



## **GLOBAL AIDS RESPONSE PROGRESS REPORT 2012**

**FOLLOW-UP TO THE 2011 POLITICAL DECLARATION ON HIV/AIDS:  
INTENSIFYING OUR EFFORTS TO ELIMINATE HIV/AIDS**

### **ZIMBABWE COUNTRY REPORT**

**Reporting Period: January 2010-December 2011**

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## **1.0 Status at a Glance**

### **1.1 Introduction**

The Global AIDS Response Progress Report 2012 provides a prospect to appraise measures taken in reducing the spread of HIV and AIDS and its impact in Zimbabwe. A Declaration of Commitment (DoC) on HIV and AIDS at the twenty-sixth United Nations General Assembly Special Session on HIV and AIDS was adopted by 189 member states including Zimbabwe in 2001.<sup>1</sup> The Heads of States and representatives of Governments met and adopted a Political Declaration on HIV and AIDS in June 2006 based on a comprehensive review of the progress achieved in realizing the targets set out in 2001. A number of goals for the achievement of country-driven specific, quantifiable and time-bound targets towards universal access to comprehensive prevention, treatment, care and support programs were established through the 2006 Political Declaration on HIV and AIDS.

Zimbabwe was among the countries that were represented at the high level meeting during the 65th Session of the United Nations General Assembly held in June 2011 to review progress made in the HIV and AIDS response since 2001. The Member States including Zimbabwe adopted Resolution 65/277, "Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS". This historic agreement reinvigorated previous commitments and set concrete targets for 2015 that Zimbabwe incorporated in her latest strategic plan for HIV and AIDS (ZNASP 2011-2015).

### **1.2 Report Writing Process**

The National AIDS Council coordinated the compilation of this report with support from the UNAIDS country office, World Health Organization (WHO) and the Ministry of Health and Child Welfare (MoHCW). The country setup Global AIDS Response Progress Report Technical Working Group (TWG), composed of the Zimbabwe National Monitoring and Evaluation Advisory Group, a multi-sectoral group of monitoring and evaluation experts, which includes government, private sector and civil society representatives. They engaged a technical assistant to compile the report. TWG created an enabling environment for the data gathering process. NAC chaired The TWG. Meetings were held with the civil society and public sector ministries, local and international organizations. A desk review of available literature on the country's response efforts to HIV and AIDS was also conducted. The final draft of the report was presented during the final meeting with stakeholders for validation.

### **1.3 Status of HIV Epidemic**

Zimbabwe has a projected population of 12.7 million people and is among the countries in Sub-Saharan Africa worst affected by the HIV and AIDS epidemic.<sup>2</sup> The estimated HIV prevalence among adults 15 years and above in 2011 was 13.1% according to the National HIV Estimates of 2010.<sup>3</sup> There were an estimated 1,159,097 adults and children that were living with HIV and AIDS in 2011.<sup>3</sup> In the meantime, an estimated population of 597,293 adults and children were in urgent need of antiretroviral therapy by the end of 2011.<sup>3</sup>

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<sup>1</sup> Declaration of Commitment on HIV AND AIDS: United Nations General Assembly Session on HIV AND AIDS 25-27 June 2001.

<sup>2</sup> Central Statistical Office Population Projections 2012

<sup>3</sup> Ministry of Health and Child Welfare, Zimbabwe National HIV Estimates, June 2010.

The decline in HIV prevalence was projected to have started in the late 1990s according to the 2010 version of spectrum. **Error! Bookmark not defined.** Using the Epidemic Projection Package (EPP) and Spectrum software, declines were observed in both sentinel surveillance of pregnant women and in the National HIV Estimates process that models available data. In the adult population (15 years and above), using the current 2010 EPP and Spectrum software, HIV prevalence in Zimbabwe was estimated to be 23.7% in 2001, and 18.4% in 2005 and further declined to 13.1% in 2011. **Error! Bookmark not defined.** Antenatal sentinel survey has been used to monitor the trend of the epidemic over the years. In 2009, the prevalence among the pregnant women (15-49 years) was 16.1% which was considered a decline from 17.7% in 2006.

The decline is attributed to successful implementation of prevention strategies especially behavior change, high condom use and reduction in multiple sexual partners. In addition, high mortality due to low ART coverage has also contributed to a lesser extent to the decline. Meanwhile, Anti-Retroviral coverage (ART) coverage has increased from 55% in 2009 to 79.7 % in 2011.

**Table 1: HIV and AIDS Status at a Glance (National HIV Estimates 2010)**

National HIV prevalence 2011	13.1%
Estimated Number of people living with HIV and AIDS 2011	1,159,097
Annual AIDS Deaths 2011	63,765
Number requiring Antiretroviral Therapy 2011	597,293
Number of New HIV infections 2011	46,250
Total AIDS orphans 2011	946, 547

Zimbabwe has also been using the Demographic Health Survey Report as its source of data for reporting. The DHS was conducted in 2011 and the report is still being finalized. However a preliminary report has been produced and the results have been used for compilation of this report.

#### **1.4 Policy and Programmatic Response**

Since the first case of HIV and AIDS was reported in Zimbabwe in 1985, the national response has been guided by the following policies and strategic plans:

- ÉEmergency Short Term Plan (ESTP) ó 1987
- ÉMid Term Plan (MTP1) ó 1993
- ÉMid Term Plan (MTP2) ó 1994-99
- ÉNational Policy on HIV and AIDS ó 1999
- ÉNational HIV and AIDS Strategic Framework ó 2000-2004
- ÉZimbabwe National HIV and AIDS Strategic Plan (ZNASP) ó 2006-2010

The Government of Zimbabwe (GoZ) has continued to demonstrate great commitment and leadership to the fight against the HIV and AIDS scourge. The GoZ through the HIV and AIDS governing body, NAC has formulated policies that affect every area of the nation's multi-sectoral response to HIV and AIDS.

A National HIV and AIDS Policy was introduced by the Government of Zimbabwe in December 1999 to guide programmes aimed at combating HIV and AIDS. Following this, efforts to implement the national policy are spearheaded by the National AIDS Council. The Council has made great strides and progress to put structures at the national, provincial and district levels for the creation of a conducive operational environment for the HIV and AIDS multi-sectoral response.

The ZNASP 2006 ó 2010 has been reviewed and subsequently ZNASP 2011 ó 2015 is now in place. Under ZNASP 2011 - 2015, Zimbabwe has identified the following two national priorities in the fight against HIV and AIDS:

- Prevention of new adult and children HIV infections: Zimbabwe aims to reduce the annual infections by 50% by 2015.
- Reduction of Mortality amongst PLHIV: Zimbabwe aims to reduce annual AIDS deaths by 38 % by 2015.

