CALLING FOR ACTION ON THE MAPUTO PLAN OF ACTION (MPoA)
Parliament Advocacy Meeting

HELD AT PANDHARI LODGE

March 23, 2010

Meeting Report

Compiled by

Sheila Machiri (Meeting Rapporteur)

TABLE OF CONTENTS

ACRONYMNS

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Antiretroviral drugs
HIV	Human Immune Deficiency Virus
CWGH	Community Working Group on Health
CSO	Civil Society Organisation
MDGs	Millennium Development Goals
MPoA	Maputo Plan of Action
GCN	Girl Child Network
GOZ	Government of Zimbabwe
IEC	Information Education and Communication
PMTCT	Prevention of Mother to Child Transmission
SRH	Sexual Reproductive Health
WAG	Women's Action Group
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Services
WAG	Women Action Group
WASN	Women Aids Support Network
ZWRCN	Zimbabwe Women Resources Centre Network

1.1 Introduction

In Africa Sexual and Reproductive Health and Rights is a constraint for Governments to meet the various MDGs (Millennium Development Goals). Approximately 25 million people are infected with HIV (10 million people in the 15-24 age groups), while 12 million children are orphaned through AIDS related deaths that currently stand at 2 million each year. Services for reproductive health conditions are low in the continent. Statistics indicate about 1 million of the deaths are maternal and new born deaths. Most countries still have unmet need for family planning and with rapid population growth often outstripping economic growth, African countries are unable to meet the growing needs of basic social services (education and health).

In Zimbabwe in accordance with a report published by the United Nations Population Fund (UNFPA) in conjunction with the University of Zimbabwe and other UN agencies revealed that HIV and AIDS causes 1 in 4 maternal deaths in Zimbabwe; that the maternal mortality rate is now 725 per 100,000 live births, with 25.5% of these deaths being accountable to HIV and AIDS. Bleeding after delivery is the second cause accounting for 14.4% and high blood pressure accounting for 13%.

Against the background of the afore-mentioned problems, in 2006, the Ministers of Health of the African Union (AU) in Maputo approved a framework for implementing the African Union's Continental Framework for Sexual and Reproductive Health Rights. The MPoA was endorsed by African Union Heads of States in 2007 to assist countries to: reduce poverty; achieve the Millennium Development Goals (MDGs) to improve maternal and child health and combat HIV/AIDS, malaria and other diseases. The respective national governments have to develop national action plans in line with the MPoA. To complement Government efforts to achieve universal access to sexual and reproductive health in line with MPoA, SAfAIDS has developed a programme to provide technical and financial support to 15 partners (GOZ and 3 CSO in Zimbabwe (Women Action Group(WAG), Girl Child Network (GCN), and the Community Working Group on Health(CWGH) to implement roadmaps and work-plans around MPoA. The meeting therefore was to provide an opportunity to WAG, GCN and CWGH to raise awareness to the parliamentarians on the MPoA and on the progress in relation to the activities the organizations are undertaking in the framework of the MPoA.

1.2 Objectives of the Meeting

The objectives of the meeting were to:

- Give a platform for lobbying parliamentarians on the Maputo Plan of Action (MPoA)

- Provide an opportunity for three partners working with SAfAIDS namely (WAG, GCN, and CWGH) to report on progress in implementation of activities in the framework of MPoA

- Identify key issues for follow up action by the policy makers to meet the requirements of MPoA.

1.3 Participation, Venue and Dates

The meeting was attended by 45 participants (20 males and 25 females) representing the following stakeholder groups – parliamentarians, civil society, donor agencies (funding partners) and media. The meeting was held at Pandhari Lodge in Harare on March 23, 2010. The full list of participants is provided on Annex 1.

1.4 Meeting Format

The meeting was chaired by Ms Nyasha Chizango, Director of the Girl Child Network (GCN). Formal presentations were made by the respective resource persons in plenary followed by discussion on the issue paper.

2. Key Highlights of the Workshop

The meeting proceedings report has a main narrative report synthesising the proceedings. It highlights the major issues that were discussed, points of consensus and some of the recommendations on the way forward.

Annexure of the report contains – the list of participants, programme of the meeting, Speech by Hon Deputy Minister of Women's Affairs, Gender and Community Development, and the presentations made at the meeting.

2.1 Opening Remarks

The meeting was opened Hon. E Masaiti, Deputy Minister of Women Affairs, Gender and Community Development. In her opening remarks, she pointed out that the Maputo Plan of Operation (MPoA) was developed in September 2006 by the African Union (AU) and was endorsed in January 2007 and has been adopted by at least 21 countries. She also pointed out that the majority of African countries had attained minimal progress in improving sexual and reproductive health services and reducing the burden of diseases associated with lack of access to these services. She further pointed out that two in three Africans still did not have access to essential services such as family planning and HIV prevention, care, treatment and support. This was due to little knowledge by key stakeholders on the Maputo Plan of Action. In addition many African countries faced critical shortages of essential medicines, skilled health professionals. Ms Masaiti further noted that public financing for Sexual and Reproductive Health was also a major constraint in the provision of essential health services.

In Zimbabwe, the Ministry of Health and Child Welfare had taken the lead to implement the Maputo Plan of Action in a bid to ensure access to universal sexual and reproductive health

services. The afore-mentioned Ministry (MOHCW) have developed a road map on Maternal and Neonatal health for use by service providers. Ms Masaiti encouraged Government to partner with the civil society in the full implementation of the objectives of the plan.

