessing antiretroviral therapy and medicine for opportunistic infections);
 - Where to access legal assistance for domestic violence or violations of inheritance and property rights;
 - The criteria for social welfare exemptions for health user fees;
 - The rights of individuals participating in clinical research trials; and
 - The broader rights of people living with HIV/AIDS to nondiscrimination.
 - All testing should be done with the fully informed consent of the individual being tested and procedures should be followed that ensure strict confidentiality of the test results; and
 - Urgently increase assistance to HIV/AIDS programs, to ensure the rapid scale-up of ART for those in need. This assistance can be through direct support of government of Zimbabwe public health facilities (including clinics, laboratories, etc) and social welfare offices, or through non-governmental organizations providing treatment and support, including private non-profit and faith based organizations. Ensure that treatment programs take into account the particular obstacles confronting women, other marginalized groups, and homeless persons in terms of accessing and adhering to treatment.

To the Global Fund to Fight AIDS, Tuberculosis and Malaria

- Take steps to ensure that grants from the Fund are allocated in a transparent and accountable manner by the government of Zimbabwe;
- Ensure participation of PLWHA and civil society, in the decision-making, monitoring and reporting process of the 2006 Global Fund grant; and
- Monitor the equity of access to ART provided by Global Fund support according to gender and geographic residence. Ensure that eligibility criteria for ART are scientifically supported and not subjected to manipulation or unnecessary, and therefore arbitrary, obstacles.

To United Nations agencies working on HIV/AIDS programs in Zimbabwe including UNAIDS, UNDP, and UNICEF

- Ensure the meaningful participation of PLWHA and civil society, in the decision-making and monitoring process of all HIV/AIDS-related funding, policy and programming. PLWHA and civil society should be included in monitoring the government's progress in the fulfillment of its commitments and obligations relating to HIV/AIDS, for example in the monitoring of the report to the United Nations General Assembly in 2008 on the establishment and progress towards national targets related to the 2006 High Level Meeting on AIDS; and
- Provide support to the Ministry of Health and Child Welfare for the means to provide monitoring and evaluation of the equity of antiretroviral treatment scale-up with measurement of individuals in need of ART accessing therapy by gender and geographic residence.

III. Methodology

This report is based on research carried out in and around the cities of Harare, Bulawayo, and Gweru in April and May 2006. Human Rights Watch researchers interviewed 109 people living with HIV/AIDS and 14 women identified as being vulnerable or at risk of infection. The researchers also interviewed 31 individuals from local HIV/AIDS NGOs, international NGOs, local health experts, doctors and medical officials from private clinics and mission hospitals, donors, government appointed provincial and district aids coordinators, and representatives from the National AIDS Council. The section on women's rights is partly based on interviews conducted with women and women's rights organizations in June and September 2005.

Human Rights Watch was unable to secure meetings with Ministry of Health officials in Zimbabwe. The researchers reviewed policy documents and official statements from the government of Zimbabwe as well as from numerous international agencies. The names of all PLWHA in this report are pseudonyms, while other names have been withheld to protect their security.

IV. Background

Political environment

The repressive political environment in Zimbabwe has been well documented in previous Human Rights Watch reports.¹ A climate of political and economic uncertainty has undermined the ability of officials, international agencies and civil society organizations to respond effectively to Zimbabwe's humanitarian problems including the HIV/AIDS pandemic. In a bid to suppress criticism of its political and economic policies, the government has routinely used restrictive legislation and violent and intimidating tactics against civil society activists and the opposition.

The government's use of legislation such as the Public Order and Security Act (POSA) has restricted the work of local and international NGO organizations including those working on HIV/AIDS. The proposed NGO bill although it has not been signed into law, continues to affect the ability of NGOs to operate effectively.² Many local HIV/AIDS NGOs are unable to advocate on issues of concern with the government, for fear of being shut down or of their registration being denied if the NGO bill eventually comes into force.

Government restrictions on humanitarian work which are frequently placed on NGOs and other humanitarian agencies were compounded last year by the government's program of evictions which took place throughout the country in May and June, and left up to 700,000 people homeless and frequently without a source of livelihood.³ In the aftermath of the evictions, the government tried to conceal the extent of the evictions and placed restrictions on the activities of local and international NGOs working in the areas where people were affected by the evictions including PLWHA.⁴

¹ See inter alia, "Zimbabwe: Civil Society Groups at Risk, Proposed Law on NGOs Would Violate Basic Rights," Human Rights Watch news release, New York, September 4, 2004, <http://hrw.org/english/docs/2004/09/04/zimbab9310.htm>; Human Rights Watch, "Under a Shadow: Civil and Political Rights in Zimbabwe," *A Human Rights Watch background briefing*, June 6 2003, <http://hrw.org/backgrounder/africa/zimbabwe060603.htm>, and "Not a Level Playing Field: Zimbabwe's Parliamentary Elections in 2005," *A Human Rights Watch background briefing*, March 2005, <http://hrw.org/backgrounder/africa/zimbabwe0305/zimbabwe0305.pdf>.

² For more on the proposed NGO bill see Human Rights Watch, "Zimbabwe's Non-governmental Organizations Bill: Out of Sync with SADC standards and a Threat to Civil Society Groups," *A Human Rights Watch background briefing*, December 2004, <http://hrw.org/backgrounder/africa/zimbabwe/2004/12/zimbabwe1204.pdf>.

³ Human Rights Watch, *Evicted and Forsaken: Internally Displaced Persons in the Aftermath of Operation Murambatsvina* (New York: Human Rights Watch, 2005), <http://hrw.org/reports/2005/zim1205/zim1205webwcover.pdf> (accessed July 24, 2006).

⁴ *Ibid.*, p. 21.

Social and economic environment

Zimbabwe's economic environment has had a particularly detrimental effect on HIV/AIDS prevention and treatment programs in the country. Zimbabwe reportedly has one of the world's "fastest shrinking economies". Real GDP declined by 6.5 percent in 2005, which was the 8th consecutive year of negative GDP growth since 1997.⁵ Over the period 1997-2005, GDP declined by more than 30 percent.⁶ The decline in food production has resulted in a serious food deficit with particularly negative consequences for the poor.

In May 2006, year-on-year inflation reached 1193 percent, the highest in the world.⁷ Contributing to the economic challenges were poor economic policies and structural changes to Zimbabwe's economic base, exacerbated by external shocks, such as continued droughts, the far-reaching impact of HIV/AIDS, and sharply reduced development aid flows.⁸

The engine of Zimbabwe's economy—agriculture—contracted drastically between 1999 and 2003, for a cumulative loss of around 26 percent, with maize production declining over 60 percent.⁹ It is estimated that production in the commercial farm sector alone fell by as much as 70 percent since 2000.¹⁰

In 2000, the government of Zimbabwe embarked on a controversial land reform program which led to the forced displacement of thousands of farm owners and farm workers, and according to economic analysts, worsened the economy and helped create acute food shortages.¹¹ The decline in food production has resulted in a serious food deficit. In 2005, an analysis carried out by the Zimbabwe Vulnerability Assessment Committee (ZimVac) —a committee composed of U.N. agencies, donors and the government—estimated that under the most optimistic scenario 2.9 million people would require food aid in 2006.¹² The mining, manufacturing and service sectors have also contracted, due to drought, shortages of foreign currency needed for imported inputs, rising production costs, as well as capital flight and large scale emigration.¹³

⁵ World Bank, "Interim Strategy note for Zimbabwe," Country Department 3, August 31, 2005, <http://siteresources.worldbank.org/INTZIMBABWE/Resources/ZIMBABWEISN.pdf> (accessed June 12, 2006).

⁶ World Bank, *Zimbabwe country brief*, April 2006, <http://web.worldbank.org> (accessed June 12, 2006).

⁷ See "May Inflation Rises to 1193.5 percent," *The Herald*, June 10 2006 citing the Central Statistical Office.

⁸ World Bank, "Interim Strategy note for Zimbabwe."

⁹ *Ibid.*

¹⁰ *Ibid.*

¹¹ *Ibid.*

¹² World Food Program, "Zimbabwe: Appeals, projected needs for 2006," February 2006, http://www.wfp.org/country_brief/indexcountry.asp?region=3§ion=9&sub_section=3&country=716# (accessed June 12, 2006). ZimVac is composed of United Nations agencies, the government and donors and assesses household vulnerability and food insecurity around the country.

¹³ *Ibid.*

The declining economy and high levels of unemployment consequently led to the development of a large thriving informal economy in the 1990s. In 2005, the International Labor Organization (ILO) estimated that 3 to 4 million Zimbabweans earned their living through informal sector employment and supported another 5 million people.¹⁴ In contrast, the formal sector employed about 1.3 million people. However tens of thousands of people lost their livelihoods in the aftermath of Operation Murambatsvina when the government destroyed thousands of flea markets, tuck shops, and craft markets. In addition, the government continues to arrest thousands of informal traders in a bid to crackdown on informal trading in the streets.¹⁵ At least 150 hair salons in Harare, Bulawayo, Mutare, and other border towns were demolished.¹⁶ Women form a significant percentage of the population working in the informal sector and many evicted traders in the informal market were women.¹⁷

The monthly average wage of Zimbabweans is estimated to be somewhere between Z\$10 million (US\$100) and Z\$20 million (US\$200).¹⁸ However according to the government's central statistical office, the average Zimbabwean needs to earn at least Z\$68 million (US\$ 680) per month to rise above the poverty line.¹⁹

Zimbabwe's social indicators, previously among the best in Africa, deteriorated rapidly between 1996 and 2004. The estimated proportion of the population living below the poverty line increased from 25% in 1990 to an estimated 70% in 2003.²⁰ The World Health Organization recently estimated the life expectancy of a woman in Zimbabwe to be 34 years, a decline from 56 years in 1978 and the lowest in the world.²¹

¹⁴ Cited in "Economy is shattered by Clean-up," *The Zimbabwean*, June 24-30, 2005.

¹⁵ U.N. Special Envoy on Human Settlement Issues in Zimbabwe, Mrs. Anna Kajumulo Tibaijuka, *Report of the Fact-Finding Missions to Zimbabwe to Assess the Scope and Impact of Operation Murambatsvina*, July 22, 2005, http://www.unhabitat.org/downloads/docs/297_96735_ZimbabweReport.pdf (accessed June 10, 2006), p.35.

¹⁶ Confidential memo from International organization working on the effects of Operation Murambatsvina on file with Human Rights Watch researchers, Harare, April 24, 2006.

¹⁷ ActionAid International, "Sectoral Impact of Operation Murambatsvina/ Restore Order," *An Analysis of Operation Murambatsvina* (Johannesburg: ActionAid International, 2005), p. 45.

¹⁸ "Remittances slow the slide into ruin," *IRINnews*, July 4, 2006, http://www.irinnews.org/report.asp?ReportID=54394&SelectRegion=Southern_Africa&SelectCountry=ZIMBABWE (accessed July 7, 2006). For more on household incomes and poverty in Zimbabwe, see Sarah Bracking and Lloyd Sachikonye, *Remittances, poverty reduction and the informalisation of household wellbeing in Zimbabwe*, Global Poverty Research Group, June 2006, <http://www.gprg.org/pubs/workingpapers/pdfs/gprg-wps-045.pdf> (accessed July 7, 2006).

¹⁹ "Family of 5 now needs Z\$ 68 million," *The Herald*, July 11, 2006, <http://www.zwnews.com/issuefull.cfm?ArticleID=14761> (accessed July 12, 2006).

²⁰ World Bank, "Interim Strategy note for Zimbabwe."

²¹ World Health Organization, "The World Health Report 2006", http://www.who.int/whr/2006/annex/06_annex1_en.pdf (accessed July 24, 2006); World Health Organization, "The World Health Report 1999," http://www.who.int/whr/1999/en/whr99_annex_en.pdf (accessed July 23, 2006).

The high poverty levels, in the absence of government social safety nets, put tremendous pressure on households taking care of PLWHA and those affected, including orphaned children and severely limit their capacity and that of communities to cope.

Health sector environment

The level of health expenditure in Zimbabwe has always ranked high relative to income. In 2000 public health expenditure in Zimbabwe was US\$43 per capita, more than double the mean total public health expenditure per capita for sub-Saharan Africa (US\$21).²² This was even after the total health expenditure decreased by 17.3% between 1990 and 2000.²³

Recent figures on health access in Zimbabwe from a 2005-6 Demographic Health Survey are expected to show both increasing user costs and decreasing numbers of trained health professionals.²⁴ However, data from the Ministry of Health suggest a long term trend in declining access for at least some services. For example, the number of children under five participating in growth monitoring programs at health centers has declined from a little over 2.5 million in 1995 to just under 1 million in 2004.²⁵ Vaccination coverage rates for DPT3 (diphtheria, pertussis, and tetanus) and measles have declined from approximately 80% in 1999 to 58% in 2002.²⁶ Infant (under age one) and child (under age five) mortality increased between 1995 and 2000.²⁷ Maternal mortality increased from 695 deaths per 100,000 live births between 1995 and 1999²⁸ to 1,100 deaths per 100,000 live births in 2000.²⁹

The impact of HIV/AIDS, harsh economic conditions, and reduced funding from international donors have all combined to severely strain the delivery of health services. The decline in the economy has led to a decrease in expenditure on health, key shortages of drugs and the emigration of medical personnel. The socio-economic and human rights situation in Zimbabwe has led three million mostly skilled professionals to leave

²² Nompumelelo Zungu-Dirwayi et al., eds., "Social Aspects of HIV/AIDS and Health Programme," in *An Audit of HIV/AIDS Policies in Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe*, (Cape Town: HSRC, 2004) p. 41.

²³ Ibid.

²⁴ Expected results from 2005-6 Democratic Health Survey (DHS) [not yet available].

²⁵ USAID, "Country Health Statistical Report, Zimbabwe," March 2004, <http://www.sokwanele.com/pdfs/zimbabweUSAID2004.pdf> (accessed June 12, 2006).

²⁶ Ibid.

²⁷ Ibid.

²⁸ Zimbabwe Millenium Development Goals: 2004 Progress Report, http://www.sarpn.org.za/documents/d0001702/Zimbabwe_MDG-report2004_goal5.pdf (accessed July 14, 2006), p. 41.

²⁹ World Bank, "Millenium Development Goals: eradicating poverty and improving lives," 2006 World Development Indicators, <http://www.devdata.worldbank.org> (accessed July 14, 2006).

the country since 2000.³⁰ In the public health sector 56% and 32% of doctor and nurse positions respectively are vacant.³¹

High and rising expenses and inadequate foreign exchange have led to shortage of funding, drugs, and supplies. A number of doctors and health workers interviewed by Human Rights Watch reported that they were frequent shortages of drugs in government run state hospitals.³²

The high cost of user fees in state hospitals puts access to quality health services well beyond the reach of many Zimbabweans. Health user fees tripled in March 2006 in state hospitals, with basic consultations increasing from Z\$300,000 (US\$3) to more than Z\$1 million (US\$10) for adults and Z\$250,000 (US\$2.50) for children (children under the age of 5 are free).³³ Fees for maternity care in public hospitals are also high at Z\$7,500,000 (US\$ 75).³⁴ Private hospitals, doctors and clinics have also increased their fees. Private sector doctors' fees increased in April 2006 by 100%—the second increase in the year—to Z\$5,700,000 (US\$58).³⁵ The private health sector is collapsing with many people switching to the already overburdened public sector.

³⁰ "Understanding the Brain Drain," *The Financial Gazette*, April 27, 2006, http://www.queensu.ca/samp/migrationnews/article.php?Mig_News_ID=2977&Mig_News_Issue=16&Mig_News_Cat=11 (accessed April 12, 2006).

³¹ U.N., "Consolidated Appeal for Zimbabwe 2006," <http://ochaonline.un.org/cap/webpage.asp?Page=1332> (accessed June 12 2006).

³² "Huge Hike in Zimbabwe Health Fees," *BBC Online news*, <http://news.bbc.co.uk/1/hi/world/africa/4942694.stm> (accessed June 26, 2006), citing report in *The Herald*, Zimbabwe, April 25, 2006.

³³ *Ibid.*

³⁴ Human Rights Watch interviews with medical personnel, Harare and Bulawayo, April 17 – May 2006.

³⁵ "Zimbabwe's Doctors Double Consultation Fees," *VOA News*, April 11 2006, <http://www.voanews.com> (accessed April 11, 2006).

V. HIV/AIDS Epidemic in Zimbabwe

Epidemiological situation

Zimbabwe has one of the highest HIV prevalence rates in the world,³⁶ with 20% of these aged 15-49 living with HIV or AIDS. An estimated 1.6 million Zimbabweans³⁷ out of a total population of 12.9 million³⁸ are living with HIV and AIDS. According to 2005 National Estimates from the Ministry of Health and Child Welfare, one hundred and fifteen thousand (115,000) of the people living with HIV/AIDS are children under the age of 15.³⁹ In 2005, 162,000 Zimbabweans were newly infected with HIV and 169,000 Zimbabweans died of AIDS—more than 3,000 each week.⁴⁰

More than half of all new infections are estimated to occur among young people aged 15-24. In this age group it is estimated that the ratio of young women living with HIV to young men living with HIV is three to one.⁴¹ According to UNAIDS, HIV infections among young people were concentrated among orphans with female double and maternal orphans most vulnerable.⁴²

HIV/AIDS experts have suggested that a number of specific populations and locations within Zimbabwe have increased rates of HIV prevalence. HIV prevalence surveys have shown higher levels of infections in border areas, growth points (rural development towns or centers), mining towns, and commercial farms.⁴³ There is also evidence that HIV prevalence is elevated in roadside trading centers along major highways⁴⁴ suggesting mobility and spousal separation as major vulnerability factors. The military is believed to

³⁶ UNICEF, "Background country report, Zimbabwe," http://unicef.org/infobycountry/zimbabwe_1403.html (accessed June 13 2006).

