Local Level Advocacy
In Health & Rights

The Case of Masvingo Province in Zimbabwe

Batanai
HIV & AIDS Service Organisation

HIV/AIDS, HUMAN RIGHTS & LAW PROJECT
ZIMBABWE

"Those who do not move, do not notice their chains."

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Acknowledgements

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As far back as we can remember, supporters of the initiative, like the Zimbabwe Network of PLHIV (ZNNP+), Zimbabwe Lawyers for Human Rights (ZLHR) and Trocaire, have stood firm on the belief that ordinary people can do so much to change their situation. Appreciation goes to OSISA, FORD, COMIC RELIEF, TROCAIRE and UNAIDS who support the HIV/AIDS, Human Rights and Law Project at ZLHR. This publication was made possible with support from UNAIDS.

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About the HIV/AIDS, Human Rights and Law Project

The HIV/AIDS, Human Rights and Law Project exists to cultivate a legal and human rights based response to HIV and AIDS in Zimbabwe by encouraging the protection, promotion and fulfilment of the rights of people living with and affected by HIV; and by advocating for the enactment of laws and policies that facilitate HIV prevention efforts, as well as for care, treatment and support for the affected.

Since 2004, we have worked to promote the rights and fundamental freedoms of people living with, affected by, and vulnerable to HIV and AIDS in Zimbabwe. The project works through advocacy committees established for PLHIV in all the provinces of the country and other tools include Community Aids Forums (CAFs), Mobile Legal Clinics, HIV/AIDS and Law Training, Advocacy Training, Community Meetings, Research, Networking, Lobby, Advocacy and Publications.

About the Health and Rights Advocacy Forum

The Health and Rights Advocacy Forum is a platform and network for activists and PLHIV that engages in advocacy on human rights and health. The Health and Rights advocacy Forum consist of advocates from all the ten provinces of Zimbabwe. The forum is supported by Zimbabwe Lawyers for Human Rights for purposes of continuous dialogue in health and rights.

What is advocacy?

"How can I say something so that you can hear me, be moved by that, changed by that?" OW 2011

Experiences in Masvingo have shown that advocacy means taking action and speaking out on a problem. The advocacy committee in Masvingo has undertaken action directed at changing the policy, practice, programme, behaviours, systems or environment in a manner that addressed the everyday problems faced by local people in the community. Case studies from Masvingo have shown that advocacy action involves putting a problem on the agenda and drawing community's attention to it and the need to solve the problem. Advocacy action highlighted herein involves a wide array of activities undertaken to achieve the desired change.

Throughout the narrative of advocacy diaries in Masvingo, it is apparent that advocacy action should first identify an **advocacy objective**. The advocacy committee or team systematically set out what they intended to achieve before embarking on advocacy action. In most instances, initial research was undertaken to provide relevant data to support advocacy arguments. **Research** has been carried out in various districts in the province on the thematic issues that have been raised in the districts as advocacy issues. It is also important to **identify advocacy target audiences**. In the various districts, advocacy audiencies consisted of a cross section of government officials and key stakeholders who have contributed immensely to changes in policies, practices and programmes. The advocacy committee has systematically identified target audiences who make decisions or influence decision making. In local level advocacy it is important to identify who makes decisions in the local

community and who can influence decision making. Building **partnerships and coalitions** is important to strengthen the advocacy voice. The power of advocacy is found in the number of persons or organisations who support an objective. Non- governmental organisations, health workers, business leaders, community leaders, politicians and church leaders have all been part of the broader network of partners identified by the Masvingo advocacy committee for the work in the province. Besides facilitating political support, large numbers of people from diverse interests assist in amplifying the voice for the agreed cause.

The Masvingo advocacy committee has adopted innovative ways of framing advocacy content and presenting it. Formulating **advocacy messages** allows for the proper framing of issues using the appropriate language and data. This also allows for **persuasive presentations** to be made to the appropriate audiences without wasting time. Usually policy makers do not have enough time to deal with many of the problems that are presented to them daily so it becomes critical to be able to package advocacy messages for efficiency and effectiveness where there are limited resources of time and limited opportunities to be heard. Lastly, **evaluation** is crucial in advocacy because it enables one to see if the strategies being employed are working or not and to work on any improvements on current strategies for future actions. This is one area where serious effort is needed to effectively measure advocacy work in the province.

Local level advocacy: An introduction

Approaches to human rights and health that generate social change have not been forthcoming in development work in Zimbabwe. In fact, such approaches are nonexistent. Approaches have always been unsound, tired and top dressed. In Masvingo, studies have shown that local level advocacy is an enduring and fluid approach whose strength lies in social investment in ordinary community members. In the past, advocacy issues used to be cascaded to the national level for them to gain recognition and prominence. This has resulted in so many critical issues being ignored despite affecting people in the local communities in a big way. The Masvingo experience has shown that local level advocacy brings to prominence critical issues in a community by using the voice of the local people who are directly affected by the issues. An issue that is forwarded to national representatives or advocacy groups may fail to get attention because it is viewed as unimportant and not urgent in terms of national perspectives.

Community participation

Local advocacy committees in Masvingo involve all people in the community by holding consultation at all levels of the community. In most cases of HIV and health, consultations involve support group leaders, youth support groups, AIDS services organisations in Masvingo like Batanai, Zimbabwe AIDS Network, National AIDS Council, Red Cross, Solidarmed and many others. Local business people provide financial assistance during community meetings and are aware of the work that the advocacy committee is doing. A diverse network of community participants are consulted and involved in the work of the provincial advocacy committee. This has enabled a shared vision with the community assisting in keeping the vision alive. For example, every time there are health rights violations in the community, e.g. drug stock-outs or discrimination,

ordinary people in the community would generally ask if the advocacy committee knows about it and make every effort to bring the issue to the attention of the advocacy committee for action. This happens because everyone in Masvingo is aware of the shared vision of community health based on a human rights agenda.

Local level advocacy is community participation.

Go to the people, Live with them, Learn from them
Love them, Start with what they know
Build with what they have, But with the best leader
When the work is done, The task is accomplished
The people say:
'We have done this ourselves.'
Lao Tzu,
Chinese philosopher, 6th century BC

At the district level, local level advocacy is advocacy action by groups of people aimed at changing and correcting situations for the betterment of their welfare and the health concerns of the district. It involves ordinary people working to change public health policy and practices in their district. Public health, properly understood, involves the duties and obligations of government towards its citizenry in promoting and protecting community health. It includes issues of availability, accessibility and affordability of basic health care and essential medicines.

It may be asked, who takes part in local level advocacy? Anyone can take part in local level advocacy in health care. Ordinary people are usually the drivers of advocacy at the local level. In most instances, like in Masvingo, the rallying point is usually some form of biosocial citizenship. Biosocial citizenship mobilisation in advocacy usually provides a sustainable platform that is driven by deep commitment. Biosocial

citizenship encompasses the sociological and medical characteristics. Medical diagnosis, for example, describes people according to their condition and thereby suggests that health and sickness is the state of a person [Parsons 1951][1]. Social definitions of people concern your family, community, culture and how people define themselves and are defined by others. Health condition becomes a social role when it affects social interaction [Ene 2009][2]. Being HIV positive, like being diabetic or having high blood pressure, becomes part of a person's new identity and groups of shared medical conditions are common. Biosocial citizenship is about the role people play in their own health and sickness. In our local advocacy initiative, biosocial citizenship has played a key role in formulating a core group of ordinary people living with HIV in the community who have taken it upon themselves to advocate for human rights in health care. This group of PLHIV in Masvingo have provided the voice of reason and advocacy in community health care issues. In Masvingo, like in other communities, family and community members associate themselves with groups of biosocial citizenship. Medical conditions and diseases of loved ones always result in people associating themselves with such groups, e.g. in Masvingo province, a number of children and family members of PLHIV are members of support groups as they come in to provide moral support.

[1] Parsons T, *The Social System*. New York: Free Press, 1951

[2] Smaranda Ene, *Biosocial Citizenship:Community Participation in Public Health,* 2009

Local level advocacy in health: The concept

The concept of local level advocacy initiatives in Zimbabwe began when Batanai HIV and AIDS Service Organisation (BHASO) in Masvingo trained the first core group of 30 advocates, who were all PLHIV in Masvingo urban district. The trained individuals formed the Advocacy and Treatment Literacy Trust (AATLT). Zimbabwe Lawyers for Human Rights came in to strengthen the concept and trained the same advocates on human rights and the law. The training was based on the ARASA Manual. Advocates became empowered in terms of the law and human rights literacy. Local level advocacy is thus spearheaded by PLHIV in the communities with knowledge on advocacy, human rights and law. The other districts consisting of Masvingo Rural, Mwenezi, Chiredzi, Zaka, Bikita, Chivi, and Gutu were all later trained and drafted into the structure. The structure creates a network or chain of advocates from the ward level up to the national level. Almost all the provinces now have functional advocacy committees coordinated and run by PLHIV. Outside Masvingo the structure is coordinated by ZLHR in partnership with ZNNP+. In 2009, the national committee used to convene as a national roundtable, which is now the National Health and Rights Advocacy Forum. The unique concept of advocacy committees is based on ownership by PLHIV who are supposed to drive the initiatives and function independently of anyone or any organisational interest. They are free to network and create partnerships in the communities as they deem fit, in order to promote the shared vision of rights and health in the communities. As seen in the initial approach started in Masvingo, and reinforced by BHASO, advocacy committees like support groups belong to the community and not to any institution or AIDS service organisation. This method seeks to dissociate the concept from the usual uneasy approach where people are owned by some person or institution. Advocacy committees therefore belong to the community and are there to hasten and be beholden to community needs and problems. They can operate independently because the concept is not expensive and is community driven.