These priorities will be achieved through the implementation of prioritized interventions that contribute to specific impact, outcome and output results. The ZNASP 2011 - 2015 has articulated three impact and twenty-four outcome level results.

The following are impact areas that have been identified in ZNASP 2011 - 2015:

- Impact 1: HIV incidence reduced by 50% from 0.85% (48, 168) for adults (2009) to 0.435% (24,084) by 2015
- Impact 2: HIV incidence reduced among children from 30% in 2010 to less than 5% by 2015
- Impact 3: HIV and AIDS related mortality reduced by 38% from 71299 (2010) for adults and 13,393 for children (2009) to 44,205 for adults and 8,304 for children by 2015
- Impact 4: The efficiency and effectiveness of the national multi-sectoral response improved: The NCPI rating is improved from 6.2 in 2010 to 9.0 in 2015

Zimbabwe has in between also conducted the Modes of Transmission study in 2010 that clearly outlines the Know Your Epidemic (KYE) and Know Your Response (KYR). The major source of new infections is low risk hetero-sexual transmission. A comprehensive M&E Plan (2011-2015) to accompany the latest strategy has been developed.

In 1999, the Government introduced the AIDS Levy which is 3 % of payee and corporate tax. The tax is collected by the Zimbabwe Revenue Authority and is directly credited on a monthly basis to the National AIDS Council that manages the fund. This was followed by the creation of the National AIDS Trust Fund (NATF), managed by a National AIDS Council Board, responsible and reporting directly to the Minister of Health and Child Welfare. Currently the AIDS levy is the major contributor of domestic funding to the national response. However, the government still receives external support from the Global Fund, US Government, Expanded Support Programme, Department for International Development (DfiD) and other international partners.



**Table 2: An overview of Indicator Data**

<b>Target 1: Reduce sexual transmission of HIV by 50 percent by 2015</b>			
<i>Indicators for the general population</i>			
<b>Year</b>	<b>2007</b>	<b>2009</b>	<b>2011</b>
1.1 Percentage of young women and men aged 15-24 who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission*	Men (45.6%) Women (43.7%) [ZDHS 20(05/6)]	72.3% (Both Sexes, PSI Database 2009)	Pending data from ZDHS 2010/2011
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.	Men (4.5%) Women (5.3%) [ZDHS 2005/6]	Men (4.5%), Women (5.0%) [NBCBS]	Pending data from ZDHS 2010/2011
1.3 Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months.	Men (14.1%) Women (1.3%) [ZDHS 2005/6]	Men (28.3%) Women (9.0%) [NBCBS 2007/8]	Men (11.6%) Women (2.3%) ZDHS 2010/2011 Preliminary Report.
1.4 Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse.	Male (71.1%) Female (46.8%) [ZDHS]	Data not available	Pending data from ZDHS 2010/2011
1.5 Percentage of adults aged 15-49 who had sexual intercourse with more than one partner in the past 12 months.	Men (14.1%) Women (1.3%) [ZDHS]	Men (28.3%) Women (9.0%) [NBCSBS]	Pending data from ZDHS 2010/2011
1.6 Percentage of young people aged 15-24 who are living with HIV*	13.1% [ZDHS 2005/6]	5.1% [National HIV Estimates 2009]	Pending data from ZDHS 2010/2011

<i>Indicators for sex workers</i>			
	<b>2007</b>	<b>2009</b>	<b>2011</b>
1.7 Percentage of sex-workers reached with HIV prevention programmes.	Data not available	Data not available	Data not available
1.8 Percentage of sex workers reporting the use of a condom with their most recent client.	Data not available	38.3% (Women only) [NBCBS 2007/8]	68.5% (Women only), [ZAPP/RDS Sex Work Programme Database]
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results.	Data not available	Data not available	58.8% (Women only), [ZAPP/RDS Sex Work Programme Database]
1.10 Percentage of sex workers who are living with HIV.	Data not available	Data not available	50% (Women only), [ZAPP/RDS Sex Work Programme Database]

<i>Indicators for men who have sex with men</i>			
	<b>2007</b>	<b>2009</b>	<b>2011</b>
1.11 Percentage of men who have sex with men reached with HIV prevention programmes.	Data not available	Data not available	Data not available
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.	Data not available	Data not available	Data not available
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results.	Data not available	Data not available	Data not available
1.14 Percentage of men who have sex with men who are living with HIV.	Data not available	Data not available	Data not available

<b>Target 2: Reduce transmission of HIV Drugs Among People Who Inject Drugs by 50% by 2015</b>			
<i>Indicators for the general population</i>			
<b>Year</b>	<b>2007</b>	<b>2009</b>	<b>2011</b>
<b>2.1</b> Number of syringes distributed per person who injects drugs per year by needle and syringe programmes.	Data not available	Data not available	Data not available
<b>2.2</b> Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	Data not available	Data not available	Data not available
<b>2.3</b> Percentage of people who inject drugs who report the use of a condom at last sexual intercourse.	Data not available	Data not available	Data not available
<b>2.4</b> Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results.	Data not available	Data not available	Data not available
<b>2.5</b> Percentage of people who inject drugs who are living with HIV.	Data not available	Data not available	Data not available

<b>Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths</b>			
<b>Year</b>	<b>2007</b>	<b>2009</b>	<b>2011</b>
<b>3.1</b> Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission.	22%	59%	98%
<b>3.2</b> Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Not Required	Not Required	29%
<b>3.3</b> Mother-to-child transmission of HIV (modeled).	29% [MOHCW, PMTCT Data base ]	30.0% [MOHCW, PMTCT Data base ]	Data Pending from Geneva.

<b>Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015</b>			
<b>Year</b>	<b>2007</b>	<b>2009</b>	<b>2011</b>
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy.	26.5% [MOHCW, ART Data base ]	56.1% [MOHCW, ART Data base ]	79.7%
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	93.1% [MOHCW, ART Database]	75.0% [ Global Fund R-5 Cohort Analysis Survey]	85.7% [NAC Cohort data 2009 - 2011

<b>Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015</b>			
<b>Year</b>	<b>2007</b>	<b>2009</b>	<b>2011</b>
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV.	2.4% [MOHCW,NTP Database]	18% [MOHCW,NTP Database]	23.5% (2010).