Ms Masaiti further expressed her hope that the meeting would clarify the roles and responsibilities of parliamentarians with regards to ensuring access to sexual and reproductive health and rights of the citizens of Zimbabwe. Ms Masaiti also highlighted Government's commitment in addressing challenges that women and girls faces due to cultural factors and expressed the need for continued partnerships between Government and the civil society to enhance effectiveness and efficiencies in implementing sexual and reproductive health and rights programmes. The Deputy Minister also encouraged the meeting to identify issues for discussion in the constitution making process.

2.2 Introduction, Background, Objectives of the MPoA Project

Mrs Mandiki, the Country Representative for SAfAIDS gave the meeting a brief on the MPoA Project. In her presentation, she summarised the vision, mission, core values, guiding principles, overall goal and information dissemination mechanisms of SAfAIDS. She also pointed out to the geographical coverage of the SAfAIDS regional programme.

Mrs Mandiki further briefed to the meeting on the MPoA project. She informed participants that the MPoA was a continental framework for SRHR and was agreed upon by the African Union in 2006 and adopted by several countries in 2007. The protocol thrust is the provision of universal access to Sexual and Reproductive Health Rights (SRHR). This has become more important, as HIV and SRHR both address similar vulnerabilities of women and girls. In line with the protocol, there was need to link SRHR and HIV programmes. Ms Mandiki also highlighted the elements of the MPoA as follows:

- Prevention and Management of Infertility
- Prevention and Management of Cancer of the Reproductive System
- Addressing mid-life concerns of boys, girls, men and women
- Health and Development
- Reduction of Gender-based Violence
- Interpersonal Communication and Counselling
- Health education

Mrs Mandiki further informed the meeting that the overall objective of the MPoA programme was for African Governments, civil society, private sector and all development partners to work together to facilitate effective implementation of the continental policy to achieve universal access to sexual and reproductive health in all countries in Africa by 2015. The MPoA is to assist African countries in achieving the MDGs by 2015. Zimbabwe was to develop a national programme in line with the Maputo plan of action. She further pointed out that it was imperative for policy makers to monitor progress in the implementation of the national programme hence the convening of the meeting.

The meeting further noted that to complement Government efforts to achieve universal access to sexual and reproductive health in line with MPoA, SAfAIDS had developed a

project proposal which was funded by the Ford Foundation. The **Programme Goal** is to complement national efforts to achieve universal access to SRHR by providing support to countries to identify bottlenecks, share lessons, define and implement actions for accelerating and monitoring progress towards achieving SRHR directives, as outlined in the Maputo Plan of Action (MPoA).

The three objectives of the programme are:

- To mobilise governments and civil society organisations to renew efforts to address universal access to SRHR information services as guided in provisions of the MPoA.
- To provide both technical and financial support to 15 partners (GOZ and 3 CSO in Zimbabwe WAG, GCN, CWGH) to implement roadmaps and work-plans around MPoA.
- To document and share at least 2 best practices of successful processes that countries are taking to implement MPoA.

The programme is being implemented during the period April 2009 to February 2011 and is focusing on four countries namely: Malawi, Tanzania, Zimbabwe and Egypt. The target beneficiaries were women and young people. Partners for the programme included Civil Society Organisations and Government.

Following the presentation by Mrs Mandiki, the following issues were raised through discussion;

- **Action plan/Road Map for Zimbabwe**

  Some parliamentarians wanted to know if the road map for Zimbabwe had been developed as required by MPoA.

  It was observed that a road map for Zimbabwe had been developed and that a meeting of stakeholders had been organised last year to discuss the road map and to roll it out to the service providers. However the roadmap included maternal and neonatal health aspects excluding adolescent health and family planning leaving a gap in these areas. It was also noted that different activities were being implemented by different ministries such as Ministry of Health and Welfare while other stakeholders such as NGOs provided some aspects of the MPoA but there was lack of adequate coordination among the stakeholders. It was further observed that WAG was to develop a directory of the various players and the activities they were undertaking to facilitate better coordination.

  It was also observed that the road map for Zimbabwe had been developed before the adoption of the MPoA and therefore some key issues had been left out in that national action plan. It was therefore necessary that the issues that had been left out be integrated into the road map. Examples of issues that had been left out included integration of HIV, AIDS and malaria, supportive policies gender based violence, strategies to reduce early marriages, improving access to condoms especially for HIV infected people, human resource training and retention of health workers at all levels, capacity of community networks, provision of youth friendly services, development of road network to support safe motherhood, provision for clinics to be a maximum of 10km walking distance (away from communities) or provision of mobile units.

  In view of the importance attached to SRH, the meeting noted that there was a possibility that this issue could be incorporated into the new Constitution.

- **Resource constraints**

  The meeting noted that financial constraints were a major constraint for Zimbabwe in implementing fully the provisions of the MPoA. For instance the provision in the MPoA for clinics to be 10 kilometers away from the communities was not being implemented in full as clinics were not readily accessible in some areas. It was further noted that for most of the clinics, the infrastructure required rehabilitation and some of the clinics did not have adequate stocks of drugs. Participants agreed that the best way forward would be to mobilize national resources from the public and private sectors as well as push for the 15% budget allocation of the national budget for the health sector in line with the Abuja commitments.

- **Sexual and Reproductive Health Rights (SRHR)**

  An expansion of the concept was provided to participants in response to their request. Participants were advised that the rights included:
  - The right to decide on whether and when to have children or not, and the number and spacing of those children
  - The right to choose a method of contraception
  - The right to self protection from HIV and STIs
  - The right to make decisions concerning reproduction health free of discrimination, force and violence
  - The right to information, education and counseling on human sexuality, reproductive health and responsible parenthood
  - The right not to be denied maternal health care that is accessible, affordable and adequate and of sufficiently high quality
  - The right to access health care without discrimination

- **Same sex marriages**

  In response to a query on how the programme could support same sex marriages, the meeting noted that same sex marriages were not permissible by the laws in Zimbabwe. It was therefore noted that service organizations could assist such couples through giving them advice on the risks/dangers to HIV and AIDS.