Local level advocacy: The structure

The structure of local level advocacy operates at five levels: at the ward level, cluster level, the district level, the provincial level and the national committees. The district committees are composed of cluster level members and the provincial committee is composed of the members from various districts. The provincial committees send representatives to the National Health and Rights Advocacy Forum. The district advocacy teams meet once a month, on a fixed date. These meetings are preceded by meetings of each of the clusters and ward team meetings. In this way, issues and concerns arising from the cluster sessions (which are in turn shaped by the ward level support group meetings), can inform the agenda and the priority actions of the district level advocacy teams.

Terms of reference for advocacy committees

- Create and disseminate advocacy messages targeted at various stakeholder groups such as politicians, policymakers, programme managers, civil society and local community leaders.
- Ensure response by policy makers and government ministries to issues that affect people living with HIV.
- Make recommendations to relevant stakeholders on policy and programme initiatives at all levels.
- Establish community task teams within the committee structure to ensure maximum participation and coordination of advocacy activities as needed in the community.

- Undertake fact finding research on advocacy issues
- Build effective networks and partnerships to promote the health needs of PLHIV.

Monitoring and evaluation (M & E) of local level advocacy initiatives

While it may be attractive to discuss both monitoring and evaluation, this section will focus mainly on evaluation as it provides an encompassing narrative. Monitoring is a continuous process whereas evaluation is episodic. Advocacy initiatives often do not have specified time frames or action plans, which makes monitoring of outcomes a nightmare. Is evaluation of local level advocacy different from evaluation of other programming interventions? No: the same tools, procedures and approach apply to local level advocacy. Evaluation looks at the prior short term and long term policy change goals of advocacy and sees if these have been achieved or not, or if there has been progress towards these. In local level advocacy, evaluation is not only about policy as such: advocacy also targets and challenges practices, behaviours and processes in the communities that are not seen to serve community needs. Key differences are important to note. Advocacy, by its very nature, is an evolving effort and priorities are likely to shift. This often makes advocacy in fast changing environments opportunistic, which inadvertently introduces new dimensions to the role of output and process indicators.

In Masvingo, the committee has used real time feedbacks as part of monitoring and this has become important in local level advocacy. "Real time feedback" refers to the regular feedback from advocates on the ground in the communities as part of the monitoring and evaluation exercise of the advocacy action. Such

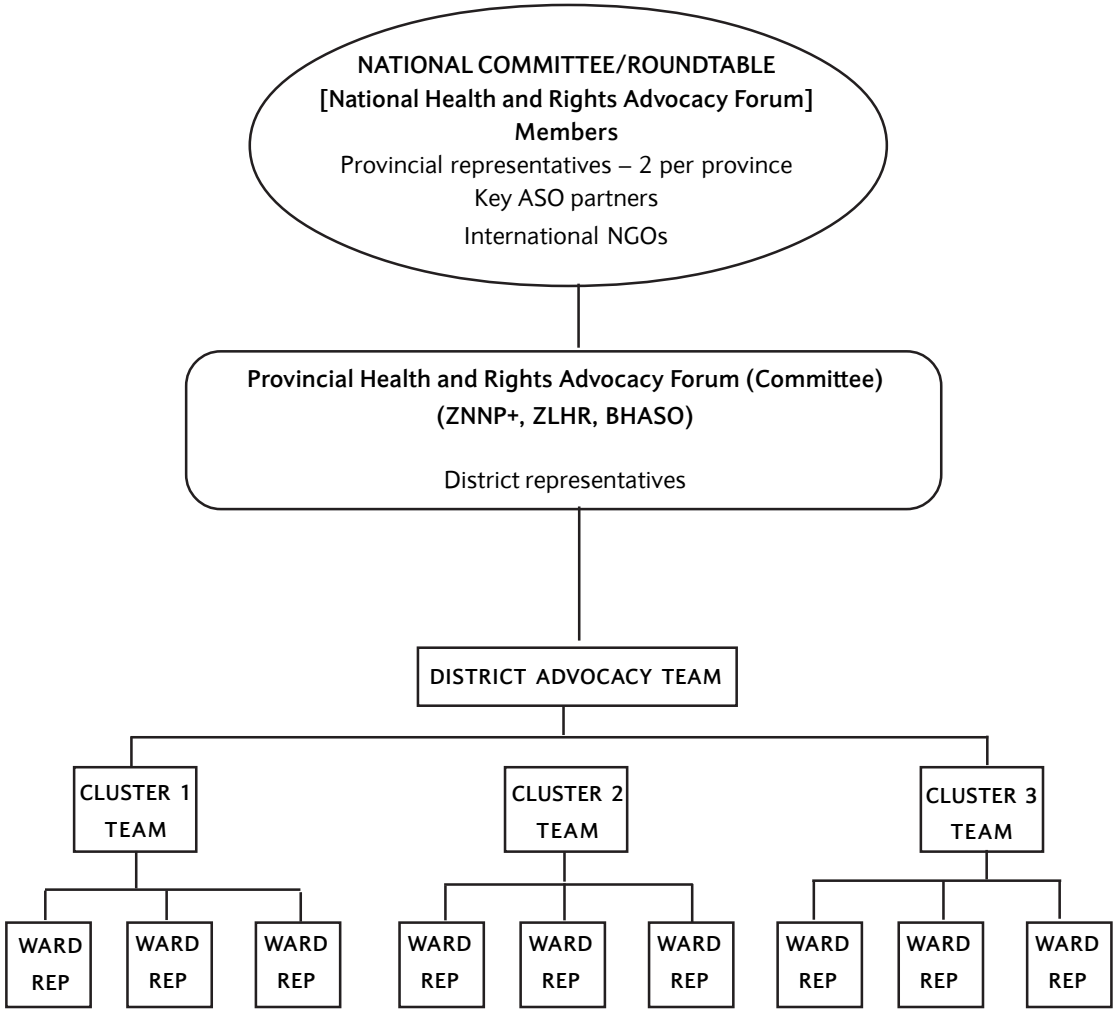
constant and periodic feedback allows for constant focus to be kept on key developments that forms a narrative. This enables critical analysis that goes beyond change of policy or law to include dimensions of community participation and empowerment. Relevant outcomes emerge that are usually not part of the original advocacy strategy. Evaluation effort therefore needs to proceed cautiously in terms of evaluating the successes or failures of advocacy efforts. Indicator setting comes in to allow demonstration of impact and set agreed indicators that show success even when policy change has not yet been achieved. Learning is an important aspect of monitoring and evaluation in such an approach.

Local level advocacy monitoring and evaluation functions best when an intervention first establishes a theory of change. A "theory of change" explains how an intervention is going to contribute to change of policy, behaviours and practices. It takes into consideration the context and environment and sets out the ways to achieve and define change. The theory should locate the change sought within a scheme of broader social change goals in health and human rights. Our local advocacy initiative locates a theory of change that submits a change of policy, programmes and practice which is located in the small actions and victories that aggregate to a bigger change at the national level. Our theory seeks change that leads to the respect and protection of all rights that pertain to PLHIV as part of the broader national rights based agenda in health care. Furthermore, our theory submits that human rights literacy provides the requisite literacy capital to empower PLHIV with knowledge of their rights and advocacy skills, allowing them to work towards promoting their and other people's rights in health care.

For our local level advocacy, M & E efforts are easier than national efforts that seek to influence policy at a macro scale. Unlike advocacy at the national scale, issues of accountability and multiplicity of players are not common challenges.

Results are easily attributable to actions undertaken as one is able to trace events, indicators and outputs. Whilst local level advocacy initiatives are local, they have proven to be drivers of change at a national level. Even where the target is not to influence broad policy agenda, the effect of local advocacy initiatives has nonetheless been felt at the broader national agenda, e.g. in Masvingo province the advocacy committee campaigned for the scrapping of user fees for PLHIV in their province and they were successful. The Ministry of Health national office sent a flier to Masvingo General Hospital and the Provincial Medical Officer advising them that user fees should not be charged. Other provinces heard about this initiative and started advocacy using the Ministry of Health flier for Masvingo as a basis. This is an example where local level advocacy, though aimed at the micro level, may in the end influence policy at the macro level as well as other macro level institutional transformations. From this experience, M & E in advocacy ceases to report just activities and outputs but includes outcome and impact.