<b>Target 6: Reach a significant level of annual global expenditure (US\$22-24 billion) in low- and middle-income countries</b>			
<b>Year</b>	<b>2007</b>	<b>2009</b>	<b>2011</b>
6.1 Domestic and international AIDS spending by categories and financing sources.	<b>USD 54,508,408.00</b> NASA Report 2007	<b>USD 83,074,221.00</b> NASA Report 2009	<b>USD 104,442,193.00</b> Data not Yet Complete Responses from Domestic and International Sources of Funding still coming.

<b>Target 7: Critical enablers and synergies with development sectors</b>			
<b>Year</b>	<b>2007</b>	<b>2009</b>	<b>2011</b>
7.1a National Commitments and Policy Instruments (NCPI), Public Sector Average Score	Not Required	50%	72%
7.1b National Commitments and Policy Instruments (NCPI), Civil Society Average Score	Not Required	78%	78%
7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.	Not Required	Not Required	41.4%
7.3 Current school attendance among orphans and non-orphans aged 10-14*	<b>Orphans</b> 87.9% [ZDHS 2005/6] <b>Non-Orphans</b> 92.4% [ZDHS 2005/6]	<b>Orphans</b> 84.1% [MIMS 2009] <b>Non-Orphans</b> 93.0% [MIMS 2009]	Data Pending [ZDHS 2010/11] Data Pending [ZDHS 2010]
7.4 Proportion of the poorest households who received external economic support in the past 3 months.	31.2% [ZDHS 2005/6]	46% [MIMS 2009]	Data Pending [ZDHS 2010/11]

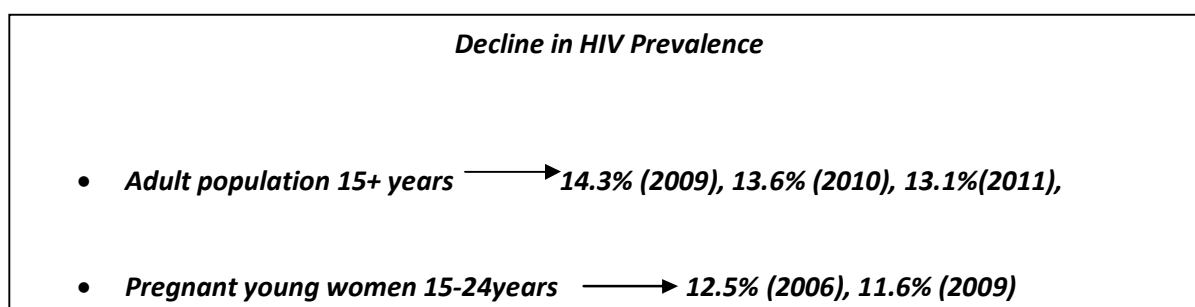
## 2.0 Overview of the AIDS epidemic

### 2.1 Background

HIV prevalence is on a decline in Zimbabwe. Using the EPP and Spectrum software 2010 HIV prevalence in the adult population in Zimbabwe was estimated to be 23.7% in 2001, and declined to 18.4% in 2005, and 13.1 % in 2011.<sup>3</sup> The adult HIV prevalence peaked in 1997 at 26.5% (Figure 1). Prevalence for males 15-24 peaked in 1996 at 25.2%.

In 2005, the MOHCW conducted an epidemiological review to confirm the decline in HIV prevalence in the country. Accordingly, a report was published in November 2005 and from data gathered from several studies there was support for the decline in HIV prevalence that began in the late 1990s.<sup>4</sup> The Zimbabwe Demography and Health Survey of 2005/06 further supported this decline by showing an HIV prevalence of 18.1% in the general population (15-49 years). The main conclusions of the epidemiological review ascribed the decline in HIV prevalence and incidence to change in sexual behavior in particular a drop in number of sexual partners, improved condom use and mortality.

A decline in HIV prevalence among all pregnant women (15-49 years) continued, with prevalence decreasing from 25.8% in 2002; 21.3% in 2004; 17.7% in 2006 to 16.1% in 2009 among antenatal clinic attendees. Similar trends were also observed among younger pregnant women (15-24 years) where prevalence declined from 20.8% in 2002; 17.4% in 2004; and 12.5% in 2006 to 11.6% in 2009. The above downward trends in HIV prevalence among women aged 15-24 could be depicting a concomitant decline in HIV incidence in the population.



### 2.2 Prevalence among Different Age Groups

Using the 2009 version of Spectrum (Table 2), the adult HIV prevalence was 14.3 % in 2009 and has declined to 13.6 % in 2010 and decreased to 13.1% (figure 1) by the end of 2011.<sup>3</sup> The estimates presented on child prevalence are based on PMTCT data inputs that could have underestimated prevalence due to insufficient data inputs.

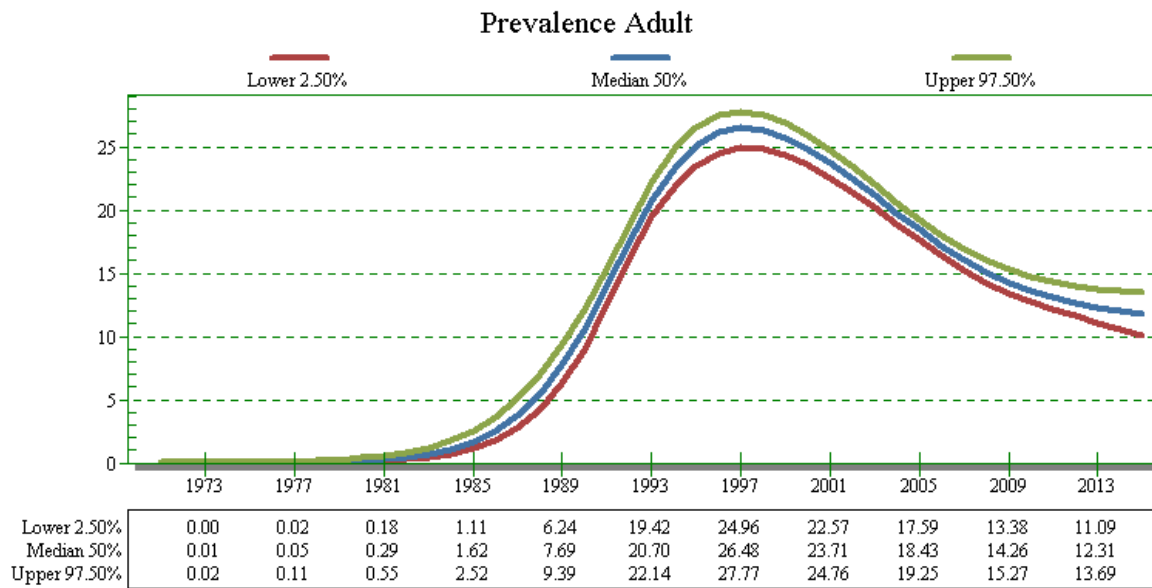
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<sup>4</sup> Evidence for HIV Decline in Zimbabwe, a comprehensive review of the epidemiological data, UNAIDS 05.26E