³⁷ UNAIDS, "Zimbabwe National HIV/AIDS Estimates 2005," *Preliminary Report*, http://www.unaids.org.zw/unaid_documents/2004Estimatesprelim.pdf (accessed June 12, 2006).

³⁸ World Bank, "2006 development indicators," <http://devdata.worldbank.org/wdi2006/contents/Section2.htm> (accessed June 13, 2006). Officially Zimbabwe's population is reported to be almost 13 million although actual population figures are considered to be quite low with reports of almost 3 million Zimbabweans having left the country because of the political and economic environment.

³⁹ UNAIDS, "Zimbabwe National HIV/AIDS Estimates 2005," *Preliminary Report*.

⁴⁰ *Ibid.*

⁴¹ *Ibid.*

⁴² "Advancing the human rights approach to HIV and AIDS in Zimbabwe," Presentation, by Hege Waagan, UNAIDS Social Mobilization Adviser, for the launch of the Zimbabwean HIV/AIDS Human Rights Charter, Harare, May 27, 2006, http://www.unaids.org.zw/unaid_documents/27may06.pdf (accessed June 26, 2006). Double orphans are children who have lost both their parents while maternal orphans are children who have lost their mothers. See UNICEF, "Children on the brink – 2004," factsheet, http://www.unicef.org/aids/files/COB_2004_fact_sheet.doc (accessed July 14, 2006).

⁴³ World Health Organization, "Summary country profile for HIV/AIDS Treatment Scale Up," June 2005, http://www.who.int/3by5/support/june2005_zwe.pdf (accessed June 12, 2006).

⁴⁴ J. Decosas and N. Padian, "The profile and context of the epidemics of sexually transmitted infections including HIV in Zimbabwe," *Sex Transm Infect.*, 2002, (Suppl 1):i40-6.

have a high prevalence of HIV and a 1998 UNAIDS⁴⁵ report states that prevalence among military personnel was three to four times higher than the civilian population.

Tuberculosis is the leading cause of death for those living with HIV/AIDS in Zimbabwe. Of the 74,000 cases of all forms of tuberculosis in 2000, about 30,000 (41%) were attributable to HIV.⁴⁶

Women's vulnerability to infection

Women have been recognized as a 'high risk' population for HIV worldwide. According to the World Health Organization, women in Zimbabwe are disproportionately affected by AIDS, constituting 51 percent of the population and 53 percent of people living with HIV/AIDS in 2003.⁴⁷ National AIDS estimates show that the majority of new cases (57%) and deaths (58%) in 2005 were also women.⁴⁸

In Zimbabwe like many other countries in the region, women are vulnerable to HIV/AIDS for a number of reasons including: the greater statistical probability of male to female transmission; a lack of protection against prejudicial cultural and traditional practices in sexual and reproductive health matters and relationships that restrict their decision-making; low incomes that make them more vulnerable to unsafe sexual practices such as forced and unprotected sex and prostitution; and laws that do not give them equal rights.⁴⁹

A key driver of the HIV/AIDS epidemic in Zimbabwe is the combined effect of poverty and inequality among women. According to a 1995 Poverty Assessment Study Survey (PASS) by the government of Zimbabwe, female-headed households constituted the majority of households living in poverty.⁵⁰ Their level of poverty is likely to make them more vulnerable to HIV infection and less able to respond effectively to its consequences. Because female-headed households are more vulnerable to poverty, they

⁴⁵ Poverty Reduction Forum, *Zimbabwe Human Development Report 2003, Redirecting our responses to HIV and AIDS Towards reducing vulnerability – the Ultimate War for Survival*, (Harare: Poverty Reduction Forum, Institute of Development Studies University of Zimbabwe, 2004); UNAIDS, "AIDS and the Military," UNAIDS Best Practice Series. May 1998.

⁴⁶ Global Fund to Fight AIDS, Tuberculosis and Malaria, "Government of Zimbabwe proposal to the Global Fund To Fight AIDS, Tuberculosis and Malaria, January 31, 2002, GFATM/B1/6A.

⁴⁷ World Health Organization, "Summary country profile for HIV/AIDS Treatment Scale Up, June 2005."

⁴⁸ UNAIDS, "Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS)," Zimbabwe Country Report, Reporting period: January 2003 – December 2005, http://data.unaids.org/pub/Report/2006/2006_country_progress_report_zimbabwe_en.pdf (accessed June 12, 2006).

⁴⁹ Poverty Reduction Forum, *Zimbabwe Human Development Report 2003*, pp. 6 – 9.

⁵⁰ Ministry of Public Services, Labour and Social Welfare, "Poverty Assessment Study Survey (1995)," Government of Zimbabwe, 1995.

are susceptible to particular livelihood strategies that open them to the risk of HIV infection.

In rural areas women generally have lower education levels than men and as a result they have limited capacity to access new technology and knowledge to enhance their productivity. Women are very often the main caregivers for those with AIDS and their dependants. They have limited means of negotiating the fidelity or condom use of their partners, or of accessing and negotiating their own female condom use. Women who are infected die at an earlier average age.⁵¹

Decline in HIV/AIDS prevalence (2000 – 2004)

The government of Zimbabwe has had some success in preventing the spread of HIV/AIDS. According to UNAIDS, the 2004 Ante Natal Care (ANC) surveillance report by the Ministry of Health and Child Welfare⁵² suggests that HIV prevalence has declined over recent years, with substantial declines in HIV prevalence in the 15-44 year-old (from 32% to 24%) and 15-24 year-old (29% to 20%) age-groups over the period 2000 to 2004. Results from a comprehensive epidemiological data review done by UNAIDS which drew upon diverse studies (including studies of postnatal women in Harare, and general population data from Manicaland) suggested that HIV prevalence has declined over the period 2000-2004, but cautioned that it was possible that the decline is “less pronounced than is indicated by the national antenatal surveillance data.”⁵³

While rising adult mortality occurring from the early-and mid-1990s contributed to the declining HIV prevalence, the authors of the UNAIDS review suggest that in Harare and rural Manicaland—the parts of the country for which the most comprehensive and detailed data are available—adult mortality appears to have stabilized, “albeit at extremely high levels.” The report states that “a substantial increase in condom use with non-regular partners and an increase in faithfulness have contributed to the decline”, and that in research from Manicaland “recent delays in onset of sexual activity, reductions in rates of sexual partner change and, for women with high rates of partner change, further increases in consistent condom use.”⁵⁴ Despite the decline it is important to note that underlying vulnerabilities such as gender inequality, population mobility, poverty and

⁵¹ UNDP, “Development Planning and HIV/AIDS in sub-Saharan Africa, Zimbabwe, 2004,” http://www.sarprn.org.za/documents/d0001371/AIDS_Dev_July2004-Zimbabwe.pdf (accessed June 24, 2006), p. 135.

⁵² UNAIDS, “Evidence for HIV decline in Zimbabwe: a comprehensive review of the epidemiological data,” November 2005, http://data.unaids.org/publications/irc-pub06/zimbabwe_epi_report_nov05_en.pdf (accessed June 13, 2006) p. 11.

⁵³ *Ibid.* p. 43.

⁵⁴ *Ibid.*, p. 39.

human rights abuses, which contribute to unsafe sexual behavior, adversely affect treatment and services and fuel the pandemic, remain of serious concern.

The impact of HIV/AIDS

A recent study by the Zimbabwe Economic Policy Analysis and Research Unit found that the HIV/AIDS epidemic has significantly weakened Zimbabwe's economy, hindering economic growth from 1994 to 2003 by 13.3%.⁵⁵ In addition, HIV/AIDS is eroding the country's workforce—composed of people ages 15 to 49—as well as national savings and investments, which now have to be spent on controlling the disease. The epidemic is also fueling food insecurity by decreasing production and productivity.⁵⁶

The loss of many small-scale and subsistence farmers to AIDS and the high level of AIDS-related morbidity have contributed to reduced food security at household level and to lower productivity overall.⁵⁷

The epidemic has resulted in a sharp increase in the burden of disease. About three hundred and fifty thousand of the 1.6 million carrying the virus need ARVs and six hundred thousand may need some care and support.⁵⁸ In 2003, UNICEF estimated that the number of orphans were 1.3 million⁵⁹ (about 19% of the child population) about 1 million of them AIDS orphans. Recent national and sub-national surveys suggest that the number of orphans may even be higher. In 2004, a Ministry of Public, Labour and Social Welfare/ UNICEF Orphans and Vulnerable Children (OVC) Survey 2004 found that 30% of the child population in the rural and urban high density regions of Zimbabwe was orphans.⁶⁰

In terms of the health sector, HIV/AIDS has also increased health expenditures. Over 70% of admissions to medical wards in Zimbabwe's major hospitals are patients with HIV and AIDS related opportunistic infections such as tuberculosis and other pneumonias.⁶¹

⁵⁵ Global Challenges, "HIV/AIDS Has Significantly Weakened Zimbabwe's Economy, Study Finds," June 19, 2006, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=37969 (accessed June 19, 2006).

⁵⁶ Ibid.

⁵⁷ FAO, "Special Report Zimbabwe," July 2005, http://www.sarpn.org.za/documents/d0000854/P971-FAO_Zimbabwe_5July2004.pdf (accessed July 6, 2006) p. 5.

⁵⁸ "Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS)," p. 8.

⁵⁹ UNICEF, "Zimbabwe statistics," http://www.unicef.org/infobycountry/zimbabwe_statistics.html#18 (accessed June 12, 2006).

⁶⁰ "Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS)."

⁶¹ Ibid. p. 7.

HIV testing and treatment

The availability of medical care provided by government and NGOs for PLWHA has increased in the past few years due to efforts to scale up access to treatment, but does not begin to meet the needs of the population. Voluntary Counseling and Testing (VCT) programs are expanding and administered free of charge or for a small nominal fee. One month of ART without additional tests costs approximately Z\$500,000 (US\$ 5) per month in the public sector and between Z\$ 2-6 million (US\$ 20-60) per month in the private sector.⁶²

In 2006, Zimbabwe announced a rapid scale-up of ARV delivery (with a goal of more than 300,000 people on ARV drugs by 2010),⁶³ but only about 23,000 out of the 350,000 Zimbabweans in need of ART are currently being treated with ARV drugs.⁶⁴ On June 16, 2006 the Minister of Health and Child Welfare David Parirenyatwa, speaking at a workshop on HIV/AIDS indicated that the government aims to have 40,000 more people on ARV drugs by the end of 2006 if the country receives more money from the *Global Fund to Fight AIDS, Tuberculosis and Malaria*.⁶⁵ More recent reports indicate that the government is actually aiming for 70,000 people on ARV drugs by the end of the year.⁶⁶

In August 2005, more than 200 facilities in the country were providing Preventing Mother-To-Child Transmission (PMTCT) services.⁶⁷ Many more patients are benefiting from active and prophylactic treatment against opportunistic infections. In most cases patients are required to pay for prescription drugs or antibiotics although treatment for tuberculosis is free. Shortages of prescription drugs often mean that patients are forced to buy them from pharmacies at increased cost.⁶⁸

Some doctors and health experts expressed the concern to Human Rights Watch that HIV/AIDS treatment programs within the NGO sector are now operating at full capacity.⁶⁹ They cite the limited capacity within the health sector for adequate medical

⁶² Human Rights Watch interviews with medical personnel, Harare and Bulawayo, April 17 – May 2 2006.

⁶³ Ministry of Health and Child Welfare, "Zimbabwe National HIV/AIDS and Strategic Plan pre-final draft, 2006-2010," April 2006.

⁶⁴ UNAIDS, "Zimbabwe National HIV/AIDS Estimates, 2005."

⁶⁵ See UNAIDS, "Minister's Speech at High level meeting," June 16, 2006, http://www.unaids.org.zw/zim_minspeech.php (accessed June 19, 2006).

⁶⁶ "Global Fund to bankroll ARV scale-up," *IRIN PlusNews*, July 10, 2006, <http://www.plusnews.org/AIDSreport.asp?ReportID=6140> (accessed July 12, 2006).

⁶⁷ USAID, "Zimbabwe HIV & AIDS Logistic Systems Assessment," January 2006, <http://www.synergyaids.com/documents/ZIMBABWE-HIV-AIDS-LIAT1.pdf> (accessed June 26, 2006) p. 5.

⁶⁸ See "Zimbabwe faces AIDS drug shortage," *BBC news online*, May 3, 2006, <http://news.bbc.co.uk/2/hi/africa/4969228.stm> (accessed May 3, 2006); Human Rights Watch interviews with PLWHA, Harare and Gweru, April 17 – May 2 2006.

⁶⁹ Human Rights Watch interviews with doctors and health experts, Harare and Bulawayo, April 17 – May 2 2006.

follow-up of large numbers of HIV/AIDS patients due to massive emigration of trained healthcare staff.

Additionally, the hike in private hospital fees has put an extra burden on the public health sector. Doctors in the public sector and the NGO sector told Human Rights Watch that due to increasing costs many Zimbabweans accessing ARV drugs in the private sector were moving to the public sector to access subsidized government treatment programs because they could no longer afford treatment in the private sector.⁷⁰ To ensure their adherence to the ARV drugs, health workers had no option but to put them to the front of waiting lists so that they could continue their treatment without disruption.

A lack of foreign currency has led to interruptions in the importation of raw materials for the local production of ARV drugs and resulted in shortages of ARV drugs in the country's major hospitals. For example one generic ARV drug, Stalanev had limited supplies available through the government sector for a period of several months in 2005.⁷¹ In May 2006, the director of the para-statal national pharmacy board reported that there was a one-month supply of ARV drugs available in the country, and that the Reserve Bank was refusing to release previously agreed-upon supplies of foreign currency needed to import anti-retroviral medicines or raw materials.⁷² Shortages of ARV drugs contributed to Zimbabwe's failure to reach the goal it set (as part of the WHO 3x5 initiative)⁷³ of 120,000 people on treatment by December 2005, by nearly 100,000 people reporting just 23,000 on therapy.⁷⁴ Interruptions in ART by PLWHA can lead to both deteriorating health conditions and can contribute to the spread of drug resistant strains of the virus.

⁷⁰ Ibid.

⁷¹ "Cost of ARVs sky rockets," *The Daily Mirror*, November 24, 2005, http://www.zimbabwesituation.com/nov24b_2005.html (accessed April 12, 2006).

⁷² "Zimbabwe faces AIDS drug shortage," *BBC news online*.

⁷³ The World Health Organization "3 by 5" initiative was launched by WHO and UNAIDS in 2003 as a global target to provide three million people living with HIV/AIDS in low and mid-income countries with life-prolonging antiretroviral treatment by the end of 2005.

⁷⁴ See World Health Organization, "Zimbabwe background document," June 2005, http://www.who.int/3by5/support/june2005_zwe.pdf (accessed June 12, 2006).

VI. Human Rights and HIV/AIDS in Zimbabwe

Human Rights Watch documented a number of human rights violations against PLWHA and those who are vulnerable to infection that threatened their rights to health, information, work, equal protection before the law, and nondiscrimination.

Government policies and practices that exacerbate the pandemic

Operation Murambatsvina and the economically harmful policies associated with informal traders have disrupted lives and increased the risk of HIV infection for thousands, while further endangering those already infected. More insidiously, the failure of the government to protect women by preventing or prosecuting domestic violence and violations of property and inheritance rights perpetuates the greater vulnerability of women and the inability of those infected to seek and receive effective care.

The impact of Operation Murambatsvina

In previous reports, Human Rights Watch has documented how Operation Murambatsvina, the government of Zimbabwe's program of forced evictions left up to 700,000 people homeless, without a source of livelihood or both.⁷⁵ The evictions also interrupted access to health care for thousands of people including PLWHA.

In November 2005, a national survey of 5,407 households of PLWHA or families living with PLWHA on the effects of Operation Murambatsvina by ActionAid found that 61 percent of PLWHA lost their access to home based care; 46 percent lost access to antiretroviral therapy; 45 percent lost treatment for opportunistic infections; 48 percent of PLWHA relocated to areas where treatment and support is limited and 22 percent lost their access to reproductive health support.⁷⁶ Human Rights Watch interviewed 19 people living with HIV/AIDS who had lost their homes during Operation Murambatsvina and they reported similar problems.

The situation of PLWHA displaced to the rural areas remains unclear as many international and local humanitarian organizations have been unable to trace people who were displaced to the rural areas. Human Rights Watch has found that in the urban areas

⁷⁵ Human Rights Watch, *Evicted and Forsaken*; Human Rights Watch, "Clear the Filth: Mass Evictions and Demolitions in Zimbabwe," *A Human Rights Watch background briefing*, September 11, 2005, <http://hrw.org/backgroundunder/africa/zimbabwe0905/>.

⁷⁶ ActionAid International in collaboration with the Counseling Services Unit (CSU), Combined Harare Resident's Association, and the Zimbabwe Peace Project, *An in-depth study on the effects of Operation Murambatsvina*, (Harare: ActionAid International, 2005), p. 21.

there was severe short-term disruption of treatment and care for many PLWHA. There were relatively few cases of long-term disruption of ART among the PLWHA interviewed by Human Rights Watch. Many reported that they were eventually able to resume home based care and ART. Nevertheless it should be noted that even short term disruption of ART can lead to the patient developing resistance to ARV drugs. Among the PLWHA interviewed by Human Rights Watch on ARV drugs, a number reported that they were unable to access drugs for periods ranging between a week and three months.