Local Level Advocacy in Health & Rights



ISSUE/PROBLEM	RESULTS OF ADVOCACY
Essential drugs, medicines and products	
Cotrimoxazole stock-out The advocacy committee handled two cases on Cotrimoxazole during the period under review. **CASE 1: DRUG STOCK-OUTS** The first case happened in May 2008 and concerned drug stock-outs in the whole province. The advocacy committee received reports from concerned community members that there was a shortage of the drug in the province. The drug was said to have been withdrawn and this was causing an increase in cases of opportunistic infections among PLHIV in the province. This resulted in PLHIV experiencing increased medical costs since they were paying consultation fees and other medical fees to treat related the opportunistic infections. Just over 1 400 PLHIV were accessing the drug. The advocacy team first engaged the District AIDS Coordinator (DAC) through a meeting where the committee highlighted the problem to the DAC, who later recommended a meeting between the advocacy committee and the Matron of Masvingo General Hospital. The meeting with the Matron did not yield much. The committee then engaged the Natpharm manager who highlighted that the Ministry of Health and Child Welfare (MoHCW) owed them a lot of money and the drugs were available but they could not be released owing to the debt. The advocacy	Natpharm released 10 boxes of Cotrimoxazole to Masvingo General Hospital on the day and more supplies were subsequently released.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
committee then had a meeting with the hospital pharmacist, who confirmed the information on condition of anonymity. From there the committee went to the Medical Superintendent and demanded a meeting. During the meeting, the Medical Superintendent said there was no fuel to collect the drugs from Harare but the committee insisted that the drugs were there at the Natpharm pharmacy and that PLHIV should access those drugs immediately. Later on the Medical Superintendent (MS) went with members of the committee to Natpharm and met with the Natpharm manager who later agreed to release ten boxes of Cotrimoxazole. *Challenges*: There was a lot of misinformation encountered by advocacy committee members during initial research on the matter, as hospital staff were not forthcoming with authentic information on the situation as regards the drug supply. The Chief Pharmacist was able to provide relevant data which made the advocacy effort easier. *Methods used:* Meetings, petition.	
CASE 2: PLHIV NOT RECEIVING COTRIMOXAZOLE The second case was handled in July 2010 in Bikita district after the advocacy team members in the district realised	The issue was considered and Solidarmed solved the issue.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
that from September 2009 to July 2010, PLHIV on the Silveira Mission ART register were not receiving Cotrimoxazole and as a result there was an increase of opportunistic infections among PLHIV. Initial research by the advocacy committee showed that Solidarmed and MoHCW officials were not collecting the drug from Natpharm Harare. Advocacy committee members had meetings with the District Nursing Officer in Bikita and the Sister in Charge over the shortage. Solidarmed tried to defend the shortage of drugs saying Cotrimoxazole was no longer prescribed for life and there was no harm if PLHIV don't take it. The advocacy committee rejected this view and insisted that the drug should be made available. Solidarmed then arranged for a consignment of Cotrimoxazole to be delivered to Bikita *Challenges*: The drugs supply at the hospital is managed by one of BHASO's allies, Solidarmed, an issue which caused the advocacy team to be hesitant to speak out on the issue. *Methods used:* Dialogue.	

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Decentralization of ART sites	
Gutu as a district has a population of 31,715 PLHIV. There were 1,700 PLHIV on ART in Gutu, and the target is that by the end of 2013 a total of 12,000 people will be able to access ART in the district. However the district had only one initiating site at Gutu Mission Hospital covering the whole district. All the services were being charged for and this forced PLHIV to travel long distances, furthest being 56km, to Buhera looking for ART services. PLHIV were concerned with the distances they were travelling to collect ARVs, a fact they indicated was discouraging others to be tested. They didn't see it wise to know their status and then face challenges in accessing drugs due to the transport costs of travelling to Gutu Mission Hospital for diagnostic tests and monthly ARV supplies. PLHIV who accessed ARVs in Buhera were so also concerned about the ever flooding Nyazvidzi River since it was now into the rainy season. In an advocacy stakeholder meeting the advocacy district team drummed up support of all stakeholders for this issue to be addressed once and for all. The advocacy committee led a consortium of community stakeholders, which included the Gutu Business Community Association, and approached MSF Belgium (who were assisting the majority of the PLHIV in Buhera) to come and operate in Gutu. The committee helped in mobilizing those who were accessing drugs outside Gutu to register at their local clinics. The registers were then used	Since 1 Jan 2011 Gutu has one initiating site and mobile initiating clinics reaching 14 local clinics providing a no-cost (including for OI infections, other medications, diagnostics, etc). By May 2011, 600 PLHIV have been initiated on ARVs locally and 450 people who previously had to travel to Buhera (approx 45km) or Murambinda (56km) to receive their medication have been transferred to the local clinics.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
by the District Nursing Officer (DNO) as evidence to convince MSF to come into the district. MSF assessed the clinics and indicated that there was need for renovation and to address security at the premises to secure the medical supplies. MSF gave a deadline of 30 December 2010. The advocacy committee and the DNO tried to make health committees take responsibility but out of the targeted 15 health centers only one managed to put screen doors and window burglar bars. With the MSF deadline looming, BHASO had to take the responsibility of putting screen bars, ceilings, burglar bars, doors and window panes into the targeted 14 clinics to be used by MSF. *Challenges*: The District Aids Coordinator and District Nursing Officer differed on which sites to be targeted. The team took a holistic approach of including both ideas. *Methods used:* Stakeholder meetings, community meetings.	

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Herbal issue	
Due to the centralised set up of ART sites in the province, PLHIV were being taken advantage of by people who were selling herbal medicine from local suppliers and from China. These entrepreneurs from China were charging services to PLHIV who were far away from ART sites and desperate to survive. PLHIV fell prey to the these herbal entrepreneurs because they would be promised free delivery of the herbs at their homes, which seemed better compared to travelling tens of kilometers to access ARVs. A traditional doctor in Gutu was also giving herbal injections which also placed people at risk of HIV transmission. Most of the PLHIV targeted were PLHIV in Gutu and Zaka. A total of seven people died after discarding their ARV regimens in favour of the herbs and many others have developed drug resistance. In November 2010, the advocacy committee went to the police to seek redress and asked for a community meeting in Gutu, but the entrepreneurs did not attend because they are politicians and looked down upon the advocacy committee and the local people. The whole case became politicised and the Officer in Charge was transferred to another police post. The advocacy committee took the matter to the provincial level and engaged with the Ministry of Health official, Dr Murungu, and the Provincial Aids Coordinator (PAC) and took them for a field visit to see the situation on the ground, targeting home based care PLHIV who were declining ARVs	Awareness campaigns have been done and the Gutu traditional doctor had been taken to court for murder charges and the chinese products had been banned in the province.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
in favour of the herbs. The MoHCW and National Aids Council (NAC) officials present realised that the situation was bad and something needed to be done. Advocacy committee members began to document the cases and provided evidence to the press. *The Mirror*, a weekly newspaper in Masvingo, reported the issue in an article (5-11 Novermber 2010 issue) entitled, "Chinese herbs kills seven aids patients". The Provincial Medical Director then directed that the agents of Chinese herbs were no longer welcome in the province. *Challenges:* The Southern African regional agent for the Chinese drugs firm is a politician and former Minister. When the advocacy team challenged the importation of these drugs to the country, politicians and war veterans oppossed them citing it to be a "Look East" policy. *Methods used:* Meetings, research, awareness campaigns, press statement.	