**Table 3: Adult and children HIV prevalence<sup>3</sup>**

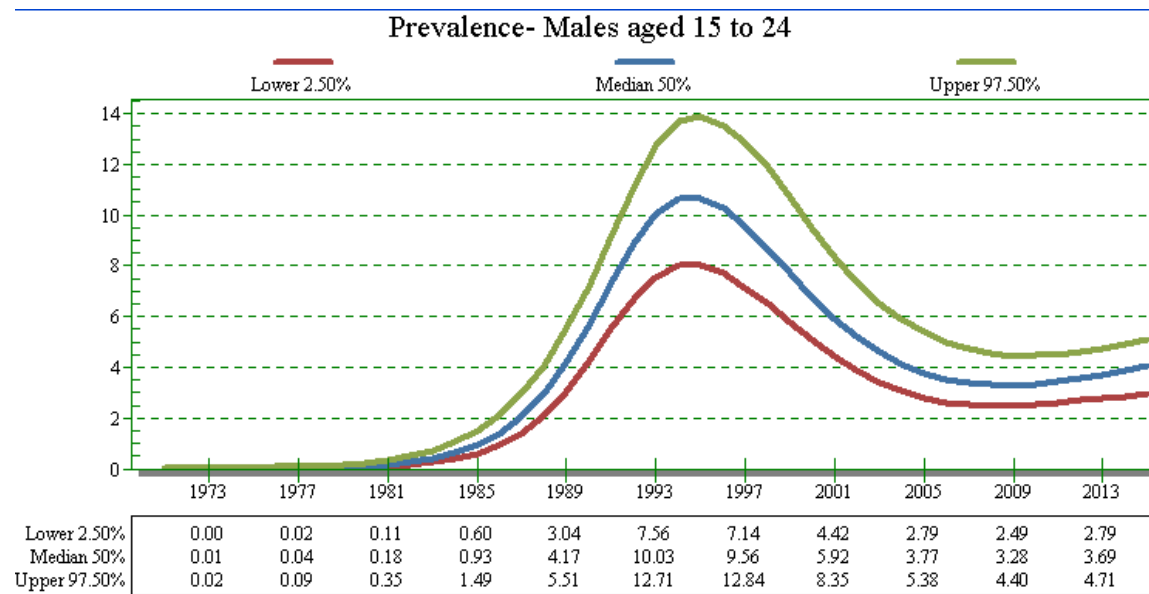
	2009	2010	2011
<b>Adult prevalence (15+ years)</b>	14.3% (13.4 ó 15.3)	13.6% (12.7 ó 14.7)	13.1% (12.1 ó 14.3)
<b>Prevalence males (15-24)</b>	3.3% (2.5 -4.4)	3.3% (2.5- 4.5)	3.4% (2.6 -4.5)
<b>Prevalence females (15-24)</b>	6.9% (5.3 ó 9.0)	6.7% (5.2 ó 8.7)	6.6% (5.1 ó 8.6)
<b>Prevalence children (0 -14)</b>	3.1% (1.8 -4.1)	2.9% (1.7 -3.9)	2.8% (1.6 -3.7)

**Figure 1: Trends in Adult HIV Prevalence, Zimbabwe 1970-2015.<sup>3</sup>**



The prevalence of HIV infection peaked to 10.7% (figure 2) in 1995 among males aged 15 to 24 years. **Error! Bookmark not defined.** In women aged 15 to 24 years, prevalence also peaked in 1995 at 26% (figure 3). **Error! Bookmark not defined.** Declining trends in HIV prevalence have been projected in both males and females aged 15 to 24 years from 1995 to 2010 and 2011 respectively. **Error! Bookmark not defined.** Thereafter, a marginal increase in HIV prevalence is projected in both age groups up to 2015.<sup>2</sup>

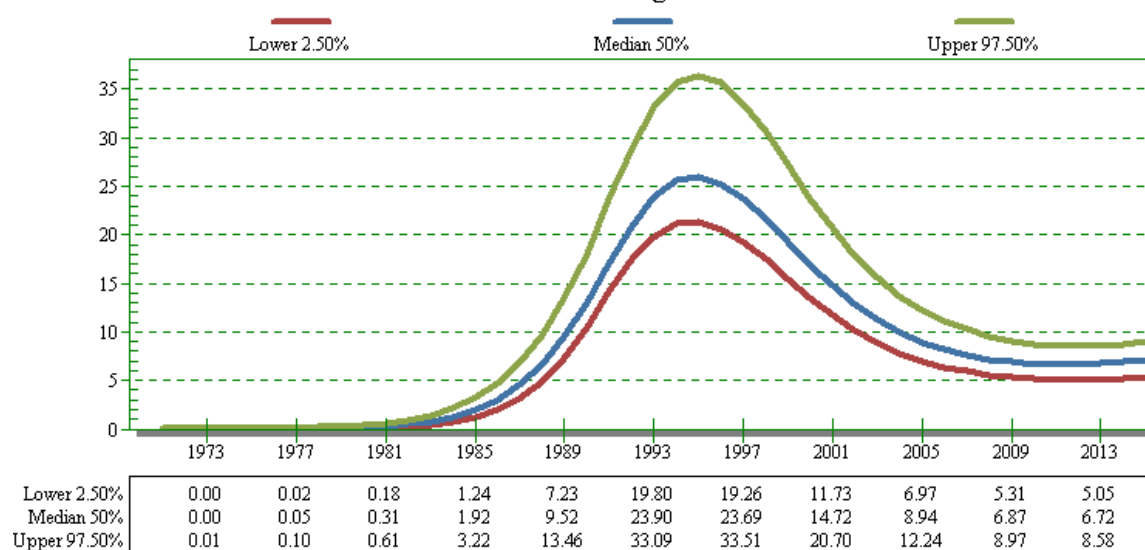
**Figure2 Trends in Male (15 -24) HIV Prevalence, Zimbabwe 1970-2015.** **Error! Bookmark not defined.**



**Figure 3: Trends in Female (15 -24 years) HIV Prevalence, Zimbabwe 1970-2015.** **Error! Bookmark not defined.**



### Prevalence- Females aged 15 to 24



It was estimated that 1 159 097 (Table 3) adults and children were living with HIV and AIDS by the end of 2011. There were 138 642 children below 15 years that were HIV infected in 2011 which represented nearly ten percent of the total number of adults and children that were infected with HIV. There was however a slight decrease in number of HIV infected children between 2009 and 2011 which could reflect increased mortality due to limited access to ART. The proportion of women living with HIV and AIDS as a part of HIV infected adults remained at about 60% between 2009 and 2011.