Human Rights Watch spoke to PLWHA in three areas affected by the evictions; Hatcliffe Extension, Mabvuku, and Highfield in Harare. In these areas, several PLWHA informed Human Rights Watch that their access to treatment and care was disrupted when they were sent to holding camps where they received little or no care for a period of up to three months. For example Teresa N., whose daughter was diagnosed HIV positive just before the evictions began and was put on ARV drugs, told Human Rights Watch, “My house was destroyed and I had to go with my sick daughter to Caledonia camp and we were sleeping out in the open.” She continued, “We were sleeping out in the open and then she fell very sick and there was no treatment for her for the three months we were there.” Teresa N., informed Human Rights Watch her daughter was eventually diagnosed with tuberculosis when they left the camp in October.⁷⁷

Many of the PLWHA affected by Operation Murambatsvina interviewed by Human Rights Watch continue to live in appalling conditions that sometimes exacerbate their condition and make them more prone to opportunistic infections. One HIV positive man took Human Rights Watch to the temporary shelter where he lived with his HIV positive wife and their children. Despite the oncoming winter, their shelter had no windows and they were sleeping on the bare ground.⁷⁸ Others told Human Rights Watch researchers that they were living in overcrowded conditions, sleeping in houses without roofs while a couple reported that they were still living out in the open almost a year after the evictions took place.

Priscilla K., a 59- year-old HIV positive widow suffering from pneumonia told Human Rights Watch:

I’m living outside because of the tsunami [Operationa Murambatsvina]⁷⁹. Before the evictions I was living in a little shack

⁷⁷ Human Rights Watch interview with Teresa N., (not her real name), Hatcliffe Extension, April 20, 2006.

⁷⁸ Human Rights Watch interview with HIV positive man, Hatcliffe Extension, April 20, 2006.

⁷⁹ Most Zimbabweans described the evictions as a “tsunami”, as the police who evicted them from their homes came without warning and destroyed everything in their path.

behind a house but they destroyed it. Now I have a bed outside. I have a little bit of plastic to cover it. Before the evictions I was growing tomatoes, vegetables; I would go find mushrooms to sell. Now I have nothing. I lived in that house for 26 years and they tore it down. It's like I'm a wild animal—living outside—and with many others all around me.⁸⁰

The fact that few of the people interviewed by Human Rights Watch suffered long term disruption to the evictions was not due to any government effort but was mainly due to the efforts of PLWHA to continue their treatment from wherever they had been displaced to, as well as the work of NGOs and clinical trials to track down patients to ensure continuity of care. As one woman in Hatcliffe Extension explained, “My house was destroyed during the tsunami and I went to Caledonia. I used to get my ARVs every two weeks and at Caledonia I had to travel to Newlands Clinic to get the ARVs. Sometimes if I didn't have the transport, I would walk there even though it was far. I knew that I couldn't stay without my medication. At Caledonia, they gave us nothing.”⁸¹

Testimony from victims of the evictions interviewed by Human Rights Watch, and analysis of NGO reports by organizations such as ActionAid on the evictions show that Operation Murambatsvina has increased vulnerability to HIV infection in an already vulnerable population. Although there is no quantitative analysis currently available on the effects of the evictions on vulnerable groups, the conclusion of international NGOs and those working with evicted populations is that the evictions have made vulnerable groups even more prone to HIV infection and sexually transmitted infections (STIs). For example, representatives of one international organization working with evicted people in some areas of Harare informed Human Rights Watch that they had noted an increase in the number of sexually transmitted infections among the evicted population.⁸² According to medical experts, STI's can increase a person's risk of becoming infected with HIV/AIDS.⁸³

Displacement resulting from the evictions has been shown to increase the risk of new infections.⁸⁴ Vulnerability to HIV increases in these situations because men and women are more likely to engage in casual (and unsafe) sex due to the breakdown of families,

⁸⁰ Human Rights Watch interview with Priscilla K., (not her real name), Highfield, April 20, 2006.

⁸¹ Human Rights Watch interview with HIV positive woman, Hatcliffe Extension, April 20, 2006.

⁸² Human Rights Watch interview with representative of international NGO, Harare, April 21, 2006.

⁸³ UNAIDS, “2006 Report on the Global AIDS Epidemic, Comprehensive HIV prevention,” http://data.unaids.org/pub/GlobalReport/2006/2006_GR_CH06_en.pdf?preview=true (accessed June 24, 2006), p. 130.

⁸⁴ For example see Belinda Dodson and Jonathan Crush, “Deadly links between mobility and HIV/AIDS,” *Crossings*, vol. 7 no. 1. March 2006, p. 2.

and for women who have lost their livelihood to exchange sex for shelter, food and protection. In many cases families were separated in the holding camps. In other cases men sent their wives and families to the rural areas while they remained in the urban areas to work.⁸⁵

As a result of the displacements, international and local NGO contacts informed Human Rights Watch that they had observed an increase in numbers of displaced women engaging in transactional sex in the aftermath of the evictions in order to survive.⁸⁶ This information is reinforced by ActionAid's study on the effects of Operation Murambatsvina, which found that 45% of respondents in its survey of 5407 households reported that they had either engaged or witnessed an increase in casual sex relationships, while 50% reported that they had either witnessed or engaged in commercial sex work as a result of the evictions.⁸⁷

Operation Murambatsvina also disrupted access to information on HIV prevention and treatment to many people including PLWHA. In turn, this affected people's right to health including for vulnerable or marginalized groups who needed it most, such as PLWHA or groups at risk of HIV infection. For example, during the operation, the national condom social marketing program was severely disrupted. The destruction of tuck shops (small shops found in the high density residential areas of cities around the country) and hair salons affected close to 2000 condom outlets representing more than 40% of outlets for distribution. Mobile sales of condoms were further affected by instability resulting from the evictions, increases in transport costs and restrictions on informal trading.⁸⁸

In Hatcliffe Extension, a clinic running a free ART and opportunistic infection treatment program under the St. Dominican Sisters was destroyed during the evictions and the program disrupted.⁸⁹ As a result, a number of PLWHA on the treatment program reported to Human Rights Watch that initially they could not access treatment as the Dominican Sisters were forced to move out of the area. Others reported that they were unable to join the program because the Dominican Sisters scaled down their operations in the aftermath of the evictions. To continue treatment, others were forced to travel a longer distance to Harare where the sisters now run their program.

⁸⁵ Human Rights Watch report, *Evicted and Forsaken*. p. 32.

⁸⁶ Human Rights Watch interviews with local and international NGOs, Harare, April 18 – May 2, 2006.

⁸⁷ ActionAid International, *An in-depth study on the effects of Operation Murambatsvina*, p. 22.

⁸⁸ Human Rights Watch interview with local and international NGOs, Harare, April 18 -May 2, 2006.

⁸⁹ Human Rights Watch, "Clear the filth," p. 28.

Netsai A., a 45-year-old woman living with HIV/AIDS told Human Rights Watch:

I have a problem with medication. The Dominican sisters were providing me with medication for opportunistic infections. When the tsunami came the Dominican sisters left. My house was demolished on May 26. I was sent to Caledonia Farm and was there for three months. I had no medication. I had pneumonia and it was winter and we were living in the open because there wasn't shelter. I didn't receive any treatment. I just recovered by myself. These days we don't get opportunistic infection treatment. We have to go to Hatcliffe poly clinic but we have to pay Z\$500000 (US\$5) [for consultation]. Then they give you a prescription to buy for yourself. When I get sick I can't afford to go to the clinic, I just buy panadol. The Dominican sisters program was disturbed by the government. Their clinic was destroyed.⁹⁰

The evictions have also revealed the stigma and discrimination that PLWHA often face. Human Rights Watch found that the evictions left some PLWHA vulnerable to discrimination from potential landlords and relatives. Although Human Rights Watch could not determine the extent of the practice, a number of PLWHA and their families reported that since they lost their homes to the evictions, they were unable to rent new accommodation because landlords refused to let out houses if they discovered that someone in the family looking to rent the house had HIV, or the potential tenant was HIV positive. According to one woman living with HIV/AIDS, "I have seen some of the evicted people being turned away or chased away from their new lodgings because of their (HIV/AIDS) status. The landlords are scared they will fall sick. They chase you politely. They try to find a reason to chase you or raise the rent exorbitantly."⁹¹ Others told Human Rights Watch that they faced discrimination from relatives whom they moved in with when their homes were destroyed.

Nelly S., a 36-year-old mother of four and her husband tested positive for HIV/AIDS in early 2005. In June 2005, police came and destroyed their house and the family was forced to move in with Nelly's aunt. Nelly S. told Human Rights Watch about the discrimination her family faced:

My auntie wants us to find our own accommodation because my husband and I are sick. Some people think that if you stay with someone with HIV you get the virus. The landlords discriminate against people

⁹⁰ Human Rights Watch interview with Netsai A., (not her real name), Hatcliffe Extension, April 20, 2006.

⁹¹ Human Rights Watch interview, woman living with HIV/AIDS, Highfield, April 20, 2006.

with HIV. I have tried to rent a house but the minute they've known my status they have said no. If you are HIV positive and disabled they say no. You can't say your status; you have to keep it a secret because if the landlord finds out they kick you out.⁹²

A number of PLWHA interviewed by Human Rights Watch researchers said that as a result of discrimination they felt unable to openly declare their status because they risked being thrown out of a relative's house or being chased away by their landlords.

Government promises to provide housing to all those affected by the evictions and prioritize the needs of vulnerable groups, seem to have amounted to little.⁹³ Human Rights Watch researchers found that most of the PLWHA affected by the evictions— with the exception of those interviewed at Hatcliffe Extension— were not provided with any shelter or accommodation by the government. The situation was only slightly better for those interviewed at Hatcliffe Extension, many of whom were living in unfinished government housing. As highlighted earlier, most of the houses had no windows and roofs. The plastic sheeting used by the evictees to provide some protection from the elements was provided by international NGOs.

Arrest and harassment of informal traders

Operation Murambatsvina also badly damaged the informal sector which the majority of poor Zimbabweans rely upon to earn a livelihood. The government's program of forced evictions and demolitions has resulted in restrictions on informal economic activities around the country. Despite the country's high unemployment rate (approximately 80%), informal traders who go into the streets to sell their wares are regularly arrested and fined by members of the Zimbabwe Republic Police and their goods confiscated. For many PLWHA, informal trading is the only means to earn money for food and medication including ART. Economic restrictions on trading have also increased the risk of infection for thousands of people working in the informal sector who have been left without any source of livelihood. The link between poverty and HIV/AIDS has been well documented by international bodies such as UNAIDS. According to UNAIDS, "The [HIV/AIDS] epidemic flourishes especially among people and communities that are deprived of the elementary benefits of successful development

⁹² Human Rights Watch interview with Nelly S., (not her real name), Mabvuku, April 22, 2006.

⁹³ According to reports the government of Zimbabwe admitted that it has rebuilt only 3000 housing units despite pledging to build over a million houses in the next four years. See "Zimbabwe houses not for officials," *News24online*, March 14 2006, http://www.news24.com/News24/Africa/News/0,,2-11-1447_1897729,00.html (accessed March 14, 2006).

(public social services such as education and health care, secure employment, shelter and social safety nets for sustaining livelihoods).⁹⁴

The government claims that informal trading has led to criminality within the high density areas of Zimbabwe and needs to be curbed and regulated.⁹⁵ As a result all those wishing to engage in informal trade are required to apply for a license to operate in a government designated area. Yet in the late 1990s, the government's own policies effectively encouraged informal activities in residential areas. As a result of measures designed to lessen hardships faced by households, the government designated new sites for informal trade and micro enterprises including, "peoples markets," and flea markets. In addition the government relaxed enforcement of regulations, especially on the operation of businesses run from people's homes.⁹⁶ The government then destroyed tens of thousands of these businesses during the 2005 evictions.

Activities such as hair dressing, tailoring and stone carving were also deregulated when the government brought into law Statutory Instrument 216 in 1994.⁹⁷ According to the report of the UN Special Envoy on the effects of the evictions, the change in the law sent a clear signal to local council authorities that the government was eager to promote the informal economy. This resulted in local council authorities "turning a blind eye to the explosion of the informal economy."⁹⁸ Thus as the formal economy has declined and unemployment risen, more and more people have turned to informal trading.

The rapid increase in the number of people engaging in informal trading activities may indeed require regulation but the government needs to recognize the rights of Zimbabweans to earn a living in an environment of high unemployment. Procedures for acquiring a license should be made more affordable and clear to applicants. Currently, the cost of acquiring a trading license to sell goods in government-designated market

⁹⁴ See UNAIDS, "HIV/AIDS, Human Resources and Sustainable Development," World Summit on Development, Johannesburg, 2002, http://data.unaids.org/Publications/IRC-pub02/JC865-WSSD_en.pdf (accessed July 10, 2006), p.5.

⁹⁵ See Government of Zimbabwe, "Response by the Government of Zimbabwe to the Report by the UN Special Envoy on Operation Murambatsvina/ Restore Order," August 2005, <http://www.un.org/dpi/ngosection/fall05/briefings/27oct-resp-zimb.pdf> (accessed June 12, 2006), pp. 15 – 16.

⁹⁶ Before the 1990s micro entrepreneurs who wanted to operate outside designated areas had to submit an application, advertise, advise neighbors, and acquire special consent. However all this changed when as part of structural adjustment programs, the government was encouraged to lessen restrictions on micro and small enterprises. For more on this subject see: Carolyn Barnes and Eric Keogha, "An assessment of the impact of Zambuko's microenterprise program in Zimbabwe: Baseline findings," *USAID, AIMS Project Brief* 23, 1999, pp. 11-12.

⁹⁷ Regional Town and Country Planning Act, Chapter 29:12, 1976. Statutory instrument 216 specifically provides for "non-residential uses in residential areas."

⁹⁸ U.N. Special Envoy on Human Settlement Issues in Zimbabwe, Report of the Fact-Finding Mission. In its critical response to the UN Envoy, the Government of Zimbabwe acknowledged that it indeed attempted to promote the informal sector in residential areas. See "Response by the Government of Zimbabwe to the Report by the UN Special Envoy on Operation Murambatsvina/ Restore Order."

places is prohibitive. For example the monthly cost of a trading stall in Harare is about \$Z1.7 million (\$US17) and is expected to increase to about \$Z4 million (\$US40) by September 2006,⁹⁹ which many women in particular cannot afford. The criteria for getting a license for those who pursue it are not always made clear to applicants.¹⁰⁰ Many women and men interviewed by Human Rights Watch reported that they were unable to secure a license and did not know the reasons for their rejection. As one woman told Human Rights Watch, “I tried to get a license to be able to sell vegetables, but the city council turned down the request. They only approved a few people to get a license.”¹⁰¹

A significant proportion of those who work in the informal sector are women.¹⁰² International organizations have highlighted the importance of economic autonomy for women in the global fight against HIV/AIDS.¹⁰³ Yet the government of Zimbabwe has made women more economically insecure by barring many of them from selling wares in the street. Human Rights Watch researchers documented many cases of police harassment, intimidation and arrest of PLWHA and other vulnerable groups such as widows who were trying to make a living as informal traders.

The harassment, intimidation and arrest of informal traders narrows the range of livelihood strategies available and in the case of women, increases their economic dependence and may drive them to undertake risky livelihood measures such as engaging in unsafe transactional sex or outright sex work, which increases their exposure to HIV infection. For example, a number of women informed Human Rights Watch that they had sought male sexual partners or considered engaging in sex work because they were unable to make money from informal trading due to police harassment. One informal

⁹⁹ Combined Harare Residents' Association, “2006 City of Harare Budget Analysis,” March 2, 2006, http://www.kubatana.net/docs/locgov/chra_harare_budget_analysis_060302.doc (accessed July 13, 2006), p. 6.

¹⁰⁰ Carolyn Barnes and Erica Keogh, “An assessment of the impact of Zambuko’s microenterprise program in Zimbabwe: Baseline findings,” *USAID, AIMS Project Brief* 23, 1999, p. 12. The government does not have an existing piece of legislation governing the operation of micro enterprises. But according to local authority regulations, anyone operating a business (including home based income generating ventures) is required to obtain a license which is renewable annually. The license depends on the type of business for example shop trading, vending or hawking. However as has already been indicated local authorities have turned a blind eye to these requirements. In addition surveys on the informal sector in the late 1990s found that most micro-entrepreneurs did not have a license which supported the conclusion that existing regulations had been relaxed until Operation Murambatsvina.

¹⁰¹ Human Rights Watch interview with informal trader, Gweru, April 26, 2006.

¹⁰² Women’s Resource Centre Network and Southern African Research and Documentation Centre, “Beyond Inequalities, Women in Zimbabwe 2005,” <http://databases.sardc.net> (accessed June 24, 2006); ActionAid International, “Sectoral Impact of Operation Murambatsvina/ Restore Order.”