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Condoms	
The advocacy committee handled a case on beer outlets which were inflating the price of male condoms. A second case pertained to low uptake of female condoms during the period under review.	
CASE 1: MALE CONDOMS Soon after dollarisation of the Zimbabwean economy condoms were sold at $1 or R10 a packet of 3condoms in most beer outlets of Masvingo, instead of the approved rate of R1 per packet of 3 condoms. At that very same time beer was selling for $1 per 3 pints. There was a high probability that patrons of beer halls preferred to spend the $1 on beer than to buy condoms, a fact which was affecting behavioural change and increasing the incidence rate among clients of sex workers, as both partners would value the money for beer rather than condoms. In March 2009, the advocacy team made an initial research with the assistance of the New Start Centre when they informed the police about the retail shops who were inflating the prices for condoms. *Challenges*: During the police raids some operators hid the product. *Methods used:* Meeting.	Prices of condoms were reduced and all perpetrators were fined by police.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
CASE 2: FEMALE CONDOMS In 2009, Masvingo province was experiencing a very low uptake of the female condoms due to myths and misconceptions. Advocacy committee members took the initiative to promote the use of female condoms. They went out into the communities, targeting both women and men and highlighting the importance of female condoms as part of behavioural change advocacy. *Challenges:* It was difficult to ascertain whether the product was being used. *Methods used:* Community sensitisation, condom demonstrations, road show.	Salons and shops recorded high demands of female condoms.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Access to ARVs by detained persons	
In July 2010, Millicent (an HIV positive single mother who survives through vending) was caught by officers from Zimbabwe Republic Police during her routine business at Mucheke bus terminus. Vending is illegal in undesignated areas. She was taken to Chikato police post and was detained. She told the officers that she was on ARVs but the officers refused her access to drugs, thus impairing her ART adherence. By this action her rights were violated. Upon hearing of the arrest, the advocacy committee members approached the police station and asked for a meeting with the Officer in Charge at Chikato Police Station whereat the advocacy committee expressed their unhappiness about the conduct of the police officer who had arrested Millicent. The advocacy committee also demanded to see the arresting officer who had refused her access to ARVs. When the advocacy committee realised that Millicent had already missed taking her pills and would likely default again the following day, they decided to pay the fine and have Millicent released. The committee then made a decision to begin advocacy among the police force in the province on the rights of detained PLHIV. A training programme was instituted through the committee and BHASO, which has so far trained 73 police officers from the province on the rights of PLHIV. *Challenges:*The police on duty were ignorant. *Methods used:* Discussion.	Millicent was released. The case resulted in the advocacy action of educating police and Prison officers on rights of PLHIV. Seventy-three officers from the province have been trained by the advocacy committee.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Initiation of ART	
In February 2010, the advocacy committee was alerted by a health worker at Mwenezi Rural Hospital that second line ARVs at Mwenezi Rural Hospital were not being dispensed because there were not enough doctors to authorise the change from first line treatment to the second line. The informant warned that the medicines were likely to expire unused (the medicines later expired). Advocacy committee members were quite aware of numerous cases where PLHIV had developed complications on the first line drugs, but could not be initiated on the second line despite drugs being available. Some patients died because they could not access second line drugs. This was due to the fact that there were no doctors to approve those who were in need of second line drugs. The policy on changing regimens spelt out that the change to second line regimen had to be approved by two doctors and yet there was only one doctor at the hospital then. Upon hearing the issue, the advocacy committee went to the PAC who later advised the PMD on the issue. The PMD addressed the issue by authorizing at least one doctor (as opposed to two) in the province to initiate patients on the second line of treatment. *Challenges*:The policy states that two doctors should authorize the change to another line from the first line. At this hospital there was only one doctor available. *Methods used:* Meetings.	Only one doctor can now approve change of treatment to second line.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Drug Containers	
During the period under review two cases dealing with management and handling of drug containers by clinic staff were handled and successfully dealt with at Silveira Mission hospital in Bikita.	
CASE 1: CONTAINERS TO PUT ARVS Silveira Mission in Bikita district instructed PLHIV on ART in the district to bring empty drug containers monthly for them to put ARVs and also bring envelopes in which to put Cotrimoxazole. Those who failed to bring the containers were unable to access drugs and would face harassment from the nurses. The reason for the shortage was that the nurses removed the pills from the original containers and would use these containers for TB sputum tests. This was unhygienic and there was no logic in removing drugs in their sealed containers and then requesting another container from a patient. Upon hearing of the issue, the advocacy team held a meeting in March 2010 with the Sister in Charge of the Opportunistic Infections Clinic (OIC) and discussed the issue highlighting the problems faced by PLHIV and hygiene issues around the requirement. At the meeting the Sister in Charge informed that the policy will be reversed. *Challenges*:There was shortage of sputum containers and it was important for TB patients to have sputum tests. *Methods used:* Meetings.	The instruction was reversed.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
CASE 2: REMOVAL OF COTTON WOOL FROM CONTAINERS In a related case to Case 1 above, PLHIV were coming to the clinic with their old containers and getting new containers. In May 2010, advocacy committee members were informed that staff at Silveira Mission Hospital OI clinic were removing cotton wool from ARV containers as they were alleging that it was a measure of hygiene because they realized that when PLHIV came for resupply, the cotton wool in the containers would be dirty. In addition to this, it was reported that PLHIV were experiencing shortages of pills when their containers were opened. The advocacy committee engaged the Sister in Charge at the OI clinic on the matter and the practice was reversed. *Methods used:* Meeting.	As in Case 1.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Health care workers and PLHIV ***Harassment and bad attitude by health workers***	
CASE 1: HARASSMENT OF PLHIV The advocacy committee was informed that there was a nurse at Masvingo Provincial Hospital OI Clinic, popularly referred to as "the bandaged nurse" (she had a bandage on her leg), who was harassing PLHIV to the extent that she beat up a person living with HIV who had come for services. PLHIV were avoiding the nurse room due to fear and this was causing congestion at the OI Clinic. In May 2009, the advocacy team had consultations with the DAC and later had a meeting with the matron. The meeting was successful and the harassment and ill treatment ceased. *Methods used:* Meeting.	The nurse was called for a hearing and ever since the harassments have stopped.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Cuban doctors	
CASE 1: LANGUAGE BARRIER WITH CUBAN DOCTORS During the economic meltdown and the subsequent crisis in the health sector there was massive exodus of medical doctors who sought greener pastures elsewhere. In an effort to address the shortages of doctors, the government brought in Cuban doctors. As a result there were many Cuban doctors at the provincial hospital who could not properly discharge their duties owing to language barriers. For most PLHIV this was a huge challenge because they could not access adequate information and counsel from their doctors. Furthermore, the Cuban doctors did not spend enough time with the patients due to this lack of communication, which violated the right to information of PLHIV. The advocacy committee discussed the issue with the Medical Superintendent in March 2010. He was the only Zimbabwean doctor at the hospital during that time. The meetings failed to yield any positive result. The matter was taken to the health adviser at the national level who took up the matter to his superiors and came back with the reply that people who complain should speak to their brothers and sisters who have left the country to come back and work in the hospitals. The matter was deadlocked. However three doctors have since joined the hospital.	Now there are three Zimbabwean doctors at the hospital.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Challenges: There were no Zimbabwean doctors to come on board full time, however, the Medical Superintendent took responsibility of the situation and covered the gaps. *Methods used:* Meeting.	

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Social assistance of PLHIV ***AMTO [Assistance Medical Treatment Order]***	
AMTO is a government social assistance document given to poor persons to enable them to access free medical care from hospitals. AMTOs are issued through the Ministry of Social Welfare. The advocacy team handled three cases regarding AMTOs.	
CASE 1: HIGH MEDICAL FEES Masvingo Provincial Hospital was refusing to accept AMTOs. With the high medical fees needed for diagnostic tests and treatment fees, PLHIV were unable to meet the charges because of poverty and as a result the majority were relying on AMTOs.The hospital was dishonouring the document because they alleged that social welfare was not making payments to the hospital for services rendered. Due to this problem, PLHIV were deteriorating because they were not seeking treatment as the majority are poor. In August 2009 the advocacy committee approached the district social welfare office to discuss the matter. A meeting between the hospital administrator, district social welfare officer and the advocacy committee resolved that the document was authentic and should be accepted as its rejection by the hospital was causing untold suffering among PLHIV.	AMTOs began to be accepted by the hospital