**Table 4: Estimated number of people living with HIV and AIDS**

	2009	2010	2011
HIV Adults + Children	1 189 279 (1 078 758 ó 1 312 981)	1 168 263 (1 058 285 ó 1 312 981)	1 159 097 (1 045 446 ó 1 290 359)
HIV Adults 15+	1 037 530 (946 671- 1 156 579)	1 023 038 930 069-1 145 109	1 020 455 923 967- 1 146 182
HIV 15+ female	617 792 (522 907-712 279)	608 700 (515 402-703 020)	605 894 (512 852-703 485)
HIV population-Children	151 749 (92 348-198 683)	145 224 (88 123-191 371)	138 642 (83 430-183 642)

### 2.3 Modes of HIV Transmission in Zimbabwe

Zimbabwe undertook modes of transmission (MoT) modeling in 2010<sup>5</sup>. The UNAIDS Modes of Transmission model was undertaken by the NAC with support from UNAIDS. The model estimated the distribution of new infections and identified populations at highest risk for HIV infection.

<sup>5</sup> Zimbabwe Analysis of HIV Epidemic, Response and Modes of Transmission, 2010.

The model shows that HIV transmission remains predominantly sexually driven. Sexual transmission accounts for over 90% of new infections. People practicing low-risk sex in the general population are the major sources of new HIV infections contributing 57.6% due to low condom use and high sexual networking. According to the MoT study the majority of new infections occur in the 20 - 29 age group. Other main sources of new infections are as shown table 5 below.

**Table 5: Modes of Transmission 2010 Results**

<b>Ranking</b>	<b>Source</b>	<b>Percentage Contribution</b>
1.	Low risk heterosexual	57.6%
2.	Partners of casual heterosexual	18.8%
3.	Casual heterosexual	7.5%
4.	Clients of heterosexual	6.4%

### **3.0 National response to the HIV and AIDS Epidemic**

#### **3.1 Policy Response**

##### **3. 1.1 National and International Policies Guiding the HIV and AIDS Response**

The National Policy on HIV and AIDS<sup>6</sup> was adopted in December 1999 followed by the creation of the National AIDS Council through an Act of Parliament. The council became operational in 2000. One of the key issues within the HIV and AIDS policy is prohibition of HIV screening for purposes of employment as well as the requirement for AIDS research to be reviewed by the national Medical Research Council of Zimbabwe (MRCZ) and other appropriate review ethics committees.

The National HIV and AIDS Strategic Framework 2000-2004 was developed in order to guide the national HIV and AIDS response in line with the 1999 HIV Policy.<sup>1</sup> In June 2006, the ZNASP 2006-2010<sup>7</sup> was developed after a comprehensive review of National HIV and AIDS Policy of 1999 and the National HIV and AIDS Strategic Framework 2000-2004. The rationale of the ZNASP was to provide an agenda for all HIV and AIDS interventions in Zimbabwe. The ZNASP 2006 ó 2010 was based on the principles that included accepting HIV as an emergency, the need for all stakeholders to work together in a multi-sectoral response, addressing gender inequality and stigma, the need for adequate resources, Zimbabwe's commitment to international goals and the need to adopt effective and evidence based strategies to fight the epidemic.

Various sectoral policies have been developed in response to HIV and AIDS within specific sectors. These have also been complemented by strategies and workplans which emphasize the importance of prevention in the response to HIV.

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<sup>6</sup> Zimbabwe Policy on HIV and AIDS 1999

<sup>7</sup> Zimbabwe National HIV and AIDS Strategic Plan 2006-2010, NAC, 2006

Following the ZNASP 2006 to 2010 Mid Term Review (MTR)<sup>8</sup>, strategic recommendations were made including harmonization of HIV and AIDS programme area strategic plans to be harmonised with the national strategic plan, strengthening coordination for enhancing prevention efforts, improving ART commodity supply, developing sustainability in mitigation interventions, intensifying resource mobilization and improving human resource capacity. These recommendations provided interim strategic guidance to the response while the country prepared for the development of ZNASP 2011 - 2015<sup>9</sup>.

The Government of Zimbabwe has continued to demonstrate commitment and leadership on the national response to HIV and AIDS by facilitating the development of ZNASP 2011 - 2015. The Strategic Plan has identified 4 impact areas that will be prioritized in terms of HIV and AIDS interventions.

Zimbabwe is further committed to fulfil international and regional obligations including the Millennium Development Goals, the 2001 United Nations Declaration of Commitment commonly known as the UNGASS Declaration, Maseru Declaration, Maputo Plan of Action, 2006 Political Declaration on HIV AIDS, 2011 Political Declaration on HIV and AIDS and the Global Plan towards elimination of new HIV infections in children and keeping mothers alive. Consequently, Zimbabwe has crafted a number of domestic HIV policies and strategies guided by international and regional agreements that have been approved over the years (see table 6).