¹⁰³ See Global Coalition on Women and AIDS, a UNAIDS initiative, “Economic Security for Women Fights AIDS,” (2006), http://data.unaids.org/pub/BriefingNote/2006/20060308_BN_GCWA_en.pdf (accessed June 13, 2006); International Community of Women Living with HIV/AIDS, “Action needed to reduce gender inequality and poverty in the lives of HIV positive women,” (2004), http://www.icw.org/tiki-download_file.php?fileId=62 (accessed, June 26, 2006).

trader said, “I sometimes think of doing the sex work when I have problems of money but I am scared of getting sexually transmitted infections and HIV/AIDS.”¹⁰⁴

Fadzai B. a widow with four children told Human Rights Watch:

I sell tomatoes to earn a living. I have been selling tomatoes for 11 years. I sometimes get arrested by the police and have to pay a fine. I have been arrested about five times now. It has been worse since Operation Murambatsvina. I have registered for the hawkers license but haven't received it yet. Things are tough. I get tired of playing hide and seek with the police. When things are really bad and the police have taken away my goods, I sometimes think of going to the bars to find men even though I have a boyfriend. I don't know if I will do it but that's what I think.¹⁰⁵

Nyandzo C., a divorced 46-year-old informal trader worked as a sex worker for eight years. Five years ago she decided to stop and become an informal trader and started growing and selling her own vegetables. During Operation Murambatsvina police started harassing informal traders, arrested them and then took away their goods and continued to do so in the aftermath of the evictions. She told Human Rights Watch researchers, “I stopped working as a sex worker because I was scared of getting the virus (HIV) after I was found with herpes. But now I need to survive so I have returned to sex work. When the police take away my goods, I go to the bars to find men so that I can recoup the money I lost. I try to insist on condoms, but not all of the men listen.”¹⁰⁶

The long and drawn out process for procuring a trading license leaves many desperate women with no choice but to operate without a license and leaves them subject to police harassment and intimidation. One organization that works with sex workers and vulnerable women informed Human Rights Watch that up to 70 of its 700 clients had not heard from the city council even though they had applied for licenses several months earlier.¹⁰⁷

¹⁰⁴ Human Rights Watch interview with informal trader, Gweru, April 26, 2006.

¹⁰⁵ Human Rights Watch interview with Fadzai B., (not her real name), Mabvuku, Harare, April 22, 2006.

¹⁰⁶ Human Rights Watch interview with Nyandzo C., (not her real name), Gweru, April 26, 2006.

¹⁰⁷ Human Rights Watch interview with director of organization (name and location withheld), April 26, 2006.

Violations of women's rights

A number of social factors put women at greater risk of HIV infection including poverty, and gender inequality. The U.N. Special Envoy for HIV/AIDS in Africa has stated that, "where AIDS is concerned, gender inequality is lethal."¹⁰⁸

Zimbabwe has taken some vital steps to improve the status of women and children by putting in place certain laws and policies. In addition, Zimbabwe's National Policy on HIV/AIDS recognizes that the government should change these underlying social cultural structures that perpetuate the vulnerability of women to HIV infection and transmission.¹⁰⁹ In October 2000, the National Gender Policy of the Republic of Zimbabwe was issued with the aim of "providing guidelines, institutional framework, and parameters to ensure the availability of resources for the successful and sustainable implementation of the Zimbabwe Constitution and legislative requirements, regional and international conventions, protocols, declarations and agreements on gender equality, equity and nondiscrimination"¹¹⁰ The Gender Policy recommends the following with regard to HIV/AIDS:

- Sensitizing and creating awareness on gender and health issues, including HIV/AIDS;
- Developing gender sensitive multi-sectoral programs for empowerment of women and girls and to enable men to assume their responsibilities in prevention of HIV/AIDS; and
- Introducing measures to counter the exposure of girls to HIV/AIDS through traditional and religious beliefs and practices.¹¹¹

Yet, as a number of women's organizations point out, a lot more needs to be done, and some of the laws so far have had little impact on the lives of most women and children.¹¹² In many cases customary laws with discriminatory elements¹¹³ continue to

¹⁰⁸ Speech by Stephen Lewis at the Centre for Strategic and International Studies, Washington DC, October 4, 2002.

¹⁰⁹ Zimbabwe, "National Policy on HIV/AIDS for Zimbabwe," (1999), Section 7.

¹¹⁰ National Gender Policy of the Republic of Zimbabwe, October, 2000, p.1.

¹¹¹ *Ibid.*, p. 12. In section 6.2.3, the Gender Policy recommends the following strategies in an effort to guarantee human rights and democracy: 1) Lobbying for the promotion of equal and equitable participation of women and men in decision making. 2) Legislate and enforce against discriminatory practices, beliefs and traditions that hinder the advancement of women and men especially the girl child. 3) Incorporate provisions of international human rights instruments into domestic law.

¹¹² Human Rights Watch interviews with women's organizations and women in Harare, Gweru and Masvingo, June 2005, September 2005 and April 2006.

¹¹³ Zimbabwe has a dual legal system. As a result women's property rights in Zimbabwe are subjected to two sources of law: general law i.e. The Roman – Dutch system of law and the customary law of the two main groups of Zimbabwe's indigenous peoples, the Ndebele and the Shona. The right to property in Zimbabwe is protected by section 16 of the Constitution of Zimbabwe, 1979.

take precedence over formal laws with regard to women's property rights, while according to local women's organizations, the attitudes of relatives, government officials, and the judiciary still reinforce traditional belief systems. Additionally, amendments to the law on inheritance have made little impact because there is little enforcement. The discrimination against women exemplified in section 23 (3)(b) of the constitution of Zimbabwe—as highlighted in the next paragraph of this section, the practice of discriminatory customary law and the inability of many women to pursue their cases in the court deprives women of their rights to property, and increases the vulnerable position of women in society. This section highlights how gender inequality, poverty and domestic violence in Zimbabwe puts women at greater risk of HIV infection and prevents women living with HIV/AIDS from mitigating the economic consequences of their condition.

Discriminatory inheritance laws and practices

The Constitution of Zimbabwe prohibits discrimination on the basis of gender. However this key provision is circumvented by, Section 23 (3) (b) of the constitution of Zimbabwe which allows discrimination on issues of personal law. This covers family laws such as adoption, marriage and inheritance, and effectively allows customary law to override other inheritance laws.¹¹⁴ Specifically this section of the constitution provides that a man's claim to family inheritance takes precedence over a woman's, regardless of the woman's age or seniority in the family.¹¹⁵ For example, in the event of a man's death, his brother's claim to the inheritance takes precedence over that of the deceased's wife. The Administration of Estates Amendment Act was introduced by the government of Zimbabwe in 1997, to make inheritance laws more favorable to widows and is supposed to address the problems women faced in inheriting property under Zimbabwe's customary laws.¹¹⁶ However there has been little enforcement of the Act in the courts.

The poor economic status of women often makes it difficult for them to pursue their cases in the courts. With few exceptions, most of the women Human Rights Watch interviewed for this report worked in the informal sector. As a result very few could

¹¹⁴ Constitution of Zimbabwe, section 23 (3) (b), 1979. The section outlines that the Application of African customary Law shall not be held to be discriminatory in other issues of personal law such as inheritance, access to communal land which then prejudice women's rights to access property. For more on women's property rights in Zimbabwe see Thandekile Ngwenya, Zimbabwe Women Lawyers Association, "Strategic Litigation – Women's Property Rights in Zimbabwe," Bulawayo presentation at a Strategic Litigation Workshop, Johannesburg, August 15-18, 2005.

¹¹⁵ An unfortunate precedent was set by this section of the Constitution in the case of *Magaya v. Magaya* when the Supreme Court ruled that under family law, a man's claim to family inheritance takes precedence over a woman's. Although the Administration of Estates Act was eventually amended in 1997 to address the problems highlighted in *Magaya v. Magaya*, the Act only applies to deaths occurring after 1 November 1997. Thus deceased estates of persons, who passed away before 1 November 1997, are bound by the *Magaya* decision.

¹¹⁶ Administration of Estates Amendment Act 6:07, 1997.

afford to take their cases to the courts. Women whose partners fall sick and die, particularly of AIDS, frequently suffer discrimination and lose their homes, inheritance, possessions or livelihoods. This was confirmed in several cases which Human Rights Watch documented, where women suffered abuses after the death of their husbands from HIV/AIDS.

Mary S., a 53- year-old widow with three children whose husband died from HIV/AIDS told Human Rights Watch:

When my husband died in 2000, his relatives came and took everything. They took the house and sold it. I had to find a place to live, for myself, my children, and my 3 grandchildren. I asked my brothers for help and they said that they've got their own family, how can they help me? I went to the police but they didn't help, they told me to go to social welfare. I went there and there was no help either. They wrote my name down. I went back and then they said they would come for a house visit. They came but they gave me no help. I don't know why. I am a dressmaker, but I have no work right now— I have no capital to get things going. I am trying to sell tomatoes to make money. It is difficult. The police arrest us; they take all of our things. We pay a fine— Z\$250000 (US\$ 2.50) — all the time.¹¹⁷

The husband of Patricia E., a 45- year-old widow, died in 2000. Patricia was diagnosed with HIV in the same year. She told Human Rights Watch:

After my husband died, his relatives came to take the house. They wanted to take it and send me away to the rural areas. I was able to stand up to them and stop them but they took all his tools (he was a mechanic). They said that because I am a woman I didn't have the power to use the tools. I wrote a will for my children so that they will not have so many problems from the relatives. I used to sell clothes in Botswana. I used to go often, but now the situation in Zimbabwe is too difficult. Now I work for other people – doing washing (clothes), in their farms. I have a small garden. My children aren't working. My youngest is still in school, but I can't afford the school fees¹¹⁸

¹¹⁷ Human Rights Watch interview with Mary S., (not her real name), Gweru, April 26, 2006.

¹¹⁸ Human Rights Watch interview with Patricia E., (not her real name), Gweru, April 26, 2006.

Property-grabbing¹¹⁹ sometimes forces women to compensate for their loss of economic security by engaging in unsafe sexual behavior. In a couple of the cases Human Rights Watch documented, women had turned to sex work in order to survive. Sibonikhile F., a 28-year-old widow told Human Rights Watch:

My husband died in 2002 when I was pregnant. His relatives took everything away and left me with nothing. At the time we were living in the rural areas and I had nowhere to go. I couldn't go back to my parents because they are dead. The chief refused to do anything so I came here (to the city). Life became very difficult and so I decided to go to the beer halls to work as a commercial sex worker. I had no one to help me. I needed money to buy nappies for the baby and so I had no option. I now have a boyfriend and decided to leave sex work because he has agreed to look after me and my child.¹²⁰

Gender based violence

There is limited data available about violence against women in Zimbabwe but press reports and reports from women's organizations indicate an increase in incidents of gender based violence in the past few years. Many women's organizations report that domestic violence is pervasive in Zimbabwe.¹²¹ On March 1 2005 UNICEF issued a press release condemning the increasing tide of violence against women in Zimbabwe and called for the enactment of the Domestic Violence bill. According to UNICEF, "a combination of an inflexible approach to cultural and traditional practices; an economic downturn that has seen women become the chief bread winners as men are made unemployed; together with odious beliefs on HIV and virgins has meant gender based violence is frighteningly common in Zimbabwe."¹²² Although the government's Sexual Offences Act legislates against rape in general and marital rape,¹²³ domestic violence in Zimbabwe is often viewed by the police and the judicial authorities as a family matter and not for the courts. The Prevention of Domestic Violence Bill of 2005 which was drafted 10 years ago will be brought before parliament in late July 2006. The bill among

¹¹⁹ Property grabbing can be defined as when a man's relatives descend upon his widow to claim the household's material possessions.

¹²⁰ Human Rights Watch interview with Sibonikhile F., (not her real name), Gweru, April 26, 2006

¹²¹ See Women's Resource Centre Network, "Beyond inequalities, Women in Zimbabwe 2005"; "Activists demand GBV law," *IRINnews*, March 7, 2006, <http://www.irinnews.org/report.asp> (accessed March 7, 2006); "Zimbabwe rape cases on rise countrywide," *AllAfrica.com*, April 12, 2006, <http://www.allafrica.com/stories/200604110253.html> (accessed April 12, 2006).

¹²² UNICEF press release, "UNICEF Denounces violence against women," Harare, March 1 2006, <http://www.unicef.org> (accessed March 1, 2006).

¹²³ Sexual Offences Act, Chapter 9:21, 2001, section 8.

other things makes domestic violence a crime in its own right and also covers economic, verbal and psychological abuse.¹²⁴

Gender based violence contributes to the risk of infection or spread of HIV/AIDS. Human Rights Watch interviewed several women who in an attempt to escape violent relationships entered into sexual relations with men in exchange for the provision of food, shelter and other goods. In the five cases that Human Rights Watch documented, the police failed to provide protection to the women. In two cases, the women were told that the violence was a family issue and not a matter for the police.

Pauline G., a 22- year-old mother of one recounted her story to Human Rights Watch:

My father died in 1996 and my mother in 1997. I lived with my aunt for a couple of years after my mother died but I had a lot of problems. She refused to pay my school fees, and refused to even give me food to eat sometimes. I moved in with my brother until I got married. I didn't want to get married really; I just got married because I needed someone to support me.

My husband was violent. He would hit me for no reason. He was a drunkard. I went to the police and they didn't do anything. I went to my brothers too. My husband took everything when we divorced. At first my brothers took care of me, but I knew I had to find my own support. I went to the bars to look for a boyfriend. I met someone, he's a truck driver. I think he has other girlfriends but he pays for the rent, for food, for clothes. He takes care of the baby.¹²⁵

Josephine H., a 21-year-old orphan was diagnosed HIV positive in November 2005. She told Human Rights Watch:

When my parents died in April last year, I went to stay with my grandmother and my uncles beat me and chased me and my sister away and so we used to go and live with boys and sleep with them for shelter and security. The father of my child is in South Africa. He left me when

¹²⁴ Email communication from Veritus Trust (Zimbabwe) to Human Rights Watch, July 1, 2006; see also "Activists demand GBV law," *IRINnews*, March 7, 2006, <http://www.irinnews.org/report.asp> (accessed March 7, 2006)

¹²⁵ Human Rights Watch interview with Pauline G., (not her real name), Gweru, April 26, 2006.

I fell sick with tuberculosis and doesn't help with anything. I am worried because every time I go to stay with my grandmother, my uncles beat me and chase me away. My six siblings and I have been chased away on several occasions. I go and stay with men because I have no choice. I know I have to use protection with them now because I am positive. My aunt went to social welfare for help to look after us but they didn't do anything. She has also reported my uncles to the police but they don't do anything.¹²⁶

Domestic violence, or even the threat of violence, also decreases a woman's ability to negotiate her sexual autonomy, making her more vulnerable to HIV infection. Women's economic dependence made worse by discriminatory laws in the case of divorce also increases their vulnerability to violence and HIV-infection and leaves them unable to escape from potentially deadly marriages or partnerships. One woman told Human Rights Watch, "I know that my boyfriend is HIV positive because I saw his medical papers. Every three months he goes to get tested but I just keep quiet. I don't ask him about his status because I am scared of him. He would not take it well if I asked him. I am also scared that I may have the disease now. But if I asked him he would say I didn't trust him."¹²⁷

Stigma and discrimination in the family

Women's vulnerability is often compounded by the stigma and discrimination that faces them once their HIV status is revealed. Women who admit to having HIV risk social exclusion or abandonment. The government's divorce laws which fail to recognize women's property rights in the case of unregistered customary marriages—some 80% of all marriages—leaves women particularly vulnerable when it comes to divorce or abandonment.¹²⁸

Numerous women reported to Human Rights Watch that once their HIV status was revealed, their male partners had abandoned them and their children, thrown them out of the house, or taken property without leaving provisions to support them and their children. The women were often left destitute and unable to deal with the economic consequences of living with HIV/AIDS.

¹²⁶ Human Rights Watch interview with Josephine H., (not her real name), Mabvuku, April 22, 2006.

¹²⁷ Human Rights Watch interview, Gweru, April 26, 2006.

¹²⁸ In Zimbabwe it is reported that almost 80% of all marriages are customary marriages. See Woman Kind, "Zimbabwe country profile," <http://www.womankind.org.uk/why-zimbabwe.html> (accessed June 20, 2006).

A number of the women told Human Rights Watch that they could not afford to take their husbands to court, while others were not aware of their right to do so. In other cases the women felt they had no recourse to the courts because they were involved in polygamous marriages or unregistered customary unions. In most of the cases the men reportedly blamed their female partner for bringing AIDS into the relationship.

Cecilia M., 40, tested positive for HIV/AIDS after her daughter died of AIDS at the age of ten. When Cecilia M. eventually fell seriously ill her husband left her:

My husband left when I fell sick. He now stays with another wife. Before my husband left I was on medical aid and then he left and I had nothing. My husband doesn't pay any maintenance and he took my property away. I hear people saying that he is showing signs of sickness now. We were together for 13 years and it's obvious that he is also positive. My relative who I stay with doesn't know that I am HIV positive. There are three other families in the same household and the others suspect that I am HIV positive and they aren't comfortable with me. If they knew they would chase me. I don't work. I do some embroidery but business isn't going well. I have had to sell some of my clothes to meet expenses. I just manage to pay the rent. We only have one meal a day in the evening. It's tough. Sometimes you just think that maybe if you die, things will get better. I have to find transport to get my ARVs and when I don't have the money I walk to get the ARVs. I am so stressed. I nearly committed suicide because things are so tough. There's no bright future because when you don't know what you are going to eat tomorrow, there's no future.¹²⁹

Several women interviewed by Human Rights Watch were particularly distraught that their relationships with their partners had deteriorated or ended since they had revealed their HIV status. Priscilla P. an HIV positive woman in Gweru told Human Rights Watch, "Since I told my boyfriend about my status he has been cold with me. He is also sick all the time but he keeps saying he has been bewitched. He won't say who (has bewitched him) but I think he blames me. He spends more time away from the house now."¹³⁰ Another woman living with HIV/AIDS told Human Rights Watch, "My boyfriend knows I am HIV positive but refuses to get tested. Now he doesn't look

¹²⁹ Human Rights interview with Cecilia M., (not her real name), Highfield, April 20, 2006.