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Challenges: The Ministry of Health was accusing the Ministry of Social Welfare of not remitting the monies owed. The committee took advantage that all ministries are government ministries and they were supposed to resolve their problems without making people suffer. *Methods used:* Meetings.	
CASE 2: HOSPITAL NOT ACCEPTING AMTOS The second case was handled in July 2010 in Gutu district at Gutu Mission Hospital which is the only initiating site in the district. The hospital was not accepting AMTOs. People who were supposed to benefit from this service were being deprived and the majority of them were PLHIV. The advocacy team raised the issue with the DAC who referred the team to the Ministry of Social Welfare. The team and the District Social Welfare Officer met with the hospital administrator. The Hospital Administrator was not forthcoming on the issue and the District Medical Officer, Dr Zimucha, was called in to resolve the issue with the management, resulting in the decision that the mission hospital was now accepting AMTOs. *Challenges*: The hospital management didn't want the service to be offered at the hospital as they argued that the Mission Hospital operates on cash for service basis. *Methods used:* Dialogue.	The AMTOs are now working at the hospital.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
CASE 3: HOSPITAL CHARGES 50% CASH TO AMTO HOLDERS The third case was handled in July 2010 in Masvingo urban district when Masvingo Provincial Hospital started to charge 50% cash to all AMTO holders. PLHIV could not afford this arrangement and this resulted in many foregoing treatment which compromised their adherence. The advocacy committee had a meeting with the hospital management in which they resolved that those who had AMTOs were poor and should be treated upon recommendation from the Advocacy Committee. *Challenges:* The hospital initially refused to reverse the decision citing non remittance of AMTO funds by the Ministry. *Methods used:* Meeting.	Advocacy team can certify an needy person to be treated on 100% AMTO.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Diagnostic services, user fees and equipment ***Consultation fees***	
The advocacy committee handled three cases on consultation fees during the period under review.	
CASE 1: Z$10 MILLION CONSULTATION FEES The first case happened in February 2008 when advocacy committee members received reports that the provincial hospital had started to charge a consultation fee of Z$10 million to PLHIV who were on ART. Without the consultation fee a patient's card could not be stamped for drug collection and this led to high cases of defaulting among HIV patients. The advocacy committee, through its representative in the DAAC, informed the other stakeholders of the issue. A meeting was arranged with the hospital management who failed to address the issue. They said the fees were justified due to the shrinking economy, a fact the advocacy team rejected. The team investigated using an insider HIV+ staff to get a document which outlines user fees for PLHIV and TB patients. The document clearly outlined that PLHIV and those on TB treatment are to access drugs for free. Armed with a photocopy of the document the advocacy team wrote a petition to the Minister of Health, copied to	The consultation fees were scrapped.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
NAC and the permanent secretary in the MoHCW. The petition was signed by over 1 000 PLHIV and the policy was reversed. *Challenges:* A trip to Zambia by the DAC delayed meetings on the issue. *Methods used:* Meeting, petition to Minister of Health.	
CASE 2: $50 CONSULTATION FEES The second case happened after dollarization, when the MoHCW instructed all the provincial hospitals to generate income to run their hospitals. Masvingo Provincial Hospital decided to peg consultation fees at $50 at a time when civil servants were earning $100 per month and the ART register had 1 200 people. There are families who have more than two or three PLHIV, therefore the fees were unacceptable and unaffordable given that PLHIV and TB patients were supposed to get the drugs for free. It made no sense to pay $50 to get drugs which should have been free and which were costing between $25-30 in pharmacies. Due to the non affordability, defaulting was high and ART adherence was not being observed. In March 2010 the advocacy team, with the support of the PAC, had two unfruitful meetings with the Medical Superintendent and Provincial Medical Director. Thereafter	The permanent secretary of MOHCW gave a directive to all health institutions in Zimbabwe not to charge PLHIV who are on ART.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
they decided to have a demonstration, which the police did not give approval for. The meeting with the ZRP Commanding Officer for Masvingo was emotional, with the team advising the police to clear all their cells to accommodate them the next day. The advocacy team walked out of the meeting – a development which showed the police chief that the team was not going to compromise. He advised the team to seek redress at the governor's office. The team heeded the advice and attended to the governor's office. At the governor's office the team was ordered to write down their grievance by the governor's personal assistant and their presentation was presented to the governor. The governor phoned the minister and permanent secretary, who denied giving any permission to hospitals to charge PLHIV. The governor advised the permanent secretary to reverse the fees and send a written letter to reverse the policy, which was eventually done. *Challenges:* PLHIV were hesitant to participate in the sit-in due to fear of being victimized by the police. *Methods used:* Sit-in, meeting, petition.	

ISSUE/PROBLEM	RESULTS OF ADVOCACY
CASE 3: $4 CONSULTATION FEES The third case happened in May 2010 at Musiso and Silveira Mission hospitals. The hospitals were charging a consultation fee of US$4 to PLHIV. The matter came to light during monitoring visits which the team undertakes with Solidarmed in the hospitals. This practice was making treatment unaffordable to most PLHIV, causing high defaulting rates. In May 2010, the advocacy team met with the sisters-in-charge at both hospitals. The advocacy team used the outcome of the previous advocacy activity on fees to convince the hospital authorities that it was against ministry policy to charge fees. *Challenges*: Being mission hospitals the management refused to remove the fee but opted to reduce it. *Methods used:* Meeting.	The consultation fee was reduced to $2.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Diagnostic services *X-Ray and CD4 Machine*	
During the period under review, the advocacy team successfully handled nine cases related to diagnostic services across the Province. The cases mainly involved non-functional CD4 Count and X ray machines, unavailability of ALT machines and fees charged when the machines were functional. Other cases included high costs of maternity care and unavailability of fuel to make some of the machines work during power cuts.	
CASE 1: NON-FUNCTIONAL CD4 COUNT AND X-RAY MACHINES AT HOSPITAL The CD4 count machine and the X-ray machine at the Masvingo Provincial Hospital were not functional and this had been the case for 11 months, leading to this advocacy action. This affected PLHIV who needed regular checks and those who wanted to be initiated on ART. When information got to the advocacy committee in October 2008, the committee undertook an investigation which indicated that the lab technician at the provincial hospital also ran a private pathology business in the city and it was alleged that it was a trick to have people access the services at his expensive pathology clinic. The advocacy committee, with the support of Evelyn Mashamba, raised the matter in the DAAC. Activists at the meeting felt a letter should	All machines were functional the next day.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Diagnostic Machines	
be written to the minister as a matter of urgency but other stakeholders wanted the matter to be referred to the PAAC. A letter was written to the minister and also the PAC was informed. Advocacy committee members were surprised that the machines became functional the following day. *Challenges*: Different opinions among stakeholders on procedures to be followed. The team used both procedures. *Methods used:* Meetings, letter to minister.	
CASE 2: NO ALT MACHINE AT HOSPITAL At Masvingo Provincial Hospital there was no ALT machine (for liver function test) and people were referred to a private pathology clinic which charged $50. Many PLHIV could not afford to pay for the service and they ended up failing to access treatment, which resulted in many people dying before they could be put on ART. In August 2009 the advocacy committee had many meetings with the PAC, Provincial Medical Director, and Medical Superintendent to show the urgency facing, and desperation of, PLHIV. All these efforts were hindered by unavailability of resources. The advocacy team	PA instructed the hospital to give the CPU a list of the needs of the hospital. The hospital got the ALT machine in April 2011.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
drummed up resources through the Civil Protection Unit (CPU) with the help of NAC, PMD and the Provincial Administrator (PA). *Methods used:* Meetings, dialogue.	
CASE 3: LIMITED CD4 COUNTS At Musiso Mission Hospital (St Anthony), CD4 counts were only done on Wednesdays every week and only 60 PLHIV were served before 10:00am per day. The hospital was the only one which offered this service in Zaka district in 2010**.** The high number of PLHIV that needed this service could not access it because of queuing problems as some had to sleep for 2 days at the growth point to be among the first 60.This was discouraging PLHIV who needed the service and it was resulting in some going for up to five years on Cotrimoxazole. In August 2010, the advocacy committee had a meeting with the matron on the matter and the time and number of PLHIV accessing the service at a particular time was adjusted. *Methods used:* Meeting.	The hospital is now giving the service every Wednesday from 6:30am to 11:00am and anyone who comes during those times is served regardless of the number. In June 2011, the advocacy committee reported that each clinic is now collecting blood samples for CD4 count for ten persons each Wednesday on behalf of Musiso Mission hospital. There are 25 clinics in the district and 11 of these clinics are under Solidarmed.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
CASE 4: HIGH DEMAND AND LONG QUEUES FOR CD4 COUNT SERVICE In the same month as case 3, in August 2010, Silveira Mission in Bikita was doing CD4 counts once every week and only 50 PLHIV were served on this day. The hospital is the only one which offers this service in the district. PLHIV who needed this service could not access it because of high demand and unbearable queues. In addition, they were sleeping at the mission hospital lodgings at a cost of R1 ($0.10) charged as fee for overnight candles. This resulted in some going for many years on Cotrimoxazole. The advocacy committee had a meeting with the sister in charge at the OIC on the matter and the R1 fee was reversed and the number of days for PLHIV to access CD4 count service was increased to two days per week. *Methods Used:* Meeting.	CD4 counts are now being done twice per week.
CASE 5: HIGH COST FOR CD4 COUNT SERVICE At Masvingo Provincial Hospital, hospital management was charging $15 for CD4 counts and many couldn't afford the service. Many people who needed the service were delayed, and some even stopped, from pursuing treatment due to the cost. In March 2010 the advocacy team engaged with the hospital management, who refused to remove the fee citing high costs in reagents and tubes. During the	The Hospital made CD4 count service free.