- **Sex Education for school children**

  A question was raised if Zimbabwe has sex education as part of their school curriculum. It was observed that sex education was included under the Science subject and that the levels depended on the age of children. It was however observed that sexual rights were excluded from the current curriculum. The meeting agreed that it was important to integrate sexual rights in the school curriculum in view of the need to create awareness to children of their rights especially with the advent of HIV so that the children could protect themselves.

2.3 Presentation on the Civic Society Position on Access to Sexual and Reproductive Health Services in Zimbabwe

Ms Maria Chiwera, Programme Officer (SRHR) WAG made a presentation on the civic society position on SRHR as part of the MPoA. This was a joint presentation developed by WAG, GCN and CWGH. Ms Chiwera's presentation is annexed to the report. Highlights of the presentation covered the following aspects:

- WAG, CWGH and GCN were collaborating in the implementation of the MPoA with support provided by SAfAIDS and Oxfam Australia. In its day to day operation, the

programme for WAG was being implemented with support from its eight network member organizations some of whom were represented at the meeting.

- At a policy level there was no integration of family planning in HIV and SRHR services

- Seventy three percent had expressed the need to be on family planning but 60% are accessing family planning service implying an unmet demand of thirteen percent, MMR study revealed 725/100 000 births and that HIV was the leading cause for the deaths. National HIV prevalence was at 13.7%.

- Research by WAG had also revealed lack of information sharing and dissemination on SRHR.

- In terms of affordability of health care facilities, the research had found out that user fees were not affordable i.e. consultation fees at a clinic is USD5; maternity fees at a clinic are USD50 and USD80 at government hospitals. User fees at some private hospitals are USD300 for normal delivery and USD800 for caesarean section.

- Accessibility to medical facilities is still a challenge as in some areas the facilities were located more than 10kilometres from the users. WAG had also observed that transport to clinic is still a challenge due to poor roads and non availability of ambulances at clinics.

- Service delivery for medical services was poor due to dilapidated infrastructure and obsolete equipment (which lacks servicing and maintenance), CD4 cell count machines were centralized which posed challenges for communities in accessing them. WAG had also observed that there are no youth friendly SRHR services, family planning was being denied to youths resulting in back street abortion, limited PMTCT coverage, unavailability of PEP, traditional birth attendants are at high risk of HIV infection and there is also a high risk of neonatal deaths.

- As regards human resources, WAG had observed that medical service centres were understaffed and in some instances under qualified and staff was demoralized due to low levels of remuneration.

- The availability and affordability of vital/essential drugs for reproductive health e.g. Oxytocin (for inducing labour) was still a challenge

Discussion

Following the presentation by Ms Maria Chiwera, the following issues were raised during discussion:

- **Access to ARVs**

  Participants expressed concern that in some cases administration of ARVs to the patients after diagnosis was delayed due to the need to do a CD4 count test before

administration of the medication. It was further observed that the CD4 count machines were centralised and limited in number and therefore accessing the facilities posed a challenge. The meeting noted that CD4 count test process had been shortened, as CD4 count can now be done later after initiation of ART. This is in line with WHO policy guideline which stipulates that a medical practitioner can look at what stage the patient is and if he/she is in the last stages of the disease infection, the practitioner can commence treatment before CD4 count.

- **Male Circumcision**

  Some participants felt that male circumcision is an important aspect in reducing the risk of HIV and should have been included in the presentation

- **Information Dissemination Strategy**

  Participants wanted to know what dissemination strategies WAG and the partners were using as it was evident that the majority of the participants were ignorant of the MPoA. It was observed that WAG is using sensitization workshops and distribution of IEC materials as strategies for disseminating information.

- **Budget Allocation**

  The issue of lobbying for a certain percentage of the budget for SRHR in the budget for health was considered. The meeting however felt that it was in order for the stakeholders to lobby for 15% budget allocation for the health sector from the national budget but felt that it would be difficult to lobby for specific percentage allocation for SRHR as this would imply making percentage allocations of all aspects of health. The meeting therefore agreed that the issue of percentage allocations was an implementation aspect and should be best left as the responsibility for the Ministry of Health and Child Welfare.

- **Monogamous relationships**

  It was suggested that the one man one woman commitment might pose a problem in Zimbabwe as the population in terms of gender disaggregation was 52% of the population are women while 48% are men. There was a suggestion that polygamy in some instances was a preventive measure in terms of reducing HIV infections as opposed to the “small house” syndrome which has led to increases in HIV infections.(please link to SRHR)

- **Harmonisation of Marriage Certification**

  A suggestion was made that consideration should be given to harmonise the Marriage Act as it was observed that as of now there were two forms of marriages namely; 5.10 which is monogamous marriage and provides for a spouse to sue the other if they engage in an adulterous relationship and the polygamous marriage under chapter 5.07 which stipulates that if a man marries more than one wife all wives have to be aware of the other marriage relationships. Harmonisation of marriages act was considered as a measure of encouraging monogamous relationships.

2.4 Responses To Issues Raised

Participants noted a synopsis of the responses to the issues raised presented by the Chairperson of the Parliamentary Committee on Health, Dr. Parirenyatwa. A summary of the responses to the issues raised is provided below:

- Universal access to sexual and reproductive health implies that every citizen should have access to health. In Zimbabwe however, HIV still poses a challenge for Zimbabwe in attaining universal access to health.