¹³⁰ Human Rights Watch interview, with Priscilla P., (not her real name), Gweru, April 26, 2006.

healthy. He keeps getting flu and fevers. I don't talk because he is rough and sometimes beats me."¹³¹

Tafadzwa K., a 36-year-old divorced woman with four children told Human Rights Watch:

I've been living with a man for 6 months now. He hasn't been tested. His 2nd wife died, so maybe he is infected. I have been too afraid to talk to him about HIV. He might leave me. He might hurt me. He loves me so much but I can't tell him that I'm positive. I want someone to share my life with. We use condoms sometimes. Sometimes he refuses and I can't convince him.¹³²

Discriminatory and arbitrary health and social welfare policies

The government of Zimbabwe's policies and actions undermining the fight against HIV/AIDS have been both sudden and catastrophic (Operation Murambatsvina), and subtle and insidious. Progress in the fight against AIDS has also been undermined by the government of Zimbabwe's social welfare policies. High user fees for health services, the collapse of the system of social welfare exemptions of health fees, and the failure to ensure that national policies on eligibility for ART are followed have resulted in thousands of individuals living with HIV/AIDS being turned away from the health care that they are entitled to, and that the government of Zimbabwe has committed itself to provide.

High user fees for health services

Many Zimbabweans face significant obstacles in accessing health services even where these are widely available. In the midst of high unemployment rates and a declining economy, the high cost of user fees for health services means that the majority of Zimbabweans who can no longer afford user fees are therefore unable to access treatment. Those living with HIV/AIDS find it even more difficult to cope with the extremely high costs of AIDS treatments, tests and hospitalizations.

Zimbabwe has long had user fees as a part of its health system. User fees are often promoted by governments as a means for rationalizing health care use and for increasing resources to the health sector. Zimbabweans pay a user fee— ranging from 250,000

¹³¹ Human Rights Watch interview, Gweru, April 26, 2006.

¹³² Human Rights Watch interview with Tafadzwa K., (not her real name), Gweru, April 26, 2006.

(US\$2.50) for children to 500,000 (US\$5) for adults to 7,500,000 (US\$75) for pregnant women (per visit) — to get a consultation at a government run hospital or clinic.¹³³ In addition, they are required to pay for any treatment they receive as well as any tests that are undertaken at clinics or hospitals. Patients seeking to go onto the government ART programs are required to pay a monthly fee of Z\$500,000 (US\$5).

Organizations such as Save the Children Fund have pointed out that user fees are not necessarily an effective cost recovery policy.¹³⁴ Other critics have argued that the uncertainty of user fees (regarding the cost of procedures and the uncertainty of getting exemptions to fees) has prevented access to treatment. Research into the impact of users fees¹³⁵ found that while the availability of resources did increase, the quality and quantity of care provided to the poor had changed little, resulting in “a kind of ‘sustainable inequality’, with fees enabling service provision to continue while concurrently preventing part of the population from using these services.”¹³⁶

However, the central problem is that for fees to become a substantial source of revenues, they must be set at a level far beyond the reach of the poorest households. In sum, experience shows that user fees not only exclude the poor from health care and education but are an ineffective tool for raising revenues.¹³⁷ A 2004 survey by the civic monitoring program on the socio economic situation in all ten provinces of Zimbabwe showed that the cost of treatment was the main reason for peoples’ inability to use health services.¹³⁸

The inability to use health services due to high user fees has had a particularly detrimental effect on PLWHA who require treatment. Although the government has pledged to make the cost of health care for HIV/AIDS treatment and care more affordable and available,¹³⁹ Human Rights Watch’s findings in the urban areas of

¹³³ Human Rights Watch interviews with medical personnel and PLWHA, Harare, Gweru and Bulawayo, April 17 – May 2 2006.

¹³⁴ The introduction of fees has rarely freed up additional resources for targeted assistance to the poor, or for intra-budget reallocations to basic services. This is because governments don’t usually allocate a fixed share of the budget to one subsector, and because the sums raised are small compared with the needs – especially after collection costs are taken into account. For example, data from 1991-92, found that user fees contributed only 3.5% of Ministry of Health recurrent expenditures in Zimbabwe. Cited in Creese, A and Kutzin J, “Lessons from cost recovery in health, Division of Strengthening Health Services,” Discussion Paper No. 2; World Health Organization, 1995; Save the Children, *An Unnecessary Evil, User fees for healthcare in low-income countries*, (London: Save the Children, 2005).

¹³⁵ F. Nyantor. and J. Kutzin., “Health for Some?: The Effects of User Fees in Volta Region of Ghana,” *Health Policy and Planning*, 1999, 14(4) pp. 329-341.

¹³⁶ *Ibid.*, p. 329.

¹³⁷ ActionAid, “User fees: the right to education and health denied.” A policy brief for the U.N. Special Session on Children, New York, May 2002.

¹³⁸ Civic Monitoring Programme, “Quarterly Community Assessment of the Socio-Economic Situation in Zimbabwe: Health and Education,” March 2004.

¹³⁹ Government of Zimbabwe, “National Policy on HIV/AIDS for Zimbabwe,” (1999) Guiding Principle 12.

Zimbabwe, show that high user fees present a significant barrier to the ability of PLWHA to access health services.

Charles L., a 48-year-old man diagnosed with HIV told Human Rights Watch:

They told me to come back for nutritional counseling, but they didn't say anything about medicine. The clinic was very, very busy. I didn't have any money for the CD4 test. I was surprised to find out I had HIV. I don't know if I'm going to die. My wife is still crying.

The clinic is 1.5 km away but the [medical] card costs 250,000 (US\$2.50) then there are prescription costs, injection costs. I can't afford it. Before the clearance the Dominican sisters ran a clinic here – they didn't require fees. But it was destroyed when they destroyed the houses.¹⁴⁰

High user fees pose even more significant problems for those on free NGO-managed ART programs and undermine the medical benefits of the treatment. For example, one man in Mabvuku told Human Rights Watch that despite being on free ARVs he was required to take regular liver function tests to assess his adherence to the ARVs. Unfortunately, he could not always afford them, "I have to buy other medicine and pay for tests. The liver function test costs Z\$3 million (\$US30). You can't take ARVs without these tests."¹⁴¹

Other PLWHA told Human Rights Watch that they were forced to resort to herbs and other unknown medications in an attempt to alleviate the symptoms of HIV/AIDS. One man explained, "I take a few herbs when I feel bad or have diarrhea. Right now I have pneumonia. I don't have any money so there's nothing I could afford."¹⁴²

Peter K., a 57- year-old man in Mabvuku, told Human Rights Watch:

I got some medicine in March 2005 from a friend who works in a chemist shop. He brought the medicine to me and I would give him a little money. I took the medicine until August and stopped because there

¹⁴⁰ Human Rights Watch interview with Charles L., (not his real name), Hatcliffe Extension, April 20, 2006.

¹⁴¹ Human Rights Watch interview, Mabvuku, April 22, 2006.

¹⁴² Ibid.

was no change. I haven't been to the doctor in a long time. I don't know where to go. I have no money.¹⁴³

Lack of exemptions for user fees for poor and vulnerable persons

The government of Zimbabwe has put in place a number of programs that allow poor and destitute Zimbabweans to access free services including medical care and education for their children. The Department of Social Services under the Ministry of Public Service, Labor and Social Welfare is responsible for running these programs. Human Rights Watch researchers documented many examples of the arbitrary assessment of applications for user fee exemptions by social welfare officers which although designed to protect poor Zimbabweans, in practice fails to protect vulnerable people such as those living with HIV/AIDS.

The public assistance scheme under the government's Social Welfare Assistance Act is specifically designed to provide assistance to:

- Persons over sixty years of age;
- Persons who are handicapped physically or mentally; or
- Persons who suffer continuous ill health;
- Dependants of a person who is destitute or otherwise incapable of looking after himself; or
- Otherwise has need of social welfare assistance.

In determining whether a person qualifies for public assistance, the Director of Social Welfare, or social welfare officers consider the degree of financial hardship of the applicant, the availability to the applicant and his dependents of any assistance financial or otherwise from any source and the state of health, educational level and the level of skills for purposes of the employment prospects of the person applying for financial assistance.¹⁴⁴ Those receiving assistance may be given a letter from the department of social welfare that exempts them from paying for health care and treatment.

To establish eligibility, potential beneficiaries have to go to social welfare officers with extensive documentation including pay slips, income tax returns and letters from social welfare offices. This information is used to determine the income of the beneficiary.

¹⁴³ Human Rights Watch interview with Peter K., (not his real name), Mabvuku, April 22, 2006.

¹⁴⁴ The Social Welfare and Assistance Act, Chapter 17:06, 1988, section 6 (1), (2) <http://www.parl.zim.gov.zw/Resources/Acts/acts.html> (accessed June 6, 2006).

Critics have noted that the requirement of such extensive documentation poses a significant obstacle to accessing the exemptions.¹⁴⁵ For example, in 1995, to qualify for exemptions for user fees patients had to prove that monthly household income was less than Z\$400. At the time it was noted that the policy ignored the situation of women who do not live with their husbands, and have no access or ability to compel them to identify their earnings.¹⁴⁶ In addition, the majority of the poor work in the informal sector and are unlikely to have wage slips as proof of earnings.

Government schemes to provide assistance to poor and destitute people have in recent years been plagued by a lack of funding. These programs were originally meant for the chronically poor in the 1990s¹⁴⁷ (i.e. destitute and poor people unable to help themselves and with no families). However the government of Zimbabwe has failed to take into account the increasing numbers of chronically poor, and the specific characteristics of those who are ill and impoverished as a result of the HIV/AIDS epidemic. Instead it has issued more health fee exemptions than it can pay for— causing hospitals and clinics to refuse to accept them and turn away those possessing them. Another result has been the arbitrary provision of exemptions by welfare officers and the refusal to provide them to those who qualify under stated eligibility criteria.

The government does not provide sufficient information to the public on the criteria for exemptions which also leads to many individuals failing to avail of them. In addition, the availability of and the process for receiving the exemptions vary from one township to the next. As a result, some PLWHA interviewed by Human Rights Watch who appeared to meet eligibility criteria under the exemption program had not even pursued the option.¹⁴⁸ Many people interviewed by Human Rights Watch reported that in some towns there were no social welfare officers to visit their homes to assess whether they could get exemptions. Several others reported that because there were no welfare officers available in their area, they had to travel long distances to get assistance. In many cases, they could not afford the transport to get to the office.

People still encountered problems even if the welfare officers were available. For example, a 65-year-old woman nursing her seriously ill HIV positive daughter told

¹⁴⁵ F. Dlodlo, "Implementation Impact of User-Fee Policy: Case Studies in Zimbabwe," Research Paper, 1995, Institute of Social Studies, The Hague.

¹⁴⁶ Ibid.

¹⁴⁷ L.T.Munro, "A social safety net for the chronically poor?: Zimbabwe's Public Assistance Programme in the 1990s," *The European Journal of Development Research*, 17 no. 1 (2005) pp. 111-131.

¹⁴⁸ Human Rights Watch interviews, Harare, April 20 and 22, 2006.

Human Rights Watch that she had made several calls to the social welfare officers in her area to request a home visit but had received no response.¹⁴⁹

An aggravating factor is that social welfare officers within the department of social welfare tend to apply and assess candidates for exemptions in an inconsistent and arbitrary manner.

For example, as stipulated in the Social Welfare and Assistance Act, an individual is required to prove that they suffer from continuous ill health which prevents them from working to receive assistance. Yet, a significant proportion of PLWHA interviewed by Human Rights Watch reported that they were unable to secure social welfare assistance even though they met such criteria. Several PLWHA presented their medical cards to Human Rights Watch that showed their continuous ill health as well as letters from health officials recommending that the patient should be given welfare assistance as a priority.¹⁵⁰

The criteria for exemptions follow the principle of necessity i.e. they are designed in accordance with who needs the exemptions most. With funds for social services in short supply it is essential that those most in need of the exemptions are properly identified to receive assistance.

Susan W., a 46- year-old unemployed widow living with HIV/AIDS has suffered from continuous ill health in the past year which has prevented her from working or earning a living. The medical card she showed Human Rights Watch indicated that she had visited the hospital nine times in the past twelve months with various opportunistic infections related to her HIV/AIDS status. She told Human Rights Watch:

I am now on cotrimoxazole which I am supposed to buy from the chemist for Z\$ 340000 [US\$3.40] a month. It's very expensive and sometimes I have to beg for the money to buy it. I have been sick on and off. I went to Harare Hospital in March 2006 and they said they were closed and not taking on any new patients for ART and that I would have to join a waiting list after my CD4 test. But I can't afford it. I went last time to the department of social welfare but I didn't get any help. They told me to come back another time. But I don't have the transport to go back. I don't work because I have constant chest pains

¹⁴⁹ Human Rights Watch interview, Hatcliffe Extension, April 20, 2006.

¹⁵⁰ Human Rights Watch interviews Hatcliffe Extension and Highfield, April 20, 2006.

and always feel weak. I am always sick on and off. Last month I had no money for cotrimoxazole, I just stayed without it. Sometimes I take herbs instead of medication.¹⁵¹

The criteria for exemption differed across townships depending on the welfare officer in that area. Different officers considered peoples' plights differently and the process for whether a person deserved free treatment or not was quite randomly applied by social welfare officers. This situation was confirmed by numerous PLWHA interviewed by Human Rights Watch in Harare who tried to access social welfare services. For example, one of the stipulations of the Social Welfare and Assistance Act is that a recipient must be destitute or over the age of sixty to qualify for exemption. However, Human Rights Watch interviewed a number of PLWHA under the age of sixty who qualified and received the exemption because they were destitute. At the same time young PLWHA of similar backgrounds who were destitute in other areas of Harare were told that they were too young to qualify for exemption and that they should go and find work.¹⁵²

Public information is not always widely available on which hospitals accept exemptions letters and which hospitals do not. In a number of cases people who had a letter of exemption from the department of welfare told Human Rights Watch that they had not received exemptions from hospital staff at Harare's main hospitals such as Parirenyatwa hospital after being told that the department of social welfare had failed to pay its bills to the hospital. Although government health workers often tell those who are destitute to apply to the welfare department for assistance to access health care, international and local NGO contacts informed Human Rights Watch that two of Harare's major hospitals, Harare and Parirenyatwa, were no longer accepting exemption letters from the department of social welfare. Instead, people who go to Parirenyatwa hospital for instance are required to pay cash up front.¹⁵³

The director of one international organization working with PLWHA told Human Rights Watch, "Sending people to the Ministry of Social Welfare is no help at all. It sometimes takes 6 to 7 months for them to receive treatment. The letter [for user fee exemption] from the department of social welfare doesn't necessarily mean they will get free ARVs."¹⁵⁴

¹⁵¹ Human Rights Watch interview with Susan W., (not her real name), Hatcliffe Extension, April 20, 2006.

¹⁵² Human Rights Watch interviews, Harare and Gweru, April 20, 22 and 26, 2006.

¹⁵³ Human Rights Watch interviews, Harare, April 17 – May 2, 2006.

¹⁵⁴ Human Rights Watch interview, Harare, April 21, 2006.

The lack of clarity about how people get exemptions leaves the process open to manipulation. PLWHA and NGOs informed Human Rights Watch that even with a social welfare letter some people were still being charged for treatment at hospitals. For example, one international organization told Human Rights Watch researchers that in Gweru, one of its NGO voluntary counseling and testing staff members presented a local hospital with bills and evidence that the hospital was charging people with a social welfare letter and was thrown out of the hospital by officials.¹⁵⁵ Although unable to confirm the allegations, Human Rights Watch researchers also received reports from NGO activists and a number of PLWHA that the process of being granted a social welfare letter was sometimes politicized or manipulated by local government officials as it required political party membership or a reference from village elders, chiefs, or ward counselors depending on location.

Mavis E., 54 and her husband were both diagnosed as HIV positive in 2005. Mavis E., has just recovered from tuberculosis. Mavis's 57-year-old husband, Paul J., also has tuberculosis which has affected his joints and left him unable to walk. They have a 21-year-old daughter with severe disabilities who is wheel chair bound and needs full time care. Both Mavis and her husband no longer work and rely on charity. They have made efforts to get an exemption letter from the department of social welfare. In their tiny one-bedroom home they told a Human Rights Watch researcher about the obstacles they faced in trying to get assistance from the department:

I was diagnosed with tuberculosis and then HIV last year together with my husband. We were both put on the waiting list to receive ART. I haven't recovered from the tuberculosis but I am on drugs. I have to go to the hospital next week for a CD4 count and I have to pay. I will have to borrow the money for that. I also have to go to the department of social welfare to collect a letter so that we can get free tests and free opportunistic infection drugs. Last year the house we owned was destroyed by Operation Murambatsvina and we stayed out in the open for three months. UNICEF gave us some support to pay for the rent [for the house] for three months. Now we can't pay the rent. Members of the church have paid for the rent for two more months but we need assistance from social welfare. If we don't get the assistance we will be homeless. Before Operation Murambatsvina I used to do selling but now it's not allowed and I have to look after my husband and daughter. My husband used to be a driver but he fell sick. As you can see his joints are swollen and he can't walk. His wheel chair is broken and he needs

¹⁵⁵ Human Rights Watch interview, Harare, April 21, 2006.

one. He shares one wheel chair with my daughter. The tuberculosis has affected his joints. To acquire a social welfare letter for free treatment, I need to take my husband to the Highfield welfare department to prove that he is sick and that we need help. Last time I took him there but there was a long queue so we had to come back. Then I need to take him to the Parirenyatwa hospital for treatment and with transport costs it's difficult. I also have to use my daughter's wheel chair to transport him in. Here in this area, the department of social welfare doesn't do home visits so I have to go all the way to Highfield which is difficult. I am weak from the tuberculosis and pushing the wheelchair is hard but we need help so we will have to find transport to go back.¹⁵⁶

As exemplified above, the lack of information on exemptions for user fees and the arbitrary application of exemptions for user fees within the social welfare system effectively deny people their right to health. With a significant proportion of Zimbabweans living below the poverty line and the government's continued policy of restricting economic activities in a climate of high unemployment, desperately poor individuals who are unable to obtain assistance from the department of social welfare, find living with HIV/AIDS onerous. Transportation fees, consultation fees, medicines and tests are well beyond the means of most Zimbabweans. Without assistance from the department of social welfare, many are unable to access healthcare.