**Table 6: International and Domestic Policy/ Legislation Approval**

<b>Policy Instrument/ Policy Approval</b>	<b>Approval</b>
<b><i>INTERNATIONAL AGREEMENTS</i></b>	
Millennium Development Goal 6: To halt and reverse the spread of the epidemic by 2015	2000
International Conference on Population and Development (ICPD)	1994
Sexual and Reproductive Health Strategy for the SADC Region 2006-2015	2006
Maseru Declaration on HIV and AIDS	2004
United Nations General Assembly Special Session on HIV and AIDS (UNGASS)	2001
2006 UN Political Declaration on HIV AIDS	2006
2011 UN Political Declaration on HIV AIDS	2011
Global Plan towards elimination of new HIV infections in children and keeping mothers alive	2011
<b><i>NATIONAL POLICIES</i></b>	
Zimbabwe National HIV and AIDS Policy	1999
Zimbabwe National Reproductive Health Policy	2006
Zimbabwe Policy Guidelines on Safe and Voluntary Male Circumcision	2009
National Gender Policy	2004
National Youth Policy	2000
<b><i>HIV PROGRAM STRATEGIES</i></b>	
The Zimbabwe National HIV and AIDS Strategic Plan 2006-2010	2006
The Zimbabwe National Behavior Change Strategy	2006
The Zimbabwe Health Sector HIV Prevention Strategic Framework 2007-2010	2007
PMTCT and Pediatric HIV prevention, care National Plan 2006-2010	2006
National Adolescent Sexual and Reproductive Health Strategy 2010-2015	2010
National Female Condom Strategy 2006-2010	2006
Ministry of Health and Child Welfare, National Guidelines on HIV Testing and Counseling Strategic Plan 2008-2010	2008

<sup>8</sup> ZNASP Mid Term Review, July 2009.

<sup>9</sup> Zimbabwe National HIV and AIDS Strategic Plan II, 2011-2015, NAC, 2011

Plan for the Nationwide Provision of Antiretroviral Therapy, 2008 ó 2012, MOHCW	2008
National Male Circumcision Strategy	2011
The Zimbabwe National HIV and AIDS Strategic Plan 2011-2015	2011

Zimbabwe has a very active multi-party parliamentary portfolio committee on Health which is executing the following functions:

- Budget oversight where the committee facilitates in resource mobilisation and advocates for allocation of more funds to the NAC. The committee also tracks external funding to the Ministry of Health and Child Welfare through NGOs and other bilateral partners. The Permanent Secretary of Health, Director of AIDS and TB Unit and Chief Executive officer of NAC have been engaged by the committee to explain HIV/AIDS funding issues between 2010 and 2011.
- Review of current policy, strategic documents and legislature so that these are in line with the current situations. The committee had significant input during the drafting of the ZNASP 2011 - 2015. In addition, the Committee is in the process of reviewing the current NAC Act. Other legislation that the Portfolio Committee constantly monitor for inconsistencies with current situations include the Public Health Act, Domestic Violence Act, Criminal Codification Act and Reform, section 78, Sexual Offences Act and the Child Protection Act all of which have relevance to HIV/AIDS.
- Monitoring the implementation of policies and legislation through site visits and interview with beneficiaries. In 2011, a number of ART sites were visited by the parliamentary portfolio committee in order to assess progress in terms of access to OI/ART services.

The country response continues to have an enabling environment which permits HIV and AIDS advocacy. The Zimbabwe AIDS Network (ZAN) is leading over 400 civil society organizations which are involved in advocacy and implementation of some of the ZNASP 2011 ó 2015 programme areas. Between 2009 and 2011 Zimbabwe witnessed further growth in the voice of networks of people living with HIV and AIDS.

### 3.1.2 Legal and Policy Instruments

Zimbabwe has over the years developed and passed bills that help maintain the rights of the most vulnerable people in the country. For example the Criminal Procedure and Evidence Amendment Act Number 8 of 1997 was crafted in response to the increase in numbers of cases of sexual abuse of minors. Subsequently, decentralized Victims Friendly Courts were created to ensure that sexually abused minors testify freely without fear. In a related development, the Criminal Procedure and Evidence Amendment Act and the Sexual Offences Act of 2000 that criminalizes the wilful transmission of HIV even between husband and wife were amended. A stiffer penalty of 20 years for rapists convicted of raping and infecting their victims with HIV was included in the Sexual Offences Act of 2000. The Child Protection Act (2006) allows for HIV testing in children up for adoption. In 2007 the Government of Zimbabwe enacted the Domestic Violence Act, which criminalises all forms of violence such as psychological,

physical and sexual. The legislation to date has been aimed at protecting those who are often vulnerable in society, including women, children, orphans and people with disabilities.

### **3.1.3 Human Rights and Vulnerable Populations**

Discrimination of HIV positive people is prohibited by GoZ under National HIV and AIDS Policy of 2000 and the Statutory Instrument (SI 202) of 1998. Instances that help explain this policy are where HIV screening for purposes of employment is prohibited and protocols for AIDS research are reviewed by the national Medical Research Council of Zimbabwe (MRCZ) and other appropriate review ethics committees. Nevertheless, these policies and regulatory guidelines are silent in terms of protecting sub-populations such as men having sex with men (MSM), intravenous drug users (IDU) and commercial sex workers (CSW). For this reason, these groups have no legal status in Zimbabwe. Protection for non-consenting men who are forced to have anal sex is provided for under the Sodomy Act. Whilst sex work and homosexuality is illegal in Zimbabwe, these groups have not been denied access to health services as a result of a specific law or policy.

Despite the current lack of legal frameworks to support targeting of high risk groups such as Sex Workers, Prisoners, MSM and IDU with prevention activities, Zimbabwe has allowed the existence of informal lobby groups for these populations. This includes organizations representing gays and lesbians living in Zimbabwe and organizations working with sex workers. However, the country still needs to put in place targeted programs such as condom promotion and other prevention strategies in order curb the spread of the HIV among these groups. The country also needs to conduct special studies such as size estimation for these groups and to understand the nature of the epidemic among them.

Within the context of the ZNASP 2006-2010, one of the guiding principles was that the needs of vulnerable populations including mobile and migrant populations should be prioritized and addressed. A major highlight of the ESP was the support to the International Office of Migration (IOM) for purposes of mitigating the impact of HIV and AIDS on migrant populations. In 2010 and 2011 ESP and IOM provided humanitarian assistance to migrant workers in the agricultural, mining, construction and transport industries, as well as cross-border traders and mobile and vulnerable populations (MVPs).

### **3.1.4 Funding the Response**

Funding mechanisms from domestic and international sources enabled Zimbabwe to fund its HIV and AIDS response. The GoZ raised funds mainly through the NATF which is a 3% levy collected from taxable income from all sectors to mitigate the impact of HIV and AIDS and is channeled directly to NAC by the Ministry of Finance. NATF contributed US\$5 143 108<sup>10</sup> in 2009, US\$20.5 million<sup>11</sup> in 2010 and US\$26.5 million<sup>12</sup> in 2011 towards HIV programmes. About 50% of NATF funds were used for procurement ARVs whilst the rest went to other HIV programmes and administrative support for coordination.