- Maputo Plan of Action is not well known by Zimbabweans except for officials in the Ministry of Health and Child Welfare. It was therefore imperative for Government and the civil society to disseminate the information on to the whole population.

- MDGs were not well known by parliamentarians and it was considered important that a platform be organized for parliamentarians to interact with each other and get more appreciation of the MDGs and MPoA.

- The presentation by WAG reflected that demand for family planning is 73%, and supply is 60% implying that there was an unmet need for family planning. Although statistics indicate that Zimbabwe was better than the other countries in providing family planning there was need for Government to meet the unfulfilled demand of 13%.

- In terms of sex and reproduction rights the issue of abortion was still a problem. In terms of the current laws, abortion in Zimbabwe is illegal and was allowed only in cases of rape, incest or in instances where the pregnancy posed a danger to the life of the mother. In other countries like South Africa, abortion was provided on demand which is not the case in Zimbabwe. The right to abortion needs to be examined especially in the light of HIV.

- Youth friendly corners were not thriving due to resource constraints. There was need for Government to promote the youth friendly corners to discourage early marriages and negative religious and cultural practices. For example in 2007, through advocacy program at the youth centres, the average sexual debut which was 15 years was raised by 9 months to 15 years 9 months. Work still needs to continue to rise this even higher.

- It was noted that 93% of women had access to anti-natal care but only 60% are getting proper medical care at delivery. There was need for Government to ensure that women get proper medical care to reduce maternal mortality and morbidity.

- Some legal issues still required further examination e.g. should condoms be distributed to children at schools and at what levels. Other related issues that require consideration is the distribution of condoms in prisons, HIV and unwanted pregnancies, and the availability and proper use of female condoms.

- Services for HIV and SRHR need to be integrated

- User fees for health services are making access difficult for women. There was need for Government to examine the issue and determine if user fees should be reduced or scrapped.

- Government needs to examine how health services which are operating below optimum level could be strengthened. There was need for Government to mobilize resources from the public sectors, private sector and CSOs to strengthen the health systems.

- There was need for partnership arrangements to continue among CSOs and with Government in the implementation of SRHR programs.

- Facilities for CD4 count classification should be decentralised to enable easy access to the facilities and to enable the health workers to monitor the progress of the patients.

- Role of parliamentarians as advocates to the respective constituencies and to other members of parliament should be strengthened and backed by correct information on pertinent issues. CSOs can be invited to support the parliamentarians with technical inputs.

- Systems for monitoring and evaluation of the plan of action need to be put in place.

- In drawing up the budgets, there was need for consultations and it was important that the other parliamentarians lobby for budget allocations for the Ministry of Health and Child Welfare but that the Ministry maintains the responsibility for implementation.

- In relation to male circumcision, it was appreciated that circumcision in males reduces infection of HIV but that the issue has to be considered as a package with the other prevention methods. As regards female circumcision, genital mutilation was considered as gender based violence. It was however noted that circumcision in some communities was promoted due to cultural preferences.

- Staff retention was still a challenge for the health sector due to brain drain to neighboring countries and to Europe. As a measure to address staff constraints, Government had undertaken an 18 months training program of primary care nurses. In relation to primary care nurses who are trained in 18 months, consideration should be given to their promotion aspects as a measure to retain them.

- Consideration should be given to include SRHR issues into the draft constitution.

3. Recommendations and the Way Forward

In the discussions which ensued under the overall guidance of Mrs. Mandiki, the meeting made the following recommendations:

- Summary of the report and the MPoA be circulated to the participants present at the meeting. In addition the various committee clerks who were present at the meeting would also draw up reports for their committee members. These reports will be used to give feedback to the full caucus and CSOs can be invited to provide technical support to the committees when the sessions are being held.

- Improvement in the education curriculum be made to include SRHR and combine it with HIV and make the subject examinable by 2011

- Parliamentarians move motions in parliament to lobby for the Ministry of Health to get 15% of national budget allocation

- Various issues raised by the meeting be taken up by the respective relevant committees and form basis for content of motions and that the respective Chairpersons of these committees include these issues in their respective work plans

- A follow-up meeting should be convened in future to assess progress on the implementation of the various aspects.

4. Closing Remarks

The meeting was closed by Honourable Mangami, Chairperson for the Parliamentary Portfolio Committee on Education, Sports and Culture. In her closing remarks she thanked the organizers of the workshop, the Honourable Deputy Minister Masaiti for her opening remarks as well as all the respective presenters. Honorable Mangami encouraged the various relevant committees to follow up on the issues under their respective portfolios.

Annex 1

Participants List

CALLING FOR ACTION ON THE MAPUTO PLAN OF ACTION (MPoA)
Parliament Advocacy Meeting
Pandhari Lodge
March 23, 2010

Name	Sex	Contact details	Constituency
Harrison Mudzuri	Male	0912849947	Zaka Central
Betty Chikava	Female	0913390416	Mt. Darwin East
Misheck Tofa Kagurabadza	Male	0912252108	Mutasa South
Margaret Matienga	Female	0913010659	Sunningdale
Meki Makuyana	Male	0912399241	Chipinge South
Ernest Mudavanhu	Male	0914164389	Zaka North
O Matshalaga	Male	0913739444	Zvishavane
R Goro	Female	0912588633	Hwedza South
V Kutyamaenza	Female	0913436847	Makonde
E Matamisa	Female	0733411220	Kadoma
J Makore	Male	0912850517	Chitungwiza
H Shoko	Male	0912667484	Bikita West
Maramba	Male	0913797307	Chirumanzi
E Masaiti	Female	011878526	Dzivarasekwa
Fani Manen Gami	Male	0912698383/ fanimunengami2002@yahoo.com	Glen View North
Oliver Chirume	Male	0912655292	Gutu Central
L Mupukuta	Male	0913912363	Gokwe and Mapfungautsi
Kizito Chivambe	Male	0912633448/011789035	Chiwundura
Tichaona Mharadza	Male	0912589280	Masvingo West
Beatrice Nyamupinga	Female	0912218029	Goromonzi West

