

"GLOBAL SOLUTIONS TO INFECTIOUS DISEASES"
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Relevant Background

- Population: ±14million (30% urban and 70% rural)
- HIV/AIDS Prevalence Rate dropped from 26% in 2000 to 18% in 2005.
- Economy.
 - Agriculture (maize, soya, cotton, tobacco, horticulture)
 - Mining (Gold, Platinum, Diamonds, Chrome, Nickel, Iron Ore, Coal, Copper)
 - Manufacturing
 - Road and Rail Networks
 - No balance of payment support in the last 7 years as part of sanctions for Zimbabwe's Land Reform Programme
- Literacy Rate: 97% (UNESCO 2007)
 - No child should walk more than 5km to the nearest primary school.
 - No child should walk more than 10km to the nearest secondary school
- Institutional developments in Education

	Number in 1980	Number in 2006
Primary Schools	3161	4842
Secondary Schools	197	1542
Private Colleges	2	+400
Polytechnics	2	8
Teachers' colleges	5	14 (Gov run)
Vocational training centres	2	10
Nurses' training centres	3	10 (Gov run)
Agricultural Colleges	5	15
Universities	1	13 (4 private)

- **Science and Technology Framework.**
 - Science and technology policy with sector specific strategies

- Biotechnology Policy – National Biotechnology Authority (2005) as main implementing and bio safety agency.
 - ICT Policy Framework after e-readiness survey (www.ict.org.zw) 2005
 - Schools Computer programme 2004 and ongoing
 - Three mobile phone companies
- **Research and Research and Development Institutions**
 - Research Council of Zimbabwe
 - Scientific Industrial Research and Development Centre (SIRDC)
 - Agricultural Research Council
 - Various Commodity Research Institutions
 - Zimbabwe National Traditional Healers Association (IKS)

Experiences: Political Commitment translated into:

- **Policy Thrust**
 - i) Preventative – *Health Education. Social safety nets (Widespread distribution of mosquito nets)*
 - ii) Curative – *Improvement of access to health facilities (establishment of infectious disease centres).*
 - iii) Rehabilitation.
- **Structure for Implementation**
 - i) Inclusive approach from village level through to the national level.
 - Primary Health Care Centres – each serving a radius of 5km.
 - District Hospital (for all the 58 rural districts)
 - Provincial Hospitals (1 in each of the 8 rural provinces)
 - Referral Hospitals (At least 5 in each of the two main cities)
 - ii) Administratively the following structures feed into each other:
 - Village Action Committees (VAC)
 - Ward Action Committees (WAC)
 - District Action Committees (DAC)
 - Provincial Action Committees (PAC)
 - National Action Committees (NAC)
 - iii) Participatory – Health workers also exist following the same structure as presented above from Village Health Worker through to the Health Minister.

- iv) Innovative/Creative – such as adapting organisations and companies to business approaches that are sensitive to infectious disease situations.

- **Resources**

- i) AIDS Levy: 3% of taxable individual income.
Levy administered through people oriented structures, programmes and projects, e.g. Village HIV/AIDS Action Committees, Ward HIV/AIDS Action Committees, District HIV/AIDS Action Committees, Provincial HIV/AIDS Action Committees and feeding to National HIV/AIDS Action Committees.
- ii) Minimal donor support: from the year 2000 each person living with HIV/AIDS in Zimbabwe has been getting an average of US\$4 per annum as compared to US\$172 for the other countries in Southern Africa.

Programmes

- i) Home-based care,
- ii) AIDS Orphan Committees at village level,
- iii) Nutrition and Herbal Gardens,
- iv) eradication of malaria vectors (effective insecticides and larvicides).
- v) Distribution of mosquito nets in malaria zones.
- vi) New Start Centres for HIV Voluntary Counselling and Testing.
- vii) Peer Education of all age groups (from primary schools to police and army establishments) with recruitment of volunteers through dramas.
- viii) Direct Observed Treatment Strategy (DOTS) for TB, (Early case detection, Sustained Financing, TB Drug availability, patient progress monitoring and reporting)

Innovative and creative approaches in implementation (ICTs and infectious diseases)

- i) Digital story telling – *testimonies of affected and infected people.*
- ii) Bold advertisement messages to de-stigmatise from
 - a. male macho fathers
 - b. loving caring mothers
 - c. ordinary to popular stars

- iii) Discussion Fora of various types
 - a. Mai Chisamba show – Zimbabwe’s own Oprah
 - b. Schools debates
 - c. Poetry
 - d. Music by popular artists

Cooperating Partners

- i) Universities CBTV
- ii) Non-Governmental Organisations – E-knowledge for Women in Southern Africa (EKOWISA , web address: www.ekowisa.org.zw)
- iii) United Nations Organisations – UNIFEM – gender based approaches in communities. (Roll Back Malaria Initiative)
- iv) Bilateral – Japan’s support to Chitungwiza Hospital.
- v) Despite minimal donor support Zimbabwe has achieved tremendous progress in dealing with infectious diseases as indicated above by the fall in the HIV prevalence rate.

Lessons Learnt

- i) Political Commitment at all levels is vital for achievement of objectives
- ii) Resource mobilisation beginning with own resources independent from others is very essential for sustained initiatives, e.g NGO abandoned programmes.
- iii) People involvement through structures that are cost effective and efficient reaching the largest possible number of victims and cultivates a sense of responsibility to eradication of infectious diseases.
- iv) Using cutting-edge technologies has proved to be very effective in communicating to the people.
- v) Using locally available appropriate technologies such as in water and sanitation e.g drilling of community boreholes and Blair toilets limits the overdependence on foreign financing.
- vi) Be systematic and tenacious in approach and resource commitment, after all, science is about being systematic.

Research

- i) Traditional/herbal medicines (Biomedical research)
- ii) Communication strategies and technologies
- iii) Appropriate technology development.

Conclusion

What has worked for us in Zimbabwe:

- policy thrust: preventative, curative and rehabilitative
- Institutional arrangements that are efficient and cost effective
- Innovative programmes that are low cost but high volume, i.e reaching the largest possible numbers of people.
- Sustainable and significant funding through the National AIDS Levy.