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<sup>10</sup> NAC Annual Report 2009

<sup>11</sup> NAC Annual Report 2010

<sup>12</sup> Draft Annual Report 2011, NAC

International partners contribution in terms of HIV and AIDS funding was US\$ 54,287,358 in 2009, US\$ 113,699,024 in 2010 and US\$ 114,586,719 in 2011 towards HIV and AIDS programs. The amounts for 2011 may not reflect the true total financial contribution from the international sources for that year, as not all of them responded to the request for information.

In 2009 UNDP was responsible for the management and disbursement of the GFTAM Round 5. This support was focused on 22 of the 62 districts for the purpose of maintaining and strengthening health service delivery and mitigating the impact of HIV and AIDS. In terms of GFTAM Round 5 disbursements, Zimbabwe received a total of US \$ 8,545,029 in 2009. More funding which covered 62 districts came through Global Fund Round 8 phase 1 amounting to US \$ 66, 042,408 in 2010 and US \$ 26, 233, 339 in 2011.

Additional resources were made available through the Expanded Support Program, which is a grouping of the following development partners: CIDA, DFID, Norwegian Aid, Irish Aid and SIDA. A total of US\$ 31 million was committed for the period 2010-11, of which 65% was earmarked for care and treatment. Prevention accounted for 12% of the ESP budget, while 10% was allocated to M&E.

The mitigation programme for OVC received significant funding from the Programme of Support (PoS), a pooled donor funding by development partners that including Australia, the European Union, Germany, Netherlands, New Zealand, Sweden and the United Kingdom. The fund committed US\$ 35 million in 2010 and US\$16.6 million in 2011 to fund the National Action Plan (NAP) for OVC. The NAP supports OVC education, healthcare, birth registration and access to HIV/AIDS prevention, treatment, and care and support services<sup>13</sup>.

### **3.1.5 Macroeconomic policies**

A number of the macroeconomic policies that Zimbabwe has adopted in the last two years have made a contribution in terms of mitigating the effects of HIV and AIDS. The Short Term Economic Recovery Plan (STERP I) in 2009 which covered the period from February 2009 to December 2009 was developed to stimulate economic growth and reduce poverty. This strategic economic recovery framework was then followed by a medium term (6 years) economic recovery plan (MTP) that covers the period 2010 to 2015.<sup>14</sup> The MTP seeks to achieve sustainable, balanced and robust economic growth and development, oriented towards poverty reduction and the integration of previously marginalized groups of people<sup>15</sup>.

In addition the MTP also looks at ways of revitalizing the health sector in order for Zimbabwe to meet its regional and global targets, especially those related to the reduction of the burden and impact of HIV and AIDS under the Millennium Development Goal number 6. Among the key health strategies that will be employed during the MTP period are the following:

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<sup>13</sup> PoS NAP OVC, Annual Reports and Programme Database 2010 to 2011.

<sup>14</sup> Medium Term Plan (MTP), January 2010 to December 2015, GoZ,

- Allocate 15 percent of the National Budget to the health sector in line with the Abuja Declaration by 2015;
- Restore basic health service delivery at community level, focusing on basic packages of preventive and curative maternal and child health, HIV and AIDS, TB and Malaria;
- Expand behavior change communication, drugs availability, community support and counseling to mitigate the impact of HIV and AIDS;

## **3.2 HIV Programmes**

### **3.2.1 HIV Prevention Programmes**

Zimbabwe has adopted an integrated strategy for the implementation of the prioritized HIV prevention interventions. Prevention of new HIV infections remains the national priority in the fight against HIV and AIDS. Among the aims of ZNASP 2011 ó 2015 are reduction or prevention of new infections if exposure has occurred, reduction of the probability of infection if transmission has occurred and finally influence behavior change where social or cultural norms, values and practices remain barriers to adopting effective prevention behaviors.

#### **3.2.1.1 Social and Behaviour Change Communication**

##### **3.2.1.1.1 Background**

Social and behavior change communication (SBCC) is key to adopting HIV prevention strategies. The combination of improved comprehensive knowledge, improved risk perception and people knowing their HIV status enables people to make informed decisions and choices on their sexuality. The National Behavior Change program that has been extensively supported by ESP and EU in the 26 districts from 2007 to 2009 is part of this strategy.

##### **3.2.1.1 .2 Achievements**

The number of people reached through interpersonal communication was 5, 219 245 whilst number of people trained in interpersonal communication (course completions) was 221 058 reached in 2011 and 649 747 cumulatively since funding of the programmatic response started.

The National Behavior Change program was extended to cover the whole country with the support of the Global Fund in 2010. These include the urban provinces (i.e. Harare and Bulawayo), which were not part of the initial phase of the BC phase program. Program included both mass media and interpersonal communication. A structured form of reaching with standardized is in place through a manual Love and Respect manual. This comprises of a seven-week course that participants from the community have to go through. At the end of the 7-week course participants are issued with certificates. The program is mainly driven by community volunteers called Behavior Change Facilitators.

The BC program has been well integrated into different sectors such as prisons with a number of prison officers and prisoners having gone through the course and graduated. Communities have realized the importance of the BC program and regularly traditional leaders contribute food for community BC



graduations. Parliamentarians moved a motion in parliament for leaders to be role models agents for behavior change.

The BC program was supported by the expanded Supported program (ESP), European Union and Global Fund.

### **3.2.1.1 .3 Challenges**

Funding for the program has been dwindling since 2009. The EU funding ended in 2010. Support for the BC program under ESP ends in March 2012. In addition there has been insufficient coverage, intensity and duration of interventions targeting young people and in particular those out of school.

### **3.2.1.1 .4 Recommendations.**

There is need to integrate BC into other prevention programs such as male circumcision and PMTCT. Moreover, there is need to provide quality life skills based HIV education in schools as well as integration of Social and Behaviour Change Communication interventions in the work place and community development programmes.

## **3.2.1.2 Condoms promotion and distribution**

### **3.2.1.2.1 Background**

The correct and consistent use of condoms has been the most effective HIV prevention strategy. Studies show that condoms effectiveness can be as high 95% when used correctly and consistently<sup>16, 17</sup> In 2009, approximately 89, 956, 552 male and 4, 491, 916 female condoms were distributed.

#### **3.2.1.2.1 Achievements**

Condom distribution has remained high between 2010 and 2011. For example, 85 million male and 5 million female condoms were distributed in 2011. There were low stock out rates through the DTTU system and PSI social marketing systems. There was strong collaboration between MoHCW and partners in terms of condom distribution.