Blessing Chebundo	Male	0913014516	Kwekwe Central
D Mangami	Female	011381819	Gokwe
J Madubeko	Male	011521252	Vungu
A Sibanda	Female	0913013716	Gwabalanda
E Shirichena	Female	011590217	Mberengwa South
R Makamure	Male	0913240320	Gutu East
E Mabhiza	Female	0914147278	Chikomba – Seke
D Parirenyatwa	Male	011200728	Murehwa West
G Ndebele	Male	0913430689	Matobo South
N Khumalo	Female	0912878662	Committee Clerk
Edna Chikuvire	Female	0912765299	Committee Clerk
Monica Mandiki	Female		SAfAIDS
Lillian Chikara	Female	0912310567	SAfAIDS
Nyasha Mazango	Female		Girl Child Network
Tariro Tandi	Female	0912211437	Girl Child Network
Lindiwe Ngwenya	Female	0918064625	ZWRCN
G Chiware	Female	0912835984	WASN
Antoinette Ngoma		04-308738	WAG
Maria Chiwera	Female	04-308738	WAG
Evelyn Mashamba	Female	0912349553	Shamiso Development Trust
Cynthia Chipeni	Female	091222798	National Healthcare Trust
Fatima Bulla	Female	0912892872	Herald
F Machivanyika	Male	0915716405	Herald
Tafadzwa Chigariro	Male	0913255541	CWGH
Roselyn Nyatsanza	Female	0913060467	OXFAM, Australia
Sheila Machiri	Female	0912254460	J S Consultancy

Annex 2

CALLING FOR ACTION ON THE MAPUTO PLAN OF ACTION (MPoA)
Parliament Advocacy Meeting
Pandhari Lodge
March 23, 2010: 0830Hrs – 1330Hrs

AGENDA

Chairing: Mrs Nyasha Mazango - Executive Director GCN

Time	Session	Session Chair/ Facilitator
08:30-08:45	**Arrival and Registration**	**CWGH**
08:45-0930	**Opening Session** **Welcome remarks and Introductions** Opening Remarks Introduction, Background, Objectives of the MPoA Project	**Ms. Nyasha Mazango** Executive Director, Girl Child Network **Hon E Masaiti** Minister of Women Affairs Gender and Community Development **Mrs. Monica Mandiki** SAfAIDS Country Representative
09:30-10:30	**Presentation:** Civil Society Position On Access to SRH Services in Zimbabwe	**Ms. Maria Chiwera** WAG Programme Officer (SRHR)
10:30-1100	**TEA BREAK**	
11:00- 11:30	Responses to issues raised	**Dr. David Parirenyatwa** Chairperson - Parliamentary Portfolio Committee on Health
11:30-12:00	Recommendations and Way Forward	**Mrs. Monica Mandiki** SAfAIDS Country Representative

12:00-12:30	Closing Remarks	**Hon. Mangami** Chairperson - Parliamentary Portfolio Committee on Education, Sports & Culture
12:30-1330	**LUNCH**	

Annex 3

Speech by the Honourable Deputy Minister of Women Affairs, Gender and Community Development, Hon. Evelyn Masaiti 'Maputo Plan of Action and Advocacy Meeting with Parliamentarians'

23 March 2010

Protocol

Chairperson Committee on Gender and Development

Chairperson Portfolio Committees on Health and Child Welfare

Chairperson Portfolio Committee on Education Sports & Culture Chairperson Portfolio Committee on Women Affairs

Honourable Members of Parliament

SAfAIDS Country Representative, Mrs Monica Mandiki

Girl Child Network Executive Director, Ms Nyasha Mazango

Community Working Group on Health Executive Director, Itai Rusike

Women's Action Group Acting Executive Director, Antoinette Ngoma

Representatives of Civil Society Organisations

Distinguished Guests here present

Ladies and Gentlemen

It gives me great pleasure to be here today, at this reflection meeting on the Maputo Plan of Action (MPoA). The Maputo Plan of Action developed in September 2006 by the African Union (AU), endorsed in January 2007 has been ratified by at least 21 countries. Four years later, the majority of African countries have done very little around improving sexual and reproductive health services and reducing the burden of diseases associated with lack of access to these services. Two in three Africans still do not have access to essential services such as family planning and HIV prevention, care, treatment and support. A number of factors have contributed to this, including the fact that many of the players expected to play an important role in the implementation do not know anything about the existence of the Maputo plan of Action. Over and above this many countries face shortage of essential medicines, skilled health professionals and public financing for Sexual and Reproductive Health Programmes.

Implementation of this plan involves activities at regional, country and community levels. In Zimbabwe the Ministry of Health and Child Welfare has taken the lead in a bid to ensure access to universal sexual and reproductive health services. However, gaps have been identified in the implementation of the plan, which has seen the need for civil society to partner with government. Community Working Group on Health, Girl Child Network, Southern Africa HIV and AIDS Information Dissemination Service and Women Action Group have come together to work on this project. Their efforts are centred on mobilising government and other civil society organisations to meet the objectives of the plan.

This meeting which will give us an overview of the project will enable us to get more details on our roles and responsibilities as parliamentarians with regard to ensuring access to comprehensive sexual and reproductive health and rights of our citizens. From the background that will be provided by SAfAIDS and the presentation on findings from the ground by CWGH, GCN and WAG should give us enough information to deliberate, respond to issues raised and map a way forward.