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meetings and engagements, the management didn't show much sympathy for the matter at hand. The advocacy team used their networking contacts to engage with Population Services International (PSI) in Masvingo to assist with CD4 count services. New Start Centre brought a mobile CD4 count service to their site for use by PLHIV. PLHIV began to access the service which was being charged at US$1 for two people. When the provincial hospital realized that their machine was not being used by PLHIV they reversed their fee policy. *Challenges:*The hospital management was not co-operative and failed to understand the situation of PLHIV in the province. *Methods used:* Meeting.	
CASE 6: HIGH COST FOR ALT In May 2011, the Masvingo Provincial Hospital was charging $30 per client to access the liver function test (ALT). This test is one of the most important before one is put on ARVs because the test's purpose is to see if one's liver can manage to handle the drug load or not, hence it is risky to put someone on drugs without this test. Masvingo Provincial Hospital is the only government hospital which is offering this service, apart from the privately run pathology clinic which was charging $25 at	The hospital management had no option besides to bow down to pressure as they settled for a charge of $9.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
the time. Most PLHIV could not afford this service. The advocacy team engaged with the hospital management and Medical Superintendent, who felt that the fees were justified since these monies were going towards servicing the machines and buying reagents. However the advocacy team rejected the explanation as they felt that the amount charged was too much and unrealistic. The hospital management bowed to the pressure and agreed to reduce the charge to $9, which is about 36% of the fee in the private sector. *Methods used:* Meetings.	
CASE 7: HIGH MATERNITY CONSULTATION FEES Masvingo Provincial Hospital was charging a maternity consultation fee of $80, which was unaffordable to many people. The majority of women, including PLHIV, could not afford the charges and there was a high risk of parent to child transmission as many pregnant mothers who were not going to antenatal clinics, preferring instead to go to faith based healers who charged far less, a situation which increased risks for HIV transmission. In September 2009 the advocacy team had a meeting with the Medical Superintendent, who totally refused to reduce the fee. However further research by the team revealed that the hospital refused to reverse the fee policy for maternity	The private doctor agreed to provide services on credit.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
consultation because the maternity ward was being run by a private doctor. After further meetings the private doctor agreed to provide services on credit. *Challenges:* There was a shortage of doctors and this presented a tricky situation as regards pursuing options to remove the private doctor from the public maternity ward, as this also would affect those who were able to pay for his services. *Methods Used:* Meeting.	
CASE 8: UNAFFORDABLE CD4 COUNT TEST FEES Gutu Mission Hospital was charging $5 for a CD4 count test, which was unaffordable for PLHIV. They said the reason for this was that reagents were expensive. With the coming in of MSF in Gutu district in January 2011, which is giving the same service to 14 health care centres for free, PLHIV who are clients at the mission hospital and the three follow up sites of Chiwore, Mukaro and Dewure felt that it was unjustifiable for them to be made to pay whilst their peers served by MSF were getting all services for free. The advocacy team had a meeting with the mission hospital. The mission refused to reverse the user fee policy. The advocacy team and DNO warned the mission hospital that they will advocate for the CD4 machine to be taken to Gutu Rural Hospital	To resolve the matter MSF offered to supply the mission with reagents and a fee of $1 was agreed for the CD4 count test to be done by the mission hospital.

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which is a government institution. The advocacy influenced one of its district partners to assist in this regard. *Methods Used:* Meeting.	
CASE 9: NO FUEL FOR HOSPITAL GENERATOR During the period (early 2008), there were fuel shortages and the government initiated a programme where vehicles from government ministries were allocated fuel at a subsidised price at a local filling station in the town of Masvingo. During the same period there were frequent power cuts which saw diagnostic services and operations being disrupted. This affected PLHIV as they would be sent home without the services(X-Ray and CD4 count). Research by the advocacy team after a woman died during a medical surgery due to power cuts showed that the Masvingo Provincial Hospital was receiving an allocation which they were mostly putting into doctor's cars rather than the backup generator, which was essential equipment at the hospital. The advocacy team had several meetings with the PA and the Medical Superintendent before the generator was allocated separate fuel allocation. *Challenges*: MoHCW denied owning the generator saying it belonged to the Ministry of Construction and Public works. *Methods Used:* Meeting.	Generator was allocated monthly fuel.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
MIPA	
The advocacy committee handled seven cases during the period under review. The team felt that PLHIV were being left out of programming processes and they claimed their space.	
CASE 1: NO REPRESENTATION OF PLHIV IN PAAC In Masvingo during the time that ZNNP+ was not functional, there was no representation of PLHIV in the Provincial Aids Action Committee (PAAC). During deliberation in the PAAC meetings, unfavourable decisions were passed without the involvement of PLHIV and this was defeating the MIPA concept. In October 2008 the advocacy team had a meeting with the PAC who supported the idea and a person living with HIV was incorporated into the meetings as a provincial core chair. *Challenges:* The PAC wanted a staff member from ZNNP+, not a card holder. *Methods Used:* Meetings.	There is now representation at provincial level in PAAC and CPU.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
CASE 2: MIPA ONLY FUNCTIONAL AT NATIONAL LEVEL MIPA technical working group was only functional at national level and there were no structures from provincial level down to ward level. This was hindering flow of information and depriving grassroots PLHIV of the relevant latest information concerning their welfare and wellbeing. In January 2010 the advocacy team, through the PAC, challenged the structure of NAC having a national MIPA coordinator at head office without a lower structure and this forced NAC to undertake provincial technical working group training, leading to the setting up of district and provincial MIPA working groups. *Challenges:* One network organisation had some misunderstanding on the issues on the ground because it felt that it was the only organisation to drive MIPA. The advocacy team managed to handle the matter by clarifying the roles of all players in the MIPA technical working group. *Methods used:* Meetings.	Provincial and district technical working groups are in place.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
CASE 3: CENTRALIZATION OF FOOD DISTRIBUTIONS TO HEALTH CENTERS Red Cross was doing food distribution targeting PLHIV and OVC in Masvingo urban in 2009. The distributions were done at open places where confidentiality was not guaranteed. People passing by and those living close to the place could tell that the beneficiaries were PLHIV and this brought a lot of labelling and stigma. In September 2009, the advocacy team raised their concerns with the Red Cross programme manager who was not sympathetic. The team had the support of the City Health Clinic's matron, who advised the team that one of the conditions to be observed was for the food distribution to be done at health centres with her involvement. The information was used to launch a complaint to the DAAC and WFP who instructed Red Cross to carry out the distributions at health centres. *Challenges*: Red Cross did not like the idea. There was no option for them because of the agreement they had signed with the City Health Department. *Methods used:* Meetings.	All non food and food items are now being distributed on council premises.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
CASE 4: HYGIENE PROGRAMME DACHICARE, a local implementer, was introducing a new programme of hygiene targeting the most vulnerable people in Wards 1 to 7 in Masvingo urban and they had already made a beneficiary database. In these wards some NGOs already had registers for other interventions which the advocacy committee thought could be useful to use for purposes of hygiene packs. The existing lists of Red Cross and CARE included the majority of PLHIV in the district and using the new compiled list would mean most PLHIV would be excluded from this programme. In a district stakeholder meeting, the advocacy committee told the stakeholders that PLHIV were not going to recognize the new vulnerable people list and all the stakeholders supported the team. *Challenges*: No significant challenges. *Methods used:* Dialogue.	All PLHIV on Red Cross and CARE registers benefitted from the programme.
CASE 5: FOOD PACKS CARE International gave Blue Ribbon a tender to supply food packs under the Joint Initiative (JI) programme. Blue Ribbon was issuing food items which were of cheap quality and this was not good for PLHIV's health e.g. some of the peanut butter was rotten. In August 2010, the advocacy	The supplier changed to giving good quality food packs to PLHIV.

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team brought the issue to the attention of the DAC who lodged a complaint to the JI manager, who later talked to the Blue Ribbon management and some adjustments were made. This advocacy initiative also resulted in PLHIV getting stipends for food as a process of phasing out the food provision initiative. *Methods used:* Meeting.	
CASE 6: MALE PARTICIPATION In Masvingo province men were not much involved in HIV awareness activities**.** Out of every ten people in the support groups there would be two men, and this imbalance of having more women being empowered than men was resulting in unbalanced decisions on safe sex and human rights issues. Due to less information being provided by males, females in SGs were reporting forms of gender based violence (GBV). In June 2010 the advocacy committee held research to see why men were not interested in support groups and later held community mobilization throughout the province by introducing games to establish male support groups which are known as men's forums. *Challenges*: Males who are HIV positive tend to seek material gain in empowerment activities. The creation of men's forum groups and sporting activities helped the situation. *Methods used:* Meetings, games.	We now have support groups of men. In Gutu there are seven forums, one forum in Chivi, one forum in Masvingo urban and more are being formed.

