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The Political Economy of the Zimbabwe's National AIDS Trust Fund

by

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prepared for the UNRISD Project on **Political Economy of HIV/AIDS**

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BEAM	Basic Education Assistance Module
DAAC	District AIDS Action Committee
HIV	Human Immunodeficiency Virus
MOHCW	Ministry of Health and Child Welfare
MPSLSW	Ministry of Public Service Labour and Social Welfare
MDC	Movement for Democratic Change
NACP	National AIDS Co-ordination Programme
NAC	National AIDS Council
NATF	National AIDS Trust Fund
NGO	Non-governmental Organization
PLWHA	People living with HIV/AIDS
PAAC	Provincial AIDS Action Committees
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United National Development Programme
UNICEF	United Nations Children's Fund
ZANU PF	Zimbabwe African National Union Patriotic Front
ZCTU	Zimbabwe Congress of Trade Unions
ZNNP+	Zimbabwe National Network for Positive People
ZWRCN	Zimbabwe Women's Resource Centre and Network

Introduction

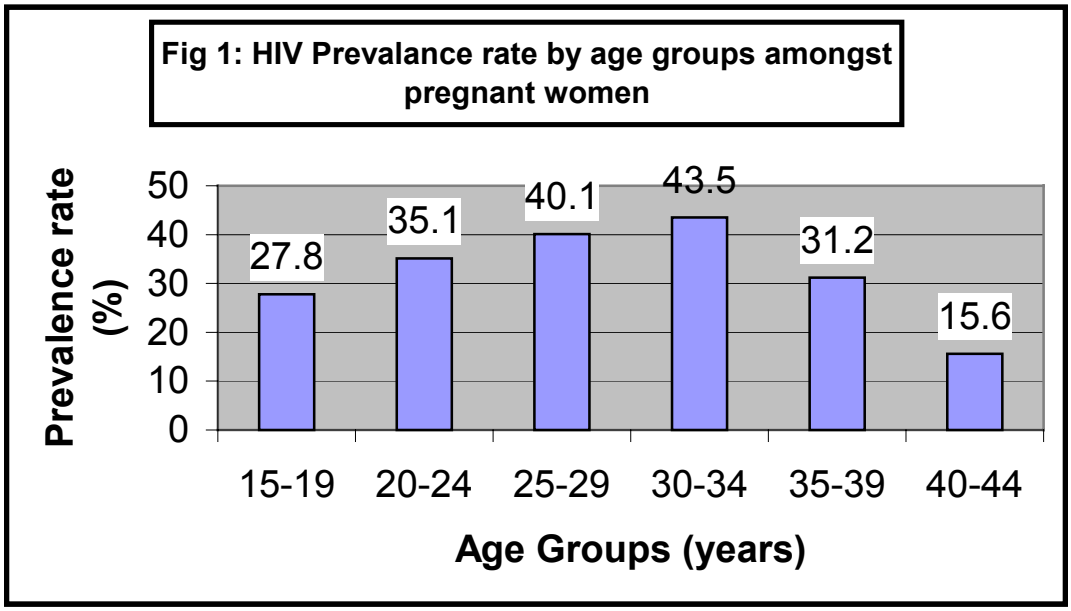
Zimbabwe has been credited by many observers for having its own dedicated resources to deal with the HIV and AIDS epidemic. Most significant of these resources has been the National AIDS Trust Fund (NAFT). Money for the Fund is acquired primarily from taxes on formal sector workers and their employers. This paper analyses the political economy of the National AIDS Trust Fund, its origins, its impacts on the society and responses by various sectors of the country during its implementation. The governance of the NATF is a critical factor in the Zimbabwean context and this will be the key focus of this paper.

HIV/AIDS in Zimbabwe

The first case of HIV/AIDS in Zimbabwe was publicly reported in 1985. By 2001 one-third of the country's adults were estimated to be infected with HIV/AIDS, the third highest prevalence in the world after Botswana (38.8%) and Swaziland (34.5%). In 2003, the Ministry of Health and Child Welfare (MOHCW) reported that the HIV/AIDS prevalence had declined from 34.5% to 24.5% due to prevention efforts in the country (Ministry of Health and Child Welfare and National AIDS Council, 2004). The data have been disputed by observers who point to flaws in the methodology used in collecting the raw data and changes in surveillance sites (UNDP, 2003).