I am happy to learn that this meeting is part of a bigger project, with similar high level meetings having been held in July, November and December 2009 respectively. Community level meetings are also being held through Community Working Group on Health and Girl Child Network. It is important to get evidence based feedback from these partners, as they help us to take up key issues within our constituencies and in parliament.

As a woman leader in Government, I am aware that there are many challenges that face us as women and girls, which some aspects of our culture tend to condone. These have been highlighted as dark aspects of our culture which need to be stopped while those good aspects can be upheld. As parliamentarians, it is imperative that we work with these technical partners to enhance our work and effectiveness in improving access to sexual and reproductive health and rights.

This meeting is therefore an important opportunity to develop recommendations and a way forward on the translation of the Maputo Plan of Action into tangible action at community level. The various parliamentary committees here present have been identified for their key roles in this work. I therefore wish you fruitful deliberations for the day.

I thank you all.

Annex 4

POWER POINT PRESENTATIONS

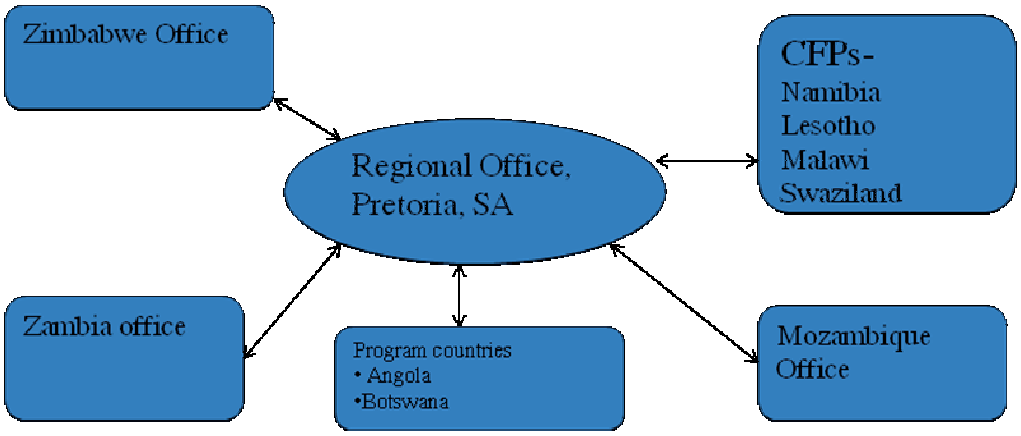
Presentation 1 on SAfAIDS

By Monica Mandiki
Country Representative
SAfAIDS
17 Beveridge Road
Avondale
Harare
Email:monica@safaids.org.zw

SAfAIDS : Who are We?

SAfAIDS Offices

SAfAIDS Offices



Vision

To be a leading southern Africa regional centre of excellence, organising, analysing, repackaging and disseminating HIV and AIDS information in response to the needs of communities

Mission

To promote ethical and effective development responses to the epidemic and its impact through HIV knowledge management, capacity development, advocacy, policy analysis and research with special regards to gender, human rights and other development concerns

Core Values

- Professionalism
- Striving for excellence
- Dedication and commitment
- Justice and equity
- Respect for diversity and human rights

Guiding Principles

- HIV as a development issue
- Disseminating quality information that is effective in promoting changes in knowledge, attitudes and behaviour.

- Promote multi-sectoral responses at regional level
- Promote MIPA- Networks are critical partners in the response**.**

SAfAIDS Overall Goal

Is to contribute meaningfully to the reduction of HIV prevalence in the region, using information as a tool to bring changes that will reduce people risks and vulnerabilities, and increase their coping abilities

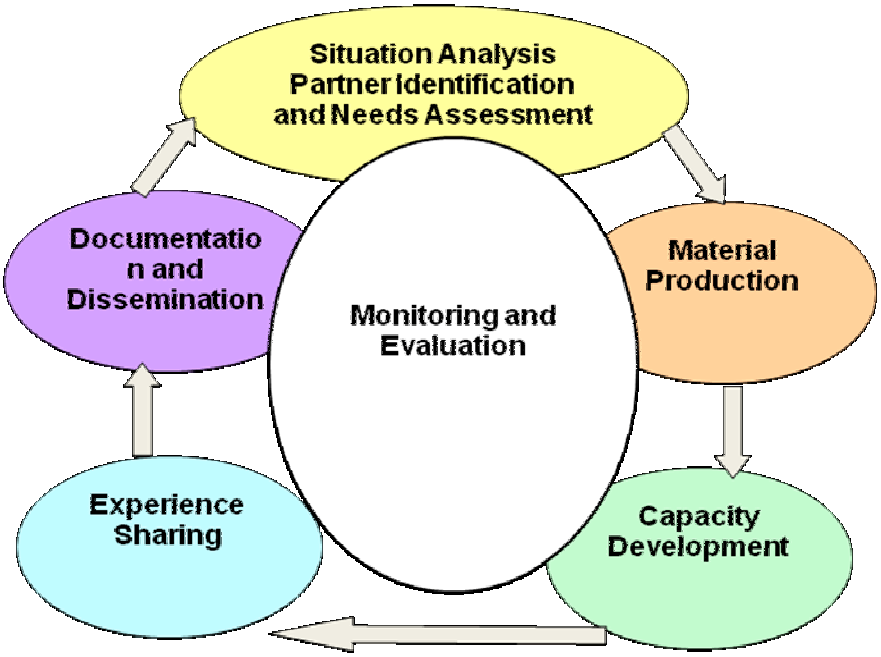
Strategic Objectives

- Scaled up availability and access to quality targeted info (on HIV/TB prevention, treatment, care and support)
- Strengthened capacity among service providers to communicate and disseminate information.
- Improved cross learning among services providers and communities through sharing of evidence based best practices.
- Enhanced advocacy on policies related to HIV/AIDS and TB prevention, treatment, care and support