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CASE 7: OVC PROGRAMME FACT Masvingo, an NGO which does OVC programming, had a new programme in which they wanted to target Wards 1, 2 and 3 in Masvingo urban. However the advocacy team felt that the area was congested with other partners who were targeting the same group and thought that the programme should go into Wards 5 and 6, which were always omitted from programming by other NGOs despite there being many OVCs there. In March 2009 the advocacy committee wrote a letter to the implementer and took the issue to the DAAC who found sense in the advocacy's team idea. *Challenges*: No significant challenges. *Methods used:* Meetings, letter.	Wards 5 and 6 were covered by the programme.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Stigma and discrimination	
Several cases were dealt with to address issues of stigma and discrimination perpetrated against PLHIV in the communities, churches and prisons. During this period, the advocacy committee dealt with a case which went for redress in the criminal courts.	
CASE 1: MORTUARY CASE In July 2010 the Masvingo provincial mortuary attendant was refusing to take corpses referring people to Silveira Mission Hospital instead, which is 100km away. The ZRP Chikato police had attended a murder case and visited the hospital with the intention of putting the corpse in the mortuary, but they were denied access and had to keep the corpse in a cell which was occupied by detained persons at their station. During an advocacy visit to the camp on other business (Millicent case reported above on access to drugs by detained persons) the team overheard two police officers talking about the matter. They found out more details from the officers and later phoned the Medical Superintendent who later told the police to bring the corpse. *Challenges*: No significant challenges. *Methods used:* Dialogue.	The hospital agreed to take in the corpse.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
CASE 2: MAMBAMA CASE In August 2010 a woman who was HIV positive was evicted from the house that she was renting in Mucheke suburb because of her HIV status. She became a destitute and support group members had to support her. This badly affected the woman who informed the district advocacy team. There was nothing that could be done to the landlord since there was no evidence that she was evicted on the basis of her status, however, the advocacy committee, through the Masvingo Urban Residence Rate payers Association (MURRA), introduced stigma and discrimination awareness campaigns to reduce stigma and increase HIV knowledge for landlords. *Challenges*: No significant challenges. *Methods used:* HIV information dissemination in MURRA workshops.	Advocacy team have not received any complaints since the incident.
CASE 3: DISCRIMINATION OF PRISONERS Prison officers were taking inmates who are HIV positive to the provincial hospital to collect drugs whilst in leg irons and handcuffs and to make matters worse, they made them hold the boxes of ARVs which resulted in them being easily identifiable as HIV positive and affecting	Prisons at Mutimurefu and remand prison are now collecting drugs for inmates and also for their officers. Inmates at Mutimurefu and remand prison now have inmates' support groups.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
their human dignity. On one such occasion in February 2011, the advocacy committee was notified by an informant and went with a camera phone to take pictures which they used as evidence when they held human rights trainings with the police and prison officers later. *Challenges:* Challenges involved addressing the policy issues in prisons. *Methods used:* Training sessions.	
CASE 4: DISCRIMINATION IN CHURCHES There were many reports from PLHIV in churches that they were being stigmatised to the extent that some pastors were labelling them during sermons and some were not given positions in the church. The advocacy team targeted churches, engaging church leadership in rights literacy of PLHIV and other issues in terms of HIV, society and religion. The main objective was to reduce levels of stigma and discrimination in churches by empowering and capacity building pastors, elders and PLHIV in the targeted 30 churches .The advocacy team had a dialogue with pastors and agreed to the establishment of HCCs (HIV Competent Committees) in all the churches in Masvingo. The HCCs comprise a pastor and their spouse, a person openly living with HIV, a female youth and elder representative, a male	A pilot project to fight stigma and discrimination was introduced in Masvingo urban targeting 30 churches. Sixteen churches now have HCCs.

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youth and elder representative and a single parent representative. The committees, which consist of eight people, are the ones who will be working directly with the teams through a focal person. A district HIV competent committee will be established to create a voice of all the churches in the district. *Challenges*: No significant challenges. *Methods used:* Meetings, letters and education sessions.	
CASE 5: BAD PUBLICITY AND LABELLING After the consultation fee issue handled by the advocacy team, the Masvingo *Mirror* covered the issue with a heading "AIDS PATIENTS UP IN ARMS WITH HOSPITAL AUTHORITIES". There was stigma and labelling in the heading which affected PLHIV. The advocacy team was not happy and in March 2010, the team had a meeting with the editor who apologised. *Challenges:* The *Mirror* editor was ignorant at first, saying the heading was catchy and marketable. *Methods used:* Meetings.	An apology was put in the next print issue and a column was created on HIV for the newspaper.

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CASE 6: HARASSMENT, PREVENTING ACCESS TO DRUGS A headmaster of a school in Gutu was not allowing an HIV+ teacher to come to Masvingo for review and to collect drugs. The woman was stressed and defaulting and a result she was thinking of transferring from the school. The woman was referred to the Masvingo district advocacy team by the Gutu DAC through the Masvingo DAC. In September 2009, the team, through the Ministry of Education, visited the school where a meeting was held with the headmaster who was given an option to leave the school or do community work by holding HIV stigma awareness campaigns in three neighbouring schools. The headmaster did the community work and the advocacy team trained all Gutu cluster heads on stigma and discrimination at the workplace. *Challenges:* There was no readily available fund to visit the school in Gutu. *Methods used:* Meeting, training.	The matter was resolved and there was an understanding between the headmaster and the teacher.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
CASE 7: PRIVACY AND CONFIDENTIALITY IN MEDICAL RECORDS Due to industrial strikes and work boycotts by civil servants because of poor salaries, the Masvingo Provincial Hospital OI Clinic was closed and this resulted in PLHIV being served at the outpatient section of the hospital which served the general public. Their right to privacy and confidentiality was infringed and there was a lot of labelling and stigmatisation by the hospital staff who at most times shouted at PLHIV in the public wards and outpatients sections. In October 2009, the advocacy team held a meeting with the Medical Superintendent over the issue and there was better communication by staff to PLHIV. *Challenges*: There was not enough staff to handle the work since there were job boycotts in government. *Methods used:* Meeting, training.	Outpatients were sensitised on the rights of PLHIV and showed respect towards them afterwards

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In June 2011, 17-year-old Chipo, (not her real name) from Masvingo urban, who was born HIV positive, was raped by her boyfriend whom she had informed of her status. After the rape, Chipo eloped to the boyfriend's house. While she was staying at the boyfriend's house, the father was informed by another person that Chipo was HIV positive and he went mad, threatening the girl and forcing both his son and Chipo to go for an HIV test. He went to New Start Centre with the two teenagers but they denied him the service. He then force marched the two to the General Hospital where he forced the health officials to do the tests, despite the fact that the girl was 17 years' old and she was not his child nor was he her guardian. The tests came out positive for the girl and negative for her boyfriend. At the hospital the father began to shout obscenities saying he cannot live with a person with HIV. From the hospital to the house, the boyfriend's father was drawing a crowd shouting the girl's status. He went to his house with the two and took a shovel, which he used to throw away the clothes and belongings of the girl, and later took the girl to her mother's house. The matter was reported to the police and the boyfriend's father was arrested and charged under section 95(1) of the Criminal Law Code dealing with criminal insult. *Challenge:* The mother of the girl is now being routinely harassed by the friends of the man who was taken to court.	The case went to court and the boyfriend's father was sentenced to 2 months in prison or a fine of $50. The man spent a week in jail and was later able to raise the fine.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Right to shelter	
CASE 1: MUNICIPAL RENTALS The City of Masvingo hiked rates in Mucheke suburb. Most residents of this surbub are those who are vulnerable, the majority being PLHIV and OVCs. The increments affected PLHIV for they could not afford them and were given notices to vacate the council houses. PLHIV who looked for alternative accommodation ended up living in unsuitable conditions. In January 2010 the advocacy committee approached the ward councillor, who was also the deputy mayor, for redress. A resolution was entered for PLHIV to be given a grace period over payment of the bill. *Challenges:* The council felt that PLHIV wanted special treatment but they are to be treated like everybody else. *Methods used:* Meeting, dialogue.	PLHIV were given a grace period and the amount was reduced.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Right to education and information	
Two cases targeting the responsible government ministries on BEAM were concluded. Advocacy committees spearheaded the formation of Youth and Children living with HIV support groups to facilitate access to information.	
CASE 1: BEAM ISSUE 1 Due to dollarisation, Basic Education Assistance Module (BEAM – a government education social assistance programme for poor people) became valueless because of the inflationary environment and the Ministry of Labour and Social Welfare was not forwarding the money to schools. Children on BEAM in Masvingo urban were affected and many dropped out of school. Parents and guardians of the children in Masvingo urban informed the advocacy committee, who with the help of the DAC, confronted the Ministry of Education Sports and Culture (MoESC) on the matter. The ministry quickly responded through an educational officer (EO) that no child on BEAM should be dismissed from school and all the affected children should be reinstated. This declaration was done by the ministry official at the stakeholders meeting which had been called by the advocacy committee in September 2009. *Challenges*:Some headmasters did not implement the new policy and continued expelling children. This made it difficult for the committee to implementing the policy directive. *Methods used:* Stakeholder meeting.	Children went back to school after a directive was issued by the EO to reinstate and not to expel the children again.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
CASE 2: EDUCATIONAL SUPPORT In January 2010 most children of PLHIV in Gutu district were not going to school because their parents and guardians could not afford to pay school fees and this was infringing the right to education of their children. PLHIV felt that their children were to be given priority in the BEAM, an issue they discussed with the advocacy committee who in turn conducted research on the BEAM programme. It was discovered that at most schools the BEAM facility was being abused by headmasters. Evidence from one school visited showed that things were not being done properly and there were violations of the implementing policy for BEAM e.g. selection committees at the school had last chosen beneficiaries five years ago and there were students on their lists who were now in secondary school. In addition, those who were still on the BEAM list were being expelled.The advocacy team engaged in two separate meetings. The second meeting was done with the Gutu DEO after the first meeting with the department in the Ministry of Education dealing with BEAM flopped due to politicisation of the issue. *Challenges:* Politicisation of the issue by some offices of government. *Methods used:* Stakeholder meeting.	MoESC instituted an investigation into the implementation of BEAM. The investigations unearthed irregularities in the implementation of the BEAM programme. Advocacy committees also engaged in advocacy education on BEAM in the communities, encouraging people to participate in the selection and oversight of the programme.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
CASE 3: SUPPORT GROUPS FOR CHILDREN There is overwhelming evidence that in Zimbabwe we have many children and youths who are infected with HIV and, if something is not done, complex situations arise when the youth come to the point of marriage or engaging in sex. Parents and guardians have been ignoring infected children and youths especially with regard to treatment. Children and youths have been sidelined for a long time when they also have the right to information and access to quality treatment. In October 2010 the advocacy teams introduced support groups for youths and children living with HIV as part of advocacy to increase knowledge among youths and children living with HIV, as this would create a conducive environment to disseminate information. This is going to empower the children and create environments where they can actually represent themselves in matters concerning their health. The support groups are a mechanism to reduce stigma in the communities and among the target group, who are going to be instilled with confidence to live positively. *Challenges:* Some community people felt that this system won't work and were sceptical of the intervention. *Methods used:* Community mobilisations, meetings.	There are now support groups for children in Masvingo urban, Chivi, Gutu, Zaka and Bikita (only Gutu and Masvingo urban had support groups for youths as at June 2011).