HIV/AIDS infection is strongly biased against women and young adults. Of the 2.3 million people who are infected, 60% are women. Over 43% of women and men in the 30-34 age group are HIV/AIDS positive (Figure 1). Life expectancy is expected to decline from 58 years in the 1980 to 39 years in 2003; it is likely to further fall to about 35 years by 2010, half

what would be expected in the absence of HIV/AIDS (**Ministry of Health and Child Welfare and** National AIDS Council 2004, pp. 31-32). An estimated 2,500 to 3,000 people die every week due to AIDS and related illnesses. The country is experiencing a rapid increase in children orphaned by the death of one or both parents to HIV/AIDS. This in itself is a major challenge, with implications for governance and national security as a growing number of children will be raised in households devoid of parental care, love, discipline and socialisation.



Source: Ministry of Health and Child Welfare2000, National survey of HIV and Syphilis prevalence amongst female attendees to antenatal clinics in Zimbabwe

Historical Economic Developments

To reverse and rectify over eight decades of the European settler economy, at independence Zimbabwe embarked on major economic reforms. The initial reforms sought to give greater economic control to the state and to Zimbabweans; reforms in the 1990s were more market oriented, in line with structural adjustment models offered by international lending agencies.

All the economic reforms had similar objectives of generating sustained economic growth to reduce poverty levels and expand social sector development. However during the late 1990s, budget allocations for security and security began to rapidly increase.

For the most part, the objectives of the economic reforms were not achieved. The social sectors, especially health, experienced budgetary cuts as a result of the structural adjustment programs. There followed a deterioration in service delivery. The structural adjustment reforms undermined the public health system just as it should have been gearing up to fully confront the growing HIV/AIDS epidemic (Basset, 2000). Very high inflation (over 600% as at February 2004) has cut into the wealth and earning power of workers and increased the price of consumer goods and basic services. Almost all major economic sectors have experienced contraction since the end of the 1990s.

Responses HIV/AIDS in Zimbabwe

"AIDS is the disease of a lack of solidarity." Werasit Sittarai UNAIDS

Civil Society

Civil society organisations have run HIV/AIDS programs since the late 1980s. Some of those programs run parallel to existing government program, others seek to fill gaps left by the public health system which collapsed following the introduction of structural adjustment policies in 1990s. Some 260 non-governmental organizations (NGOs) are members of the Zimbabwe AIDS Network. Religious groups have provided various forms of care for people living with HIV/AIDS (PLWHA) and affected families and to mitigate the situation of orphaned children. The secular response of condom promotion has produced angry reactions

from many churches that argue that this encourages promiscuity and the denial of personal moral responsibility. Further, it has been noted: "Denominations lack cohesive policies that articulate clearly how they will address the AIDS issues in their Churches. Most Churches or denominations have not developed strategies for this purpose. Prevention efforts have always been haphazard and piece meal." (George Tembo, UNAIDS, personal communication)

Although many NGOs and community-based organizations play major roles in delivering HIV/AIDS related services, some are very small to offer a wide impact and others lack transparency in how they use their funds. Many remain dependent on external donor funding. Government has not able to fund established NGOs from the AIDS Levy as their requests are more than what government can afford.

Government

The official government response to HIV and AIDS has been slow, but has gradually evolved to include many of the elements normally associated with an effective response by the international community. A National AIDS Co-ordination Programme (NACP) was set up in 1987, and it adopted the WHO model of “medium term plans.” In 1999 the President ratified the National AIDS policy which set out a framework for a multisectoral approach to the epidemic, with coordination from the National AIDS Council (NAC). The policy recognized the need to address HIV/AIDS as a major priority for political support and promoted forms of social and resource mobilisation to mitigate the impacts of the pandemic.

Following the creation of the NAC, the President appointed a multi-sectoral board responsible for formulating policy, controlling the operations of the NAC and disbursing funding generated by the National AIDS Trust Fund.

The Donor Community

It is difficult to identify specific levels of funding for HIV/AIDS from the international donor community. In recent years, donors have been unwilling to resource the NATF or the NAC structures or any other government institution for varying reasons such as lack of democracy or respect for human rights and the absence of transparency in operations, including the Land Resettlement Programme. Bilateral funding for HIV/AIDS and other social programs has continued, directed almost entirely to NGOs. However, NGOs that receive external funding for HIV/AIDS programmes have been labelled enemies of the state by Government.

The National AIDS Trust Fund

The National AIDS Trust Fund was established in 1999 to provide resources to cushion the impact of the AIDS pandemic on individuals. The NAFT was a mechanism, unique to