Requirement of CD4 test to receive ART

The government of Zimbabwe's failure to provide information to public sector physicians, AIDS service organizations and networks of people living with HIV/AIDS, as well as patients testing HIV positive, on the national standards for antiretroviral therapy eligibility and the misapplication of these standards has restricted access to treatment for thousands of people in desperate need of the life-saving drugs.¹⁵⁷

Human Rights Watch found significant misconceptions about ART and CD4 test requirements (CD4 tests are a marker of immune system function) among PLWHA, AIDS service organizations, government AIDS officials, and medical providers. All these individuals and organizations believe that all HIV positive individuals are required to have a CD4 test to be eligible for ART. The cost of a CD4 test is between \$7-15 million (US\$ 70-150).

¹⁵⁶ Human Rights Watch interview with Mavis E., and Paul J., Mufakose, (not their real names), April 30, 2006.

¹⁵⁷ According to: J.T. Boerma et al., "Monitoring the scale-up of antiretroviral therapy programmes: methods to estimate coverage," *Bull World Health Organ*, February 23, 2006, 84(2), Epub 2006, individuals with advanced symptoms of AIDS who meet eligibility criteria for ART but who do not receive it would be expected to die within 2 years. pp. 145-50.

However, under the government's national guidelines for treatment of HIV/AIDS (which are based upon World Health Organization guidelines)¹⁵⁸ ART should be commenced in all individuals with a positive HIV test and: (1) a CD4 count of less than 200 mm³ (regardless of clinical symptoms) or (2) clinical symptoms consistent with WHO HIV clinical stages III or IV (with or without a CD4 test).¹⁵⁹ These guidelines therefore do not require a CD4 test for a patient in the latter clinical stages of AIDS to receive ART if for some reason the test has not been taken or is not available.

The unnecessary requirement by government health care providers that all PLWHA with WHO HIV clinical stage III or IV undergo a CD4 count before commencing treatment poses a significant barrier to access ART for seriously ill individuals particularly for those who cannot afford the test. Human Rights Watch interviewed over 30 PLWHA in Harare who were turned away from life-saving ART because medical providers had told them they required a CD4 test which they did not in fact need and could not afford.¹⁶²

Patricia M., a 46-year-old widow with two children, tested positive for HIV in February 2006. She was diagnosed with tuberculosis in 1998 and in 2003 and told a Human Rights Watch researcher that she had a severe rash all over her body. She told Human Rights Watch that after she was diagnosed with HIV she went to Parirenyatwa hospital to get onto the government ARV program. "They told me that I had to go for a special test first (CD4) before I could get on the ARV program," she said, "but when I asked for it they required money. I can't afford it so I won't go."¹⁶⁰

James L. told Human Rights Watch that he tested positive for HIV shortly after he was diagnosed with TB. He was told that he should start taking anti-retroviral drugs, but that he first needed to get a CD4 test. When he went for the test, he was told that the CD4 machine wasn't working and that he had to go to a private clinic. The government hospital gave him a letter of referral to a private clinic, but it cost 10 million Zimbabwe

¹⁵⁸ WHO, "Scaling up ART in resource-limited settings: guidelines for a public health approach. WHO, 2003," <http://www.who.int/docstore/hiv/scaling/anex1.html> (accessed July 11, 2006). WHO stage III or IV symptoms include: unexplained chronic diarrhea for longer than one month, unexplained persistent fever (intermittent or constant for longer than one month), severe weight loss (>10% of presumed or measured body weight), oral candidiasis, oral hairy leukoplakia, pulmonary tuberculosis diagnosed in the last year, severe presumed bacterial infections (e.g., pneumonia, empyema, meningitis, bacteraemia, pyomyositis, bone or joint infection) or acute necrotizing ulcerative stomatitis, gingivitis or periodontitis (stage III); and HIV wasting syndrome, Pneumocystis pneumonia, recurrent severe or radiological bacterial pneumonia, chronic herpes simplex infection (orolabial, genital or anorectal of more than one month's duration), oesophageal candidiasis, extrapulmonary tuberculosis, Kaposi's sarcoma, central nervous system toxoplasmosis, and HIV encephalopathy (stage IV).

¹⁵⁹ Ministry of Health and Child Welfare, *Zimbabwe HIV/AIDS Standard Treatment Guidelines*, 1st edition, 2004. (Harare: Ministry of Health and Child Welfare, 2004), p. 40.

¹⁶² Human Rights Watch interviews with PLWHA in Hatcliffe Extension, Highfield, Mabvuku, and Gweru, April 20, 22 and 26.

¹⁶⁰ Human Rights Watch interview with Patricia M., (not her real name), Mabvuku, April 22, 2006.

dollars (US\$100) for the test and he didn't have the money. As a result James was unable to get onto the program.¹⁶¹

Margaret, C., a 25-year-old mother of two in Mabvuku, Harare was diagnosed with tuberculosis and then tested positive for HIV. After her tuberculosis treatment she was told to go for a CD4 test to get access to the government ARV program. "I tried to go and get a CD4 test at Parirenyatwa," she said, "But they wanted money and I had none. I then went to an NGO giving out free ARVs but they told me they had enough people and that I should go back in six months. Right now I have chest problems and severe rashes. I also have problems eating. I have tried to get help from the church but they don't have the money to help." She concluded, "I think I am going to die."¹⁶²

Human Rights Watch researchers also documented cases where private doctors and even health personnel in some government hospitals deliberately withheld the results of CD4 tests if patients did not pay for the test.

Chipo D., in Mabvuku, told Human Rights Watch:

My husband was cleared of tuberculosis in February but is very sick and is bed ridden. I went to see a private doctor who said he had pneumonia. He went for a CD4 count at the private doctor which cost me Z\$15 million (US\$150) and it was 78 and so they said he should be put on ARVs but I couldn't afford the treatment for ARVs so he just went on treatment for pneumonia. He had ten injections and all in all it cost me about Z\$ 12 million (US\$120) and then the tablets cost about Z\$3 million (US\$30). I am not working but got some money from relatives but now they have stopped giving me money so my husband is just at home and we need help. I haven't tried going to the department of social welfare because those guys are a problem. Some people who have gone there say that it's just a waste of time.

I am thinking of getting my husband on free government ARVs but to get his CD 4 results from the private doctor is a problem because he thinks that I am going to run away. When I asked him for my husband's results he asked me why I wanted them. I told him it was to go for free ARVs and he refused to give me the tests. When we were first diagnosed

¹⁶¹ Human Rights Watch interview with James L., (not his real name), Mabvuku, April 22 2006.

¹⁶² Human Rights Watch interview with Margaret C., (not her real name), Mabvuku, April 22, 2006.

we were counseled at a government centre and told about the government program but they said there was a waiting list and that to get on it we needed the CD4 test results but they are with the private doctor.¹⁶³

Abigail J., a 42-year-old widow told Human Rights Watch:

I went for an HIV test in 2005 because I was very sick. I have sores on my back and feel very sick. I went to Parirenyatwa hospital in Harare for a CD4 test but was not given the results because I had no money. Then I went there with a letter from the department of social welfare but they are refusing because they say that the Ministry of Social Welfare doesn't pay the bills and the CD4 count has to be paid for even with a letter. I am not on ARVs because I have no CD4 test. I can't afford the medicine for the sores on my back. I go to the clinic [in her area] and they give me prescriptions for antibiotics but I can't afford to buy them.¹⁶⁴

Human Rights Watch was unable to determine precisely why medical care providers required all HIV positive patients to get the CD4 test, and it is likely that there are multiple reasons. Universal CD4 tests are generally preferred by physicians to best manage patient care, and a simple lack of knowledge of the hardship CD4 test costs pose, the lack of exemptions for diagnostic tests, or official ART policy is one possible reason for the situation of requiring CD4 tests for all patients. Some NGOs and advocates for PLWHA suggested, but not confirmed, that other reasons may be behind the requirement for CD4 tests. These include: an intention by health care providers to recoup costs or make money (as other costs are minimally covered, e.g., consultancy costs) or an intention to minimize waiting lists of patients for ARV drugs (as those who fail to undergo a CD4 test cannot get on to the waiting list to receive ARV drugs). The ability to pay for the CD4 test as a proxy measure of ability of the patient to adhere to the ARV drug regimen was also suggested as a possible reason by some NGOs.¹⁶⁵ One private medical provider told Human Rights Watch that the ability of patients to afford transportation to the clinic was a requirement for eligibility for ARVs.¹⁶⁶

¹⁶³ Human Rights Watch interview with Chipu D., (not her real name), Mabvuku, April 22, 2006.

¹⁶⁴ Human Rights Watch interview with Abigail J., (not her real name), Highfield, April 20, 2006.

¹⁶⁵ Human Rights interviews with NGO representatives and HIV/AIDS activists, Harare and Bulawayo, April 17 – May 2, 2006.

¹⁶⁶ Human Rights Watch interview with medical provider, Bulawayo, April 24, 2006.

Regardless of the reasons for this requirement, the failure of the government to inform individuals who test HIV positive about ART eligibility criteria and government's failure to ensure that medical providers follow national ART guidelines, has resulted in thousands of people turned away from care that they need and are eligible for. In addition, other individuals, who do not fulfill the WHO stage III or IV clinical guidelines, but cannot afford the cost of a CD4 test are potentially excluded from necessary care, if their CD4 count is below 200 mm³. These individuals, despite the lack of clinical symptoms, face as dire an outcome as individuals with advanced AIDS symptoms when they are turned away from CD4 testing because of an inability to pay and the failure of the social welfare system to provide for exemptions for payment of these diagnostic tests.

Government restrictions on activities of HIV/AIDS NGOs and PLWHA

The political and human rights environment in which HIV/AIDS organizations and PLWHA operate has hampered their effectiveness in addressing the crisis.

Articles 19, 21 and 22 of the International Covenant on Civil and Political Rights (ICCPR) to which Zimbabwe is party protect the rights to freedom of expression, assembly and association respectively. In addition, PLWHA should have the right to receive information regarding HIV/AIDS as well as to participate in representative mechanisms to advocate for provisions that improve their access to health.¹⁶⁷

The government's inclusion of HIV/AIDS organizations and PLWHA in national HIV/AIDS strategies has done little to increase debate and activism on HIV/AIDS or to improve the rights of PLWHA. Human Rights Watch is concerned that a climate of fear exists in Zimbabwe that curtails people's ability to exercise their right to freedom of expression, association and assembly. PLWHA and HIV/AIDS activists to whom Human Rights Watch researchers spoke reported problems expressing their concerns within the context of advocating for HIV/AIDS and human rights. The government was particularly hostile when they commented on the human rights ramifications of government policies on PLHWA, financial management or equitable distribution of resources to HIV/AIDS associations and NGOs.

¹⁶⁷ Committee on Economic, Social and Cultural Rights (CESCR), *The Right to the Highest Attainable Standard of Health*, (Art 12), E/C.12/2000/4, (August. 11, 2000) General Comment no. 14, on the normative content of article 12 of the ICESCR, para 11. The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information.

In interviews with Human Rights Watch several HIV/AIDS organizations questioned the disbursement of the national AIDS levy and the government's utilization of resources meant for HIV/AIDS. They also expressed concerns about the lack of transparency within the National AIDS Council (NAC) when it came to disbursing funds for HIV/AIDS programs to different organizations. When voiced publicly within Zimbabwe, these concerns were often met with hostility by the government. For instance, on December 1 2005— World AIDS Day— demonstrations to focus attention on the need for greater budget transparency and accountability for the HIV/AIDS levy were disrupted by police and five HIV/AIDS activists arrested under the Public Order and Security Act (POSA) for incitement— despite a judicial ruling allowing the protests. The activists were detained for two days and then released without charge.¹⁶⁸ Commenting on the arrests one activist said, "Because of the arrests, it will be difficult to get the people to attend future marches or protests to advocate for their rights."¹⁶⁹

The government has also used the state run media to criticize and intimidate activists and NGO organizations who speak out about some of its policies and their effects on HIV/AIDS. For example, the representative of one international organization which highlighted the effects of Operation Murambatsvina on PLWHA told Human Rights Watch that it got repeated "tongue lashings" from the state-run newspapers.¹⁷⁰

The generalized atmosphere of intimidation and repression that exists in Zimbabwe limits the ability of people to freely express their views. As the director of one organization advocating for the rights of PLWHA said, "The problem we have nowadays is if you raise the political and economic crisis and its effect on HIV/AIDS, the government takes it politically. Even issues like the inability of the poor being able to access health are seen as political and can put your work in jeopardy. And yet these issues are a barrier to people accessing health services."¹⁷¹

The government of Zimbabwe has promulgated a raft of restrictive legislation that violates the rights of people to freedom of expression, association and assembly. This has affected the work of NGO's including those working on HIV/AIDS. Advocating for the human rights of PLWHA under such laws has not always been easy. As one NGO representative in Harare pointed out to Human Rights Watch:

¹⁶⁸ Human Rights Watch interviews, Harare, April 19 and 20, 2006.

¹⁶⁹ Human Rights Watch interview with HIV/AIDS activist, (name withheld), Harare, April 20, 2006.

¹⁷⁰ Human Rights Watch interview with international NGO representative, (name withheld), Harare, April 19, 2006.

¹⁷¹ Human Rights Watch telephone interview with local NGO Director, (name withheld), Harare, June 19, 2006.

Unfortunately the laws we have make it criminal for NGOs to act on human rights and we have been gagged in raising the issue of human rights even in connection with HIV/AIDS. The proposed NGO bill makes it difficult for us to make noise because if we do we want be registered as an NGO. NGOs are now towing the line. There's no one to make noise about human rights issues. We know that civil servants and ministers are benefiting from the public roll out system for ARVs but we can't say that.¹⁷²

The representative of an NGO in Harare informed Human Rights Researchers, “Once we started making noise about Operation Murambatsvina and its effects on PLWHA and the general health of the population, we got a call from the Office of the President reminding us that we had submitted papers for registration as a PVO and that we were putting this in jeopardy.”¹⁷³ Another HIV/AIDS activist in Harare confirmed, “The political environment seems to play at the back of the minds of civil society organizations. They feel they have to restrain themselves in terms of advocating for the hard issues. You concentrate on what you can do without ruffling feathers.”¹⁷⁴

Restrictive legislation such as POSA requires all NGOs to request permission to hold public meetings or workshops. Although local HIV/AIDS organizations are supposed to be exempt from such requirements this is not the case in practice.¹⁷⁵

In one incident, the representative of an organization working with HIV positive women informed Human Rights Watch that when she visited an area in Mashonaland province—a stronghold of the ruling ZANU PF party—to hold a workshop on HIV/AIDS, she was denied permission to do so by the local ZANU PF officer who accused her of being a member of the opposition.¹⁷⁶

NGO representatives and human rights activists are routinely harassed and interrogated by members of the central intelligence organization, while peaceful protests are regularly disrupted by the police and the demonstrators arrested. As has already been highlighted earlier such clampdowns are not restricted to human rights activism but extend to activism by HIV/AIDS organizations.

¹⁷² Human Rights Watch interview with HIV/AIDS NGO representative, (name withheld), Harare, April 21, 2006

¹⁷³ Human Rights Watch interview with director of local NGO, (name withheld), Harare, April 21, 2006.

¹⁷⁴ Human Rights Watch interview with HIV/AIDS activist, (name withheld), Harare, April 20, 2006.

¹⁷⁵ Under POSA Chapter 11:17, AIDS service organizations are exempt from procedures relating to political organization.

¹⁷⁶ Human Rights Watch interview with HIV/AIDS NGO representative. (name withheld), Harare, April 21, 2006.

International and local NGOs are also required to go through a vetting process and seek permission from the governor's office, and district administration officers to be able to operate. Such requirements prevent NGOs from freely airing their views on various political issues. As one HIV/AIDS NGO representative in Harare said, "The people we seek permission from are the same groups that we have to criticize if things go wrong." He continued, "If we do then these same people can chase us away and refuse to give us authority to work in their areas. It makes it difficult. The space for activism is very narrow now."¹⁷⁷

The politicized environment has led to an extreme level of paranoia within government structures and amongst government officials. Increased tension between the government and civil society as well as the government and western donors means that many local and cabinet level government officials view local and international NGOs with great suspicion. Local NGOs are accused of being supporters of the opposition and of receiving funds from western donors who are enemies of the government. Similarly international NGOs are also seen as backing the opposition and out to destabilize the country.¹⁷⁸ Although the government has been less obstructive with NGOs working on HIV/AIDS compared to other NGOs, they nevertheless have to tread carefully when they interact with western donors and governments. They are often closely watched and routinely interrogated by government operatives.

The director of one NGO working on HIV/AIDS prevention programs described to Human Rights Watch how he was routinely harassed by CIO:

I am under the spotlight from the government. Sometimes I get CIO visiting me and asking, 'Where do you get your funding? Do the funders tell you what to do?' If a foreign official visits me, I get questions. Each time we distribute mealie meal to our orphans, vulnerable children and PLWHA we have to inform the CIO. They want to know who is giving us the mealie meal because they think we are opposition. They don't like to see NGOs competing with the government. For example when one

¹⁷⁷ Human Rights Watch interview with local NGO representative, (name withheld), Harare, April 21, 2006.