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Right to food	
CASE 1: DOUBLE DIPPING In Masvingo urban there were many organisations who were doing target feeding to vulnerable groups which included PLHIV, OVCs and the elderly. Due to lack of coordination among the partners, some families were getting handouts from more than one partner, resulting in other families in need not accessing any food handouts. This was unfair. Upon getting reports in September 2009, the advocacy team decided to engage in some social justice initiative where they sought to promote fair distribution of handouts among the target groups. Investigations by the advocacy committee revealed a number of families who were double dipping and most of these were families of PLHIV. All the identified families were removed from other lists thereby bringing to a stop the double dipping that was happening. *Challenges*: Irregularities could not be easily picked up due to the fact that some beneficiaries used names of their spouses. *Methods used:* Spot checking examination of all registers.	Several names were identified and the culprits were stopped from receiving double benefits.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Governance	
The advocacy committee on three separate occasions challenged the BEAM management systems that affected PLHIV. The committee sought the inclusion of PLHIV in BEAM and health committees because their continued sidelining resulted in unfavorable decisions at cross purposes with interests of PLHIV.	
CASE 1: BEAM SELECTION COMMITTEES The policy states that BEAM selection committees should have a person representing PLHIV in its structure. Masvingo province PLHIV were not happy with the set-up of BEAM selection committees, for in many committees the person said to be representing PLHIV would not be a person living with HIV. The committee selectors were instead taking nurses and other people whom they thought knowledgeable in HIV issues. This resulted in most children who were orphaned due to HIV being left out from benefitting because there was no one putting forward their position. After many concerns from PLHIV the advocacy committee began some meetings in November 2010 with all the eight districts. The meetings were held at district level with the School Development Committee (SDC) committees and the District Education Officers (DEOs) resulting in a policy being adopted making it mandatory for PLHIV to sit in the committees.	PLHIV are now in BEAM selection committees.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
Challenges: Some headmasters were arguing that since the committees had nurses, HIV people were duly represented. Meetings between the DACs and the DEOs clarified the matter. *Methods used:* Meetings.	
CASE 2: HEALTH COMMITTEES PLHIV were not well represented in rural health centre committees in as much as they constitute the majority of clientele at health centres. PLHIV in Masvingo province were not happy with the set-up of health committees for in many committees there was no representation of PLHIV. This resulted in decisions unfavourable to PLHIV, because there was no one who could understand their issues. After many concerns were raised by PLHIV the advocacy committees met with various district health committees and DNOs in October 2010 when these concerns were raised and the composition of the committee was changed to include PLHIV. *Challenges*: No challenges were faced. *Methods used:* Meetings.	Most health centers in the province now have PLHIV in health committees.

ISSUE/PROBLEM	RESULTS OF ADVOCACY
CASE 3: ZUNDE RAMAMBO Zunde Ramambo is a traditional concept where local people go to work in the local chief's field to cultivate crops for the chief so that the chief will be able to store grain to assist poor people in times of drought or hardships. Every headman is supposed to bring all people to the chief for the field day. Failure to attend the field day usually results in the person being asked to pay a fine which is usually in the form of chicken. In the districts which were practising the concept, advocacy committees received information that headmen were making PLHIV who were sick and on home based care (HBC) pay fines for not attending the Zunde Ramambo field day. These fines were wiping out the fowl runs of PLHIV who also needed the chickens for their nutritional needs. Advocacy committees in January 2011 engaged with the local headmen and chiefs and sensitized them on HIV and human rights for them to understand the plight of PLHIV in the communities. The chiefs began to exempt PLHIV on HBC. *Challenges*: No challenges were faced. *Methods used:* Meetings.	There is now high level of understanding by chiefs and headman to the extent that they no longer fine HBC clients.

Conclusion

In Masvingo advocacy team members are the voice of reason, the opinion leaders and drivers of social justice, speaking out on issues and being proactive. Key highlights of this local level advocacy effort include action for policy and programme change in Gutu ART services, which have been de-centralised to 14 local clinics and provided on a no-cost basis (including for OI infections, other essential medicines, diagnostics etc.). In the last three months (from May - July 2011) 150 PLHIV have been initiated on ARVs locally in Gutu and 450 people who previously had to travel to Buhera (approx 45km) or Murambinda (56km) to receive their medication are now accessing these at the local clinic. Before the clinics became operational there were 1,700 people on ART in Gutu, and the target is that by the end of 2013 there would be 12,000 people accessing ART locally in the district.

Aside from pursuing specific advocacy issues and meeting with key health and administrative personnel in the districts, advocacy teams are involved in broad based awareness raising campaigns on issues of prevention, stigma, VCT, positive living, right to health in the constitution, etc.). Advocacy team members feel that there is broad support for their work at a community level and a shared vision around the theory of change in the health system. It is also important to note that some of the successes to date are of benefit to the community at large, and not solely people who are living with HIV, as noted by the Trocaire project officer who said, "If given the right support, the teams are a great model for providing the space and the structure for people living with HIV to get issues of common concern on the agenda and to advocate for change".

LIST OF ACRONYMS

AATLT ..... Advocacy and Treatment Literacy Trust

ALT ..... Alanine Aminotransferase Test

AMTO ..... Assisted Medical Treatment Order

ARASA ..... AIDS Rights Alliance of Southern Africa

ART ..... Anti-Retroviral Therapy

BEAM ..... Basic Education Assistance Module

BHASO ..... Batanai HIV & AIDS Service Organisation

CAFs ..... Community AIDS Forums

DAAC ..... District AIDS Action Committee

DACHICARE ..... Dananai Child Care

DEO ..... District Education Officer

DNO ..... District Nursing Officer

EO ..... Education Officer

GBV ..... Gender Based Violence

HBC ..... Home Based Care

HCCs ..... HIV Competent Committees

JI ..... Joint Initiative (A pool of donor resources administered by CARE in Masvingo)

OI ..... Opportunistic Infections

OIC ..... Opportunistic Infection Clinic

OVC ..... Orphans and Vulnerable Children

PMD ..... Provincial Medical Director

MIPA ..... Meaningful Involvement of PLHIV

MoESC ..... Ministry of Education Sport and Culture

MoHCW ..... Ministry of Health and Child Welfare

MSF ..... Medicines Sans Frontieres

MURRA ..... Masvingo United Residence and Rate Payers Association

NAC ..... National AIDS Council

PA ..... Provincial Administrator

PAAC ..... Provincial AIDS Action Committe

PAC ..... Provincial AIDS Coordinator

PLHIV ..... People Living with HIV

PSI ..... Population Services International

SDC ..... School Development Committee

SG ..... Support Group

VCT ..... Voluntary Counsel Testing

WFP ..... World Food Programme

ZLHR ..... Zimbabwe Lawyers for Human Rights

ZNNP+ ..... Zimbabwe Network of PLHIV