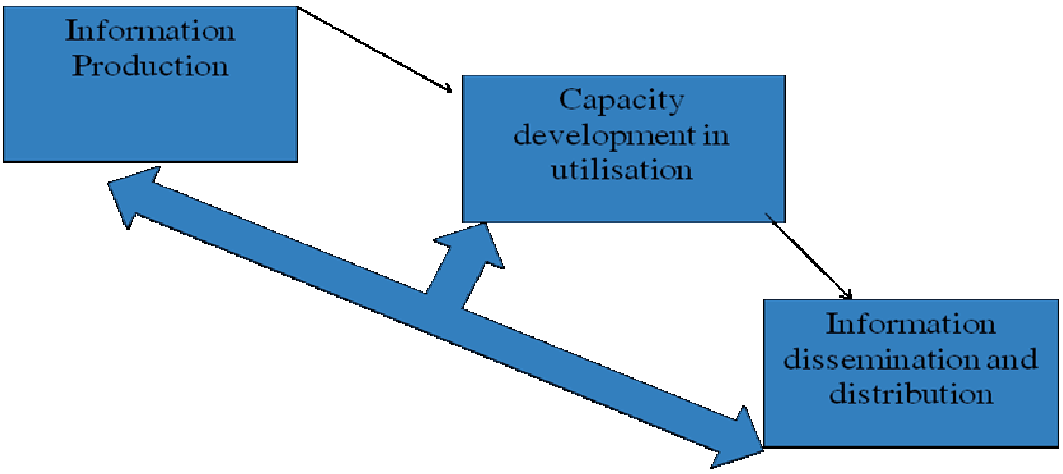
Key Areas of Focus

- Intensify prevention efforts at regional level
- Reduce stigma and discrimination faced by people affected and infected with HIV
- Gender , rights based approaches and empowerment of women and girls
- Universal access to treatment through community preparedness and mobilization
- Prevention, treatment, care and support in the world of work through policy development and implementation

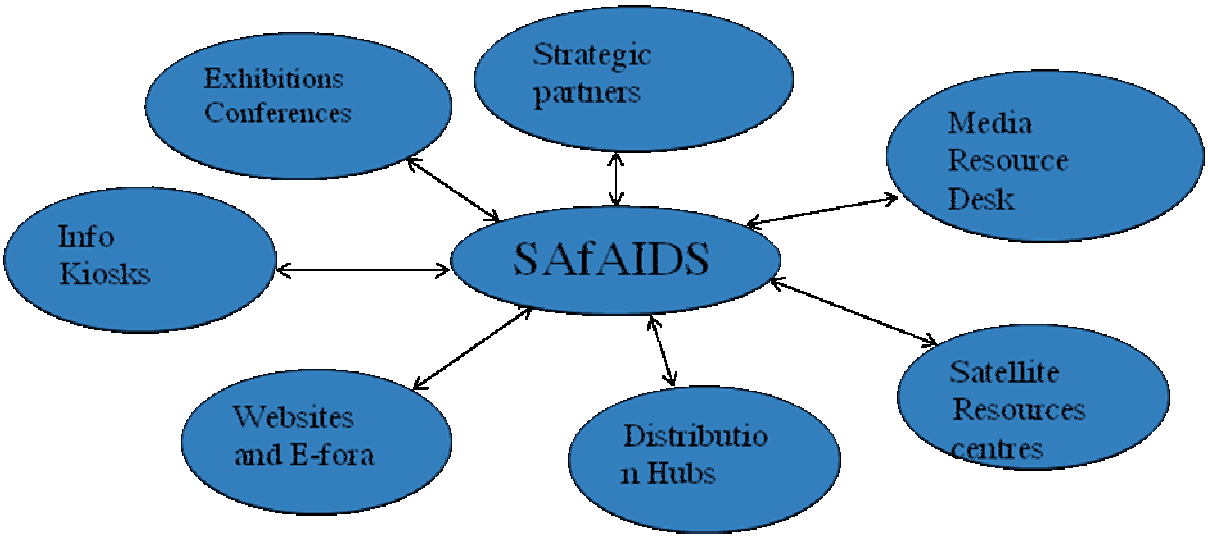
SAfAIDS' Operational Strategy



Strategic info pathways



How do we disseminate?



ACHIEVEMENTS

Presentation 2: Brief on the MPoA

By Mrs Monica Mandiki
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Complementing Government Efforts to Achieve Universal Access to Sexual and Reproductive Health and Rights

Background

- The Maputo Plan of Action (MPoA) is the continental framework for SRHR as agreed by the African Union in 2006 and ratified by several countries in 2007.
- Provision of universal access to Sexual and Reproductive Health Rights (SRHR) becoming a cornerstone of development responses
- The need to link SRHR and HIV programmes and policies becoming increasingly critical as they address similar vulnerabilities for women and girls
- Background Facts25 million Africans infected with HIV
- 12 million children orphaned due to deaths related to AIDS.
- 2 million deaths from AIDS each year
- Women increasingly affected with the feminization of the epidemic
- 1 million maternal and newborn deaths annually
- High unmet need for family planning with rapid population growth often outstripping economic growth and the growth of basic social services (education and health) - contributing to the vicious cycle of poverty and ill-health

What are the MPoA Elements

These elements include;