¹⁷⁸ Government representatives have routinely accused local NGOs and international NGOs of supporting the opposition. For example in a speech at the inaugural session of the human rights council on June 21 2006, the Minister of Justice, Legal and Parliamentary Affairs, Patrick Chinamasa accused local NGOs working on human rights and governance as being "financed by developed countries as instruments of their foreign policy," and called for the security council to produce a framework which "prohibits direct funding of local NGOs". According to the Minister, the objectives of these foreign governments were to undermine sovereignty and promote disaffection and hostility among the local population. The full text of the speech can be found online: <http://www.ohchr.org/english/bodies/hrcouncil/docs/statements/zimbabwe.pdf> (accessed June 22, 2006).

foreign official came to visit we had three CIO coming to ask us what we were discussing. It was an intimidating tactic.¹⁷⁹

A representative of one NGO in Harare informed Human Rights Watch that during elections, it was difficult to distribute condoms in the high density urban areas of Harare because employees distributing the condoms were sometimes harassed and attacked by police, ZANU-PF officials and youth militia who accused them of working for the opposition.¹⁸⁰

¹⁷⁹ Human Rights Watch interview with director of HIV/AIDS NGO, (name and location withheld), April 26, 2006.

¹⁸⁰ Human Rights Watch interview with representative of NGO, (name withheld), Harare, April 21, 2006.

VII. National and International responses to HIV/AIDS

Government response to HIV/AIDS

Zimbabwe has put in place some of the required policies as set by the United Nations General Assembly Special Session on HIV/AIDS in its declaration on HIV/AIDS and other international guidelines for an effective HIV/AIDS intervention strategy. However, not all the policies have translated into action.¹⁸¹

There has been little or no incorporation of international guidelines on HIV/AIDS into Zimbabwe's domestic legislation. Zimbabwe's National AIDS policy states, as part of its general human rights strategies that legislation which protects individuals against human rights violations and discrimination in terms of HIV/AIDS should be promoted and enforced.¹⁸² However, only labor legislation refers to HIV status as grounds for nondiscrimination. HIV/AIDS legislation is limited to criminal and labor law. Two pieces of legislation the Sexual Offences Act (Act 8 of 2001) and the Labor Relations (HIV and AIDS) Regulations of 1998 specifically address HIV/AIDS and PLWHA.¹⁸³

Zimbabwe's response to the HIV/AIDS epidemic— which began in 1985— is currently led by the National AIDS Council (NAC), a coordinating body under the Ministry of Health and Child Welfare (MoHCW). NAC was established soon after the government adopted an official national HIV and AIDS policy on World AIDS Day, December 1, 1999 and declared AIDS as a national emergency. NAC was charged with managing funds from a newly created “AIDS levy” payroll tax which paid into a National AIDS Trust Fund (NATF).¹⁸⁴

While initially conceived as a coordinating body, NAC has also played a role in implementing AIDS interventions. NAC funds the purchase of ARV drugs, supports the Zimbabwe National Family Planning Council's HIV/AIDS activities, Ministry of Health

¹⁸¹ Declaration of Commitment on HIV/AIDS resolution adopted by the General Assembly, August 2, 2001, <http://www.un.org/ga/aids/docs/aress262.pdf> (accessed July 23, 2006); Zimbabwe Country Report to UNGASS, Reporting period: January 2003 – December 2005, http://www.unaids.org.zw/unaid_documents/2006_country_progress_report_zimbabwe_en.pdf (accessed July 23, 2006).

¹⁸² Zimbabwe, “National Policy on HIV/AIDS for Zimbabwe,” (1999).

¹⁸³ In the Sexual Offences Act, section 15 makes it a criminal offence to willfully infect another with HIV. Section 16 provides for greater punishment for a rapist with HIV positive status. In addition, marital rape is included in the definition of rape. The Labor Relations (HIV and AIDS) Regulations of 1998 requires that HIV/AIDS education and information be made available in the workplace. No pre-employment testing or unfair dismissal on the grounds of HIV/AIDS is allowed. It also protects confidentiality of HIV/AIDS in the workplace.

¹⁸⁴ A secretariat was appointed in January 2001 to manage the day-to-day activities of the NAC. The former NACP within the MOHCW was renamed the National AIDS & TB Unit. This Unit continues to be responsible for all health sector activities related to HIV, STIs, and TB.

and Child Welfare, as well as directly funding program proposals submitted by NGOs, as well as the education sector (e.g., through the Basic Education Assistance Module (BEAM) for the payment of school fees), army, prison services and churches, and directly distributing food, blankets, home-based care kits, as well as conducting Information Education Communication (IEC) programs.¹⁸⁵

NAC has also set up Provincial, District, Ward and Village AIDS Action Committees, which coordinate the HIV/AIDS response through local government structures.¹⁸⁶ These participatory structures involve communities in identifying people infected and affected by HIV/AIDS, including orphans to enable them to access resources from NAC. Provincial governors and traditional leaders are involved in these structures. Within the government all ministries are included in the committees, including the Ministry of Health and Child Welfare, the Ministry of Education, Sports and Culture, the Ministry of Higher and Tertiary Education, Ministry of Youth, Gender and Employment Creation, Ministry of Local Government and National Housing as well as the Ministry of Public Service, Labour and Social Welfare (MPSLSW). NGOs and faith based organizations are involved at all levels of the NAC. In February, NAC disbursed more than Z\$210 billion (US\$2,100,000) to the country's more than 90 district AIDS action committees¹⁸⁷ and the purchase of ART (NAC reportedly spends US\$250,000 every month on ARVs (US\$3,000,000 or Z\$300 billion annually).¹⁸⁸

In 2000, the National AIDS Coordination Program (NACP) — also established in 1985 by the MoHCW - released a National HIV and AIDS Strategy Framework for the period 2000-2004.¹⁸⁹ The strategy emphasized the importance of protecting and promoting human rights as 'Key Principles' of the national response.¹⁹⁰ One of the key principles in the national response was that comprehensive, cost effective and affordable care should be made available to PLWHA.¹⁹¹

During this time period further plans for specific prevention, treatment and care strategies and for different economic and social sectors were developed. For example in 2001-2 a "Plan for the Nationwide Provision of ART" called for a detailed implementation strategy to be developed for all aspects of ART.¹⁹² It recommended that ART be introduced

¹⁸⁵ Nompumelelo Zungu-Dirwayi et al., eds., *Audit of HIV/AIDS policies in Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe*.

¹⁸⁶ "Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS)."

¹⁸⁷ "National AIDS Council Pays out \$210bn," *The Herald*, February 27, 2006.

¹⁸⁸ "Country running out of drugs to treat AIDS," *The Herald*, May 1, 2006.

¹⁸⁹ National AIDS Council, *The HIV and AIDS epidemic in Zimbabwe: Where are we now? Where are we going?* (Harare: Ministry of Health and Child Welfare, 2004).

¹⁹⁰ *Ibid.*

¹⁹¹ *Ibid.*

¹⁹² *Ibid.*

initially at a limited number of central sites and gradually decentralized to the provinces as more health personnel receive in-service training.¹⁹³ Availability, affordability and accessibility of ARV drugs were identified as an important gap in HIV/AIDS programming in the country. The MOHCW started its roll out plan in April 2004 and by May 2005, 27 public health institutions were offering ART services.¹⁹⁴

In 2005 UNAIDS reported that the overall coordination of the national response was fragmented due to “inconsistent National AIDS Council leadership, a difficult donor government relationship, and the existence of a multitude of topic specific coordination and partnership bodies” but that the situation was improving.¹⁹⁵

Although NAC has made extensive efforts to involve NGOs in its activities, local HIV/AIDS organizations interviewed by Human Rights Watch questioned the extent to which their participation translated into actual influence over HIV/AIDS – policy and programs.¹⁹⁶ They expressed concern about what they perceived was a lack of consultation and proper coordination by NAC. A number pointed out that NAC was highly centralized and that they felt unable to question some of NAC’s proposals.

NAC’s role coordinating the distribution of funds raised from the AIDS levy has also been the subject of criticism in the past. There have been reports by HIV/AIDS organizations of irregularities in spending of AIDS Levy funds¹⁹⁷ and lack of inclusiveness (eg farm workers) of projects supported.¹⁹⁸ The government has responded to some of these criticisms with investigations into expenditures of AIDS Levy funds in the past.¹⁹⁹ Nevertheless local and international NGOs that spoke to Human Rights Watch believe that the investigations have not resulted in any changes in the way funds are disbursed and that the government needs to do much more to ensure

¹⁹³ Ibid. The first four suggested “pilot” hospitals were Harare and Mpilo Central hospitals, Wilkins Infections Diseases Hospital, and the Genitourinary Center in Bulawayo.¹⁹³ Under the plan, an estimated 7,500 patients would begin treatment at these four sites in the first three months. After three months, ART would be initiated in another three hospitals (Parirenyatwa, United Bulawayo, Chitungwiza), followed three months later by provincial hospitals (sites not specified). The authors estimated that it would be possible to treat 71,000 adults over a 12-month period. The monthly cost at this coverage level was estimated to be between U.S.\$1.8 million and U.S.\$3.6 million.

¹⁹⁴ Government of Zimbabwe 5th round proposal to the Global Fund To Fight AIDS, Tuberculosis and Malaria, “Proposal to provide ART in 22 districts, strengthen the national TB control program and make ACT available for treatment of malaria in Zimbabwe,” June 14, 2005, http://www.theglobalfund.org/search/docs/5ZIMH_1257_0_full.pdf (accessed May 5, 2006). p. 18.

¹⁹⁵ UNAIDS, “Zimbabwe country profile,” <http://www.unaids.org> (accessed June 12, 2006).

¹⁹⁶ Human Rights Watch interviews, Harare and Bulawayo, April 18- May 2, 2006.

¹⁹⁷ “AIDS body threatens demo,” *The Standard*, May 7, 2000, [online], <http://allafrica.com/stories/200005070043.html>; and “Amount in AIDS trust fund queried,” *The Standard newspaper*, April 30 2000, <http://allafrica.com/stories/200004300118.html> (accessed June 19, 2006).

¹⁹⁸ “Farm workers slam NAC,” *The Standard*, March 6, 2005, <http://allafrica.com/stories/200503070672.html> (accessed June 19, 2006).

¹⁹⁹ “Government orders probe into HIV/AIDS fund,” *Financial Gazette*, October 25 2001, <http://allafrica.com/stories/200110240511.html> (accessed June 19, 2006).

transparency.²⁰⁰ More recently spending of Global Fund Grants has also been questioned by local HIV/AIDS organizations.²⁰¹

In May 2006, the government produced a draft of a new medium term plan, the Zimbabwe National AIDS Strategic Plan for dealing with the epidemic for 2006-2010.²⁰² This draft plan, like the others,²⁰³ lacks specific operational or implementation details. For example the plan fails to specify responsible agencies, outputs, timelines, and budgets, providing instead broad-based objectives and a limited number of objectives and key indicators, with ambitious targets for 2010.

The plan includes 4 main strategies: (1) HIV prevention, with a focus on behavior change promotion; (2) increased access and utilization of treatment and care services; (3) improved support for individuals, families and communities infected and affected by HIV and AIDS; and (4) effective management and coordination of the national HIV and AIDS response.²⁰⁴

The plan presents targets related to each strategy: (1) the reduction of HIV prevalence among 15-24 year olds from the current 17% to single digits; (2) a coverage of 75% of those in need with opportunistic infection treatment and ART; (3) coverage of at least 50% of OVCs and affected households with a basic package of support services; and (4) a “fully operational” NAC with “coordination, partnership, resource tracking, M&E (monitoring and evaluation) and strategic information functions” including “costed annual work plans, including all funding streams”.²⁰⁵ The document states as the baseline for the fourth strategy that the NAC has a functional monitoring and evaluation department and NAC work plans.

Zimbabwe has set itself ambitious targets through its national HIV/AIDS policies and strategies but as yet it is not clear how these targets will be reached. The 2000-2004 national strategic framework mentions human rights as part of the strategy against

²⁰⁰ Human Rights Watch interviews, Harare, Bulawayo, Gweru, April 17 – May 2, 2006.

²⁰¹ “Global Fund Grant buys Posh Cars,” *The Standard*, November 20, 2005.

²⁰² Zimbabwe National Aids Strategic Plan, 2006-2010, pre-final draft, May 2006. At the time of writing a final draft of the strategic plan was not available.

²⁰³ Between 1987 and 1988 the first emergency strategic plan for HIV/AIDS was developed with the objective of creating public awareness through IEC and training of health personnel. This short-term plan was followed by a medium term plan (MTP) for 1988-1993,²⁰³ which focused on consolidating and expanding interventions related to behavior change (particularly with high risk populations), counseling and caring for people with HIV/AIDS, and monitoring the epidemic through epidemiologic surveillance. Towards the end of the MTP, in 1992, the government obtained a World Bank loan for AIDS prevention and to set up the NACP in the Ministry of Health and Child Welfare (MOHCW). A second MTP for 1994-1998 was developed which adopted a multi-sectoral approach and led to the establishment of the National AIDS Council.

²⁰⁴ Zimbabwe National Aids Strategic Plan, 2006-2010, pre-final draft, May 2006.

²⁰⁵ *Ibid.*

HIV/AIDS while the latest draft plan refers to improved support for PLWHA and families affected by HIV/AIDS. On the other hand as this report has highlighted, the government's own policies and practices violate the human rights of many PLWHA and threaten to worsen the HIV/AIDS pandemic. Negative political and economic policies, as well as poor relations with human rights organizations and international donors have also had a particularly detrimental effect on the government's response to the epidemic.

International response to HIV/AIDS

In the past six years donors – who blame the government for the country's social and economic crisis - have suspended direct aid to the government of Zimbabwe citing political violence, state repression and abrogation of the rule of law.²⁰⁶ The largely negative image of the Zimbabwean leadership among key western donors, including opposition to Zimbabwe's human rights record and its controversial land reform program, seem to be key factors that have led to the exclusion of Zimbabwe from large scale donor schemes, such as the US President's Initiative on HIV/AIDS, the President's Emergency Fund for AIDS Relief (PEPFAR) that provide for a substantial contribution to donor funding for AIDS treatment in other countries in the southern African region such as Zambia, South Africa, Botswana, Namibia, and Mozambique.

In comparison to the mid 1990s, donor funding has been sharply reduced and is mainly limited to humanitarian assistance in response to recurrent drought and food shortages and the widespread HIV/AIDS crisis. Donor assistance to the Ministry of Health and Child Welfare, for instance, fell from US\$71.27 million in 1997 to only US\$6.68 million in 2002. ²⁰⁷ This has had a debilitating impact on the health sector and the government's HIV/AIDS interventions.

Bilateral funding for HIV/AIDS and other social programs has continued, directed almost entirely at NGOs. At the same time bilateral donors have supported the national ART program through UNAIDS and the Zimbabwe National AIDS Council. Major ART partners include the US government with imminent scale up of technical support and funding expected from the European Union (EU) and the UK government's Department for International Development (DfID).²⁰⁸

²⁰⁶ For instance the British Government's Development Agency makes it clear in its country profile on Zimbabwe that it does not provide direct funding to Zimbabwe. See <http://www.dfid.gov.uk/countries/africa/zimbabwe.asp> (accessed June 24, 2006).

²⁰⁷ Ibid.

²⁰⁸ Government of Zimbabwe 5th Round proposal to the Global Fund To Fight AIDS, Tuberculosis and Malaria.

Even in the NGO sector, Zimbabwe is under funded for HIV services in comparison to countries in the region. For example, according to UNICEF, Zambia received \$187 in international aid for every HIV-positive citizen in 2004, whereas Zimbabwe's strained relations with some donors meant that it received just \$10 per person.²⁰⁹ Further, despite the world's fourth highest rate of HIV infection, and the greatest rise in child mortality in any nation, Zimbabweans were receiving just a fraction of donor funding compared to other countries in the region.²¹⁰ UNICEF also noted that in 2004-05 Zimbabwe received little or no HIV/AIDS funding support from the main donor initiatives. The World Bank estimates that Zimbabweans receive US \$14 per capita from both development assistance and aid - less than one-quarter of what Namibians (\$68) receive, and around 12 percent of those in neighboring Mozambique (\$111).²¹¹

Donor funding to local and international HIV/AIDS NGO programs amounts to about US\$70million.²¹² Significantly, in a welcome reversal of the trend of the past five years, funding is likely to increase in the coming two years to address gaps in funding for HIV/AIDS programs. In April 2005, the Global Fund to Fight AIDS, Tuberculosis and Malaria allocated US\$10.3 million to Zimbabwe to fight HIV/AIDS.²¹³ The previous year, the Global Fund had rejected Zimbabwe's application for a five-year, US\$218 million HIV/AIDS program citing unspecified technical reasons.²¹⁴ The government of Zimbabwe accused it of politicizing funds for HIV/AIDS programs in the country.²¹⁵ In 2005, the fund finally approved a US\$62.4 million grant for the next five years; although the first installment of US\$35.9 million is yet to be released. An agreement for the release of the funds is yet to be signed as the Global Fund is waiting to receive relevant documents from the government.²¹⁶

US official assistance for HIV/AIDS in Zimbabwe accounted for US\$24 million in the 2005 fiscal year.²¹⁷ On February 16, the US government pledged a further US\$26 million

²⁰⁹ UNICEF press release, "Zimbabwe's Forgotten Children," March 17, 2005, http://www.unicef.org/media/media_25617.html (accessed June 13, 2006).

²¹⁰ *Ibid.*

²¹¹ *Ibid.* Cited in UNICEF press release.

²¹² "Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS)."

²¹³ The Global Fund To Fight AIDS, Tuberculosis and Malaria, "Grant Round 1, to strengthen and scale up disease prevention and care for HIV/AIDS in Zimbabwe," April 2005, <http://www.theglobalfund.org/programs/grantdetails.aspx?compid=581&grantid=369&lang=en&CountryId=ZIM> (accessed June 13, 2006).