- Prevention and Management of Infertility
- Prevention and Management of Cancers of the Reproductive System
- Addressing mid-life concerns of boys, girls, men and women
- Health and Development
- Reduction of Gender-based Violence
- Interpersonal Communication and Counselling
- Health education

Programme Goal

The Programme Goal is to complement national efforts to achieve universal access to SRHR by providing support to countries to identify bottlenecks, share lessons, define and implement actions for accelerating and monitoring progress towards achieving SRHR directives, as outlined in the Maputo Plan of Action (MPoA**).**

Overall Goal

- Is for
  - African Governments
  - civil society
  - private sector
  - all development partners

to join forces and redouble efforts, so that together the effective implementation of the continental policy including universal access to sexual and reproductive health by 2015 in all countries in Africa can be achieved

Programme Thrust:

- Coverage : Malawi, Tanzania, Zimbabwe and Egypt
- Beneficiaries : Specific focus on women and young people
- Partners : Civil Society Organisations s and Government bodies
- Programme Duration: April 2009 - February 2011

Programme Thrust: How?

Methodology: Tri-pronged programme to accelerate implementation of MPoA.

- Country-mapping reviews, measure progress and identify bottlenecks in participatory process with CSO and Govt partnerships
- Advocacy interventions facilitated by technical grants to implementing partners,
- Cross-learning facilitated by lessons sharing platforms

Program Objective 1

To mobilise governments and civil society organisations to renew efforts to address universal access to SRHR information services as guided in provisions of the MPoA.

- Expected result:
  - Governments supported to renew efforts on implementing MPoA: roadmaps developed; monitoring plans set; CSO advocacy strengthened.

Program Objective 2

To provide both technical and financial support to 15 partners (GOZ and 3 CSO in Zimbabwe WAG,GCN,CWGH) to implement roadmaps and work-plans around MPoA.

- Expected result:
  - Increased advocacy and monitoring activities at country level by Civil Society on MPoA

Program Objective 3

To document and share at least 2 best practices of successful processes that countries are taking to implement MPoA.

- Expected result:
  - Increased learning and sharing among countries on progress made around MPoA directives, and what works to catalyse meeting MPoA commitments

Key issues to keep in mind….

- Sustainability
- Ownership
- Tracking and reporting outcome/impact
- Increased advocacy at all levels national, provincial and community

Presentation 3 : Civil Society Position on Access to SRH Services in Zimbabwe

By Ms Maria Chiwera
Programme Officer (SRHR) WAG

Presentation outline:

- Def: reproductive health
- Policy issues
- Statistics
- Affordability
- Accessibility
- Service Delivery
- Cultural and religious practices
- Recommendations

Definition of reproductive health

- RH is a state of complete physical , mental and social well being in all matters related to the reproductive system and to its functions and processes.
    - This implies that people should have satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so
- (ICPD 1994)

Policy Level

- Policies on paper and not being implemented e.g. Maputo Plan of Action signed 4 years ago, SADC Protocol on Gender and Development, MDGs
- Poor co-ordination and integration of HIV/SRHR in primary health care/ vertical approach
- National budget process not consultative enough
- No demonstration of commitment on budget allocation to SRHR
- Lack of information sharing or dissemination on existing policies on SRHR
- Lack of simplified and translated policiesThere is no integration of family planning in HIV and SRHR services
- 73% expressed the desire to be on family planning but 60% are accessing family planning services

Statistics

- CPR: 60%, Unmet need 13%
- MMR: 725/100 000 live births
    - HIV leading cause, then haemorrhage (blood)
- HIV prevalence: 13.7% (National HIV and AIDS Estimates 2009)

Affordability

- User fees are not affordable
    - US$5 consultation fee at council clinics (card)
    - maternity $50
    - Excessive bleeding requires at least 3 units of blood at US$100/pint
- Baines-$300 normal delivery

  -add $800 for caesarean section

Chitungwiza-consultation-$10

-$31 maternity fees

-$25 scan

-$400 caesarean

Hospital bill on discharge $200+

Service Delivery

- Infrastructure – water, electricity, incomplete structures, newly resettled communities have no clinics
- Equipment – obsolete equipment, lack of proper equipment, no servicing/maintenance, lack of essential equipment (sterilisation equipment, obsolete lab equipment, CD4 cell count machines – to be decentralized)
- Case detection through X-ray (HIV & TB co-infection)
- Hospital acquired infections
- Resource allocation and prioritisation
- Reactive to situations e.g. cholera
- No youth friendly SRHR services
- Family planning being denied to the youth resulting in high back street abortions
- Limited PMTCT coverage
- Unavailability of PEP
- Traditional birth attendants are at high risk of HIV infection and there is also a high risk of neonatal deaths
- Recreational facilities

Human Resources

- Understaffed
- Under qualified e.g. Primary Care Nurse is trained for 18 months
- Demoralised – remuneration

Drugs

- Availability
- Affordability

- Government commitment – unavailability of essential drugs for reproductive health e.g. Oxytocin (inducing labour)
- Imported expired/poor quality drugs

Cultural and Religious Practices

- Apostolic sect contributes 29% of maternal mortality rate-Manicaland
- Outburst by MPs at gatherings, sometimes derails progress
- Some cultural practices in the constituencies are harmful e.g. polygamy, wife inheritance etc

Recommendations

- Review of curriculum –sexual rights
- Subsidise sanitary ware
- Avail recreation facilities
- Budget for refresher courses for health personnel to meet the needs of adolescents
- Improve access to female controlled devices compare with male circumcision National budget processes should be consultative enough
- Adopt a one stop shop approach to health services delivery
- Encourage dialogue on negative cultural practices that fuel gender based violence