²¹⁴ *Ibid.*

²¹⁵ "Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS)."

²¹⁶ The Global Fund To Fight AIDS, Tuberculosis and Malaria, Grant Round 5, <http://www.theglobalfund.org/programs/Portfolio.aspx?CountryId=ZIM&Round=1&lang=en> (accessed June 13, 2006); Human Rights Watch telephone interview with Global Fund southern African cluster representative, London, July 6, 2006.

²¹⁷ U.S. Embassy Statement, "The Reduction in Zimbabwe's HIV prevalence Rate Credible," *News and Views from around the World*, United States Embassy, Harare, Zimbabwe, October/November 2005.

to support the Zimbabwean government in the fight against HIV/AIDS.²¹⁸ On the other hand as already indicated, Zimbabwe has received no funding from PEPFAR.

DfID one of the biggest donors of HIV/AIDS projects in Zimbabwe is working on a proposal for £25m over 5 years to address the rising mortality rate in mothers and newborns through its underlying cause: HIV/AIDS.²¹⁹ This is in addition to £18m over three years on prevention and treatment, £20m over 5 years on behavior change and condom social marketing and £22m over 4 years on programs for orphans and vulnerable children. Since 2000, DfID's aid framework in Zimbabwe has doubled to £38 million in 2005/6.²²⁰ In a parliamentary session on May 3, 2006, the UK government indicated that DfID was at an advanced stage in developing a new phase of support, jointly with other donors, which would include scaling up AIDS treatment in Zimbabwe. The aim was to establish a U.N.-managed multi-donor fund for procurement of anti-retroviral drugs, including pediatric formulations that would be delivered through the public health service.²²¹

In spite of all these funding initiatives, key donors such as the UK and the US governments have made it clear that they will continue to withhold direct funding to the government, unless the political situation improves and the government engages in serious steps to redress the declining economic and social conditions in the country.²²² For example, despite DfID's involvement in U.N.-led technical discussions with the Zimbabwean Ministry of Health and Child Welfare, over its new HIV/AIDS funding initiatives, at the parliamentary session on May 3, the government reiterated that no DfID funding would go directly to the government of Zimbabwe.²²³ More recently the EU and US governments pledged to uphold sanctions and restriction on visas for government of Zimbabwe officials until the political and economic situation improved.²²⁴

The stance of the international donor community has often angered the government of Zimbabwe which has accused donors of politicizing aid to Zimbabwe. In a recent speech at a high level meeting on HIV/AIDS in New York, the Minister of Health Dr. David Parirenyatwa, claimed that there had been an apparent politicization of HIV/AIDS in Zimbabwe by international donors and said, "The international isolation of Zimbabwe has

²¹⁸ "U.S. Pledges \$26M for HIV/AIDS Programs in Zimbabwe," *Medical News Today*, February 21, 2006, <http://www.medicalnewstoday.com/medicalnews.php?newsid=38038> (accessed July 24, 2006).

²¹⁹ Human Rights Watch interview with DFID representatives, Harare, April 27, 2006, see also DFID country profile.

²²⁰ *Ibid.*

²²¹ UK Parliamentary activities on Zimbabwe, London, May 1-5, 2006.

²²² *Ibid.*, Human Rights Watch interviews with DFID representatives, Harare, April 27, 2006.

²²³ UK Parliamentary activities on Zimbabwe, London, May 1-5, 2006.

²²⁴ "EU, US vow to maintain targeted sanctions against Mugabe," *ZimObserver News*, June 26, 2006.

not helped the situation irrespective of the humanitarian situation of HIV/AIDS.”²²⁵ The government also blames its declining healthcare system and ARV drug shortages on economic sanctions imposed by developed countries which it describes as ‘illegal’. In March, Deputy Minister of Health, Edwin Muguti was quoted by the state Herald newspaper as saying, “sanctions kill...as can already be seen by their effects on our livelihoods as a people...look at fuel, look at drug supply and even ARVs.”²²⁶

Donor concerns about the government’s poor human rights record and flawed economic policies are indeed justified. Nonetheless, given the enormity of the HIV/AIDS epidemic in Zimbabwe, a substantial increase in donor funding is crucial. Zimbabwe desperately needs international aid and technical assistance to effectively address the HIV/AIDS crisis. Thousands of Zimbabweans remain in need of ART and opportunistic infection treatment and the prevention programs need bolstering. In such circumstances the needs of the population must take precedence over political tensions between the government and the international community. At the same time in providing such assistance, international donors also have a key role to play in ensuring that the states they are assisting comply with their international human rights obligations.

²²⁵ Speech by Minister Dr David Parirenyatwa at 2006 High-Level Meeting on AIDS, May – June 2006, http://www.unaids.org.zw/zim_minspeech.php (accessed June 24, 2006).

²²⁶ “Sanctions blamed for poor ARV roll out,” *IRIN PlusNews*, March 13, 2006, <http://www.plusnews.org/AIDSreport.asp?ReportID=5767&SelectRegion=Africa&SelectCountry=ZIMBABWE> (accessed, July 11, 2006).

VIII. Zimbabwe's Obligations under Regional and International Law

Every person has the right to the highest attainable standard of health, the right to life, the right to seek, receive and impart information of all kinds, the right to nondiscrimination and equal protection of the law, and the right to be protected from violence. International human rights law also requires states to address persistent violations of human rights and take measures to prevent their occurrence.

These rights are guaranteed by important international and regional treaties to which Zimbabwe is a party. These include the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), the U.N. Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), and the African Charter on Human and Peoples' Rights (ACHPR).

The Joint U.N. Program on HIV/AIDS (UNAIDS) and the Office of the U.N. High Commissioner for Human Rights (UNHCR) have developed specific guidelines on HIV/AIDS and Human Rights. A range of documents developed by various U.N. agencies, emphasize the links between HIV/AIDS and human rights and highlight how the violations of human rights drive the epidemic.

The right to health

The right to enjoy the highest attainable standard of health is guaranteed by the ICESCR,²²⁷ CEDAW,²²⁸ and the ACHPR.²²⁹ This right imposes an obligation on states to take necessary steps for the prevention, treatment and control of epidemic and other diseases. In meeting this obligation, states "should ensure that appropriate goods, services and information for the prevention and treatment of STDs, including HIV/AIDS, are available and accessible".²³⁰

²²⁷International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXXI), 993 U.N.T.S. 3 (entered into force January 2, 1976), acceded to in Zimbabwe in May 1991. Article 12 of the ICESCR states that state parties to the covenant should take steps to the present Covenant to achieve the full realization of this rights which shall include those necessary for, "the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and the creation of conditions which could assure to all medical service and medical attention in the event of sickness.

²²⁸ CEDAW, adopted December 18, 1979, G.A. Res. 34/180, U.N. Doc. A/34/46, entered into force September 3, 1981 and acceded to by Zimbabwe on May 13, 1991, article 12.

²²⁹ African Charter on Human and Peoples' Rights, adopted June 27, 1981, OAU doc. CAB/LEG/67/3rev.5 21 I.L.M. 58 (1982) (entered into force October 21, 1986), ratified by Zimbabwe in 1986, article 16.

²³⁰ Committee on Economic, Social and Cultural Rights (CESCR), *The Right to the Highest Attainable Standard of Health*, (Art 12), E/C.12/2000/4, (August. 11, 2000) General Comment no. 14, on the normative content of article 12 of the ICESCR, para 9.

General Comment 14 of the Committee on Economic, Social and Cultural Rights on the right to the highest attainable standard of health says clearly that “the committee interprets the right to health as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health such as ...access to health related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health –related decision-making at the community, national and international levels.”²³¹

On nondiscrimination and equal treatment, General Comment 14 states:

By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The Committee stresses that many measures, such as most strategies and programs designed to eliminate health-related discrimination can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information. The Committee recalls General Comment No. 3 paragraph 12, which states that even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low cost targeted programs.

With respect to the right to health, equality of access to health care and health services has to be emphasized. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health care facilities, and to prevent any discrimination on internationally prohibited grounds in the provisions of health care and health services, especially with respect of the core obligations of the right to health. Inappropriate health resource allocation can lead to discrimination that may not be overt. For example investments should not disproportionately favor extensive curative

²³¹ General Comment No. 14: The right to the highest attainable standard of health (art. 12), Adopted at the 22nd Session of the Committee on Economic, Social and Cultural Rights, E/C.12/2000/4, August 11, 2000.

health services, which are often accessible only to a small, privileged fraction of the population, rather than primary and preventative health care benefiting a larger part of the population.

Therefore access to health cannot be limited on the basis of discrimination or cost. All people must be able to access health care, regardless of gender, ethnicity, sexual identity, poverty or other status. Zimbabwe's constitution does not guarantee the right to health but reference is made to health care.²³²

The government of Zimbabwe has failed to ensure that the most vulnerable members of society such as poor PLWHA are adequately protected through its user health fee exemption policies. Nor has it created more affordable health programs to increase effective access to health care for the increasing number of poor people living with HIV/AIDS. Restrictions that are not necessary such as those placed on CD4 tests and user fee exemptions that are often randomly applied and subject to review, violate the Zimbabwe's government's obligations to recognize and fully realize the right to health.

The right to information

Access to information about HIV/AIDS has been reaffirmed as a human right. Article 21 of the ICCPR recognizes that everyone has the right to "seek, receive and impart information of all kinds."²³³ Access to information is also essential to secure the right to the highest attainable standard of health,²³⁴ and accurate information is necessary to allow persons to make decisions about their personal and private lives. Accurate information should be available, accessible, and in a format that is relevant to the target audience in order to ensure its maximum impact.

The United Nations International Guidelines on HIV/AIDS and Human Rights, while not binding, similarly call on states to take positive steps to ensure access to adequate health information and education, including information related to HIV/AIDS prevention and care.

Taking these requirements into account, the government of Zimbabwe in order to meet its obligations, should be ensuring that people are informed that a CD4 count is not required to access ART, and ensuring that government hospital staffs are aware that the

²³² Constitution of Zimbabwe, 1979.

²³³ International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, (entered into force March. 23, 1976), acceded by Zimbabwe, May 13, 1991, article. 19.

²³⁴ See CESCR, General Comment no. 14. para. 12.

requirement of a CD4 count is not necessary to provide treatment. PLWHA cannot exercise their right to treatment if the government fails to inform them that a CD4 test is not necessary before commencing ART, and are barred by third parties from accessing ART without the test. The government must provide information to the public on the criteria for user fee exemption and on criteria for applying for informal trading licenses.

The right to work

Article 23 of the Universal Declaration on Human Rights sets out that “Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.” This is articulated as a binding obligation in article 6 of the ICESCR which calls on state parties to “recognize the right to work, which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts...”

The government of Zimbabwe has an obligation to provide its citizens with opportunities to earn a livelihood in whatever field they choose including the informal sector. The right to work in the informal sector is especially important in the current environment of high unemployment in the country.

Women’s rights

The UN Commission on Human Rights has emphasized “that violence against women and girls...increases their vulnerability to HIV/AIDS, that HIV further increases women’s and girls’ vulnerability to violence and that violence against women and girls contributes to the conditions fostering the spread of HIV/AIDS.”²³⁵

According to the CESCR Committee, the failure to prosecute perpetrators of domestic violence, to discourage harmful traditional practices both in law and in fact, and to adopt a gender-sensitive approach to health, amount to violations of a state’s obligations under CEDAW.²³⁶

The CEDAW Committee recommends that States “intensify efforts in disseminating information to increase public awareness of the risk of HIV infection and AIDS, especially in women and children, and of its effects on them.”²³⁷ The Committee further

²³⁵ U.N. Commission on Human Rights 2004/46, resolution on the Elimination of Violence against Women, <http://www.unhcr.ch/html/menu2/7/b/women/2004-46.doc> (accessed July 24, 2006)

²³⁶ CESCR Committee, General Comment No. 14, *The right to the highest attainable standard of health*, paras. 51 and 52.

²³⁷ CEDAW Committee, General Recommendation 15, *Avoidance of discrimination against women in national strategies for the prevention and control of acquired immunodeficiency syndrome (AIDS)*, (Ninth session, 1990),

recommends that HIV/AIDS programs “give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection.”²³⁸

The HIV/AIDS and Human Rights: International Guidelines, issued in 1998 by the Office of the U.N. High Commissioner for Human Rights and UNAIDS, highlight the need for legislation addressing discrimination and violence against women including harmful traditional practices.²³⁹ The 2001 U.N. General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS emphasized the need to integrate the rights of women and girls into the global struggle against HIV/AIDS.²⁴⁰

While Zimbabwe has made some efforts to incorporate the vulnerable position of women and children into its HIV/AIDS policies, and has legislated against some harmful practices, it has failed to incorporate key provisions of CEDAW that protect women from gender based violence and discrimination. Zimbabwe has an obligation to take all appropriate measures to eliminate violence against girls and women more generally, and to ensure their access to health and social services without discrimination. The government has also failed to adequately address the issue of property-grabbing that continues to take place despite amendments to inheritance laws, in clear violation of the human rights to nondiscrimination and equality under the law.

Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.1 at 81 (1994), (contained in document A/45/38), recommendation (a).

²³⁸ Ibid., recommendation (b).

²³⁹ Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, *HIVAIDS and Human Rights: International Guidelines* (from the second international consultation on HIV/AIDS and human rights, 23-25 September 1996, Geneva,) U.N. Doc. HR/PUB/98/1, Geneva, 1998.

²⁴⁰ United Nations General Assembly, *Declaration of Commitment on HIV/AIDS*, (Twenty-sixth special session), U.N. Doc. A/RES/S-26-2, August 2, 2001, para. 61.

IX. Conclusion

The government of Zimbabwe has shown commitment in trying to address the HIV/AIDS crisis. Like many other countries in southern Africa, it faces numerous social and economic obstacles in the fight against the pandemic. In contrast to other countries, Zimbabwe has had to deal with reduced donor funding towards HIV/AIDS. However, at the same time the government has promoted policies and practices that violate human rights, exacerbate the pandemic and increase vulnerability to infection.

The government's response to HIV/AIDS has also been compromised by numerous other political and social crises that have dominated political attention and overshadowed the implementation of national policies on HIV/AIDS. The government has made apparent its political commitment towards fighting AIDS, but the government's poor political and economic policies cannot be ignored. These include the land reform program which has increased food and economic insecurity; and the government's disregard for democracy, the rule of law and human rights which has led to political tensions between the government and the international community and resulted in reduced donor funding. Such decisions have effectively left the government unable to adequately address the crisis.

Poor and marginalized groups are often the ones who lack access to HIV/AIDS treatment and care because they are frequently confronted with numerous economic obstacles. As detailed in this report the government's actions have had a particularly detrimental affect on the lives of poor and marginalized people living with HIV/AIDS and other groups such as divorced and widowed women. The government risks a reversal in the progress on HIV/AIDS treatment and prevention achieved thus far unless it takes serious steps to address violations of human rights and creates an environment that is conducive to debate and activism on human rights and HIV/AIDS.

The poor have also borne the greater brunt of the international community's ire with the government of Zimbabwe which has translated into reduced funding towards HIV/AIDS prevention and treatment programs. The international community should continue to put pressure on the government of Zimbabwe to improve its human rights record. However without increased funding and technical assistance the government of Zimbabwe faces an uphill battle in trying to address the pandemic. Ultimately it will be the poor and most vulnerable Zimbabweans who suffer the most from a lack of donor funding and not the government of Zimbabwe.

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No Bright Future

Government Failures, Human Rights Abuses and Squandered Progress in the Fight against AIDS in Zimbabwe

Violations of human rights and inadequate health and social welfare policies are undermining progress in the fight against HIV/AIDS in Zimbabwe, where 20% of adults are HIV positive—one of the highest prevalence rates in the world. Zimbabwe is in the midst of a severe crisis with some 350,000 of the 1.6 million Zimbabweans carrying the virus in immediate need of life-saving antiretroviral drugs and another 600,000 in need of care and support.

No Bright Future shows how government policies and practices are worsening the epidemic and increasing vulnerability to infection. Tens of thousands of people living with HIV/AIDS face formidable obstacles in accessing life-saving treatment because of the high and escalating cost of user fees for health services and the inconsistent and arbitrary manner in which exemptions for health user fees are determined by government officials. A lack of public information and misperceptions about antiretroviral therapy policies have also restricted access to treatment for thousands of people in desperate need of life-saving antiretroviral drugs. The government's program of forced evictions, Operation Murambatsvina, and the economically ruinous policies towards informal traders have disrupted lives and livelihoods and increased the risk of HIV infection for thousands, while further imperiling those already infected. The failure of the government to protect women by, for example, prosecuting domestic violence and property grabbing, perpetuates the greater vulnerability of women and the barriers to those women infected to seek and receive effective care. Non-governmental organizations working to combat HIV/AIDS and discrimination are often subjected to harassment and intimidation by members of the government's central intelligence organization and local government officials.

The report also examines the role of the international donor community which has significantly pulled back direct assistance to Zimbabwe since 2000. Given the enormity of the HIV/AIDS epidemic in Zimbabwe, a substantial and immediate increase in donor funding to programs and professionals working with people living with HIV/AIDS is crucial.

The report calls on the government of Zimbabwe to respect the rights of its citizens and show its commitment to fighting the HIV/AIDS pandemic by: providing equitable access to health care for all people, addressing poor economic and social policies that further impoverish vulnerable sections of the population, ceasing policies that prevent and restrict advocacy on the part of people living with HIV/AIDS, and supporting the efforts of international and local organizations providing treatment and care to people living with HIV/AIDS.

*Zimbabwean women's pressure groups
march in Harare on December 1, 2005
to mark World AIDS Day.*

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