#### **3.2.1.2.1 Challenges**

There are no approaches for promoting condom use in PLWH especially in the context of discordance. In addition, socialization norms create barriers to communication on sex and negotiating for safe sex, in particular within marriages. Condom use has also been found to be low in long term relationships. Moreover, there are myths, misconceptions and negative perception by many of on the public sector distributed condoms compared to the social marketed condoms. Meanwhile, female condoms uptake has remained low compared to the male condoms.

#### **3.2.1.2.1 Recommendations**

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<sup>16</sup> Padian, S Nancy S. et al (2008): Lancet Biomedical interventions to prevent HIV infection: evidence, challenges, and way forward, Lancet (On line August 6, 2008),

<sup>17</sup> Pinkerton SD et al. (1997): Effectiveness of Condoms in Preventing HIV Transmission, Social Science Med 1997,

From 2012 to 2015, the following priority populations will be targeted in terms of condom distribution: Sexually active young people and adults, couples in discordant relationships, PLHIV enrolled in the Pre-ART and ART programme, men and women testing positive in HTC sites, key populations (Sex workers, MSM) and their clients men under going male circumcision

Efforts will be made to integrate condoms education, awareness and distribution in other services such as adolescent sexual reproductive health including family planning, PMTCT, male circumcision and control of STIs. Advocacy and education will be strengthened to address social norms that create barriers to communication on sex and negotiating safer sex in particular within marriages, sero-discordant couples and young people in-schools. In order to ensure comprehensive outreach multi-media channels will be used. Advocacy work will be carried out with PLHIV to promote and support positive health, dignity, and prevention in the context of condom use.

### **3.2.1.3 Male circumcision**

#### **3.2.1.3.1 Background**

Male circumcision (MC) has been shown to reduce the probability of HIV infection in an HIV negative male by about 60%.<sup>18</sup> Zimbabwe has adopted MC as a key prevention strategy. A national MC policy was developed and launched in November 2009 and a pilot roll out of the programme to five learning sites was carried out. In 2009, pilot MC programme managed to circumcise 2801 males.

#### **3.2.1.3.1 Achievements**

The number of males circumcised increased from 11 176 in 2010 to 36742 in 2011. A five-year 2010-2015 Voluntary Male Circumcision Strategy was developed. The strategy aims to reduce HIV incidence through MC by between 25% and 35%, by circumcising at least 80% of people aged 15 ó 29 years by 2015. The communication strategy for male circumcision was developed in 2011 and it aims to mobilize the target population for circumcision.

In the meantime, a cumulative number of 540 health care workers had been trained on male circumcision by 2011. Besides, the 5 static sites (located in 4 provinces of the country) MC activities have also been rolled out using the outreach model. Collaboration between traditional circumcisers and health care workers in traditionally circumcising communities has resulted in increased number of clients coming for medical circumcision.

The Prepex device for male circumcision was piloted and its safety profile was evaluated in 2011. It is envisaged that this device could facilitate task shifting and sharing from doctors to nurses when it comes to MC since it is user friendly.

#### **3.2.1.3.1 Challenges**

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<sup>18</sup> Bongaarts et al. 1989; Moses et al, 1990; Auvert et al, 2005; Drain PK et al. 2006, Bailey RC et al., 2007; Gray et al., 2007).

There was limited funding for male circumcision hence there were only 5 static sites providing MC in the whole country. Consequently, roll out of MC in district and community level health facilities has been slow and inadequate. In addition, there has been low uptake of male circumcision attributed to low levels of community mobilization and education on male circumcision. Moreover, there is inadequate capacity at health facilities to conduct counseling and testing and voluntary MC procedures.

### **3.2.1.3.1 Recommendations**

There is need to strengthen health facilities and health systems in general to support provision of sustained MC services coupled with redefining scope of practice of certain cadres. Moreover, there is need for intensifying education, awareness, and community mobilization to generate demand for MC.

## **3.2.1.4 Prevention of mother to child transmission of HIV**

### **3.2.1.4 .1 Background**

Zimbabwe has been guided by a number of strategic plans and guidelines in the implementation of PMTCT activities since 1999.<sup>19,20, 21</sup> The PMTCT program has been one of the strongest pillars of the HIV and AIDS responses in Zimbabwe. It is integrated within the broader framework of reproductive health service provision.<sup>22</sup> Consequently, there is improved access and coverage of PMTCT services in Zimbabwe. As of December 2009, 59% of HIV positive pregnant women received ARVS for prophylaxis whilst 35% of HIV exposed infants received prophylactic ARVs.<sup>23</sup> Furthermore, a total of 4 498 DNA PCR tests were conducted among HIV exposed infants by December 2009.<sup>2</sup>

### **3.2.1.4 .2 Achievements**

In 2010, Zimbabwe adopted the new WHO guidelines on PMTCT which among other recommendations highlighted extended MER for HIV positive pregnant mothers and extended ARV prophylaxis for HIV exposed infants.

The proportion of estimated HIV positive pregnant women receiving ARVs for prophylaxis increased from 84% in 2010 to 98 % in 2011. Hence, universal access to ARVs for PMTCT prophylaxis was achieved for both 2010 and 2011.<sup>24</sup> The proportion of HIV infected pregnant women who received MER during pregnancy was 69.6 % (31165) in 2010. Meanwhile, there was an increase in the proportion of HIV exposed infants on ARV prophylaxis from 74% in 2010 to 94 % in 2011.

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<sup>19</sup> Zimbabwe National HIV and AIDS Policy, 1999.

<sup>20</sup> HIV and AIDS Framework 1999- 2004

<sup>21</sup> Zimbabwe National HIV and AIDS Strategic Plan 2006-2010

<sup>22</sup> PMTCT and Paediatric HIV Prevention, Treatment and Care National Plan, 2006 – 2010, MOHCW, 2006

<sup>23</sup> PMTCT Programme 2009 Annual Report, AIDS & TB Unit, MOHCW

<sup>24</sup> PMTCT Database, AIDS and TB Unit, MOHCW, March 2012

PMTCT programme has rapidly expanded with 95 % (1560) of the facilities in the public sector offering services. An increase in the proportion of PMTCT sites offering comprehensive services was noted from 77% (1200) in 2010 to 89 % (1390) in 2011.<sup>6</sup> There was accelerated training of health workers in MER such that there was an increase in the cumulative number of health workers trained.

EID services have expanded rapidly, resulting in an increase in HIV exposed infants tested from 16 532 in 2010 to 34,667 in 2011. Number of sites performing DBS collection increased from 48 in 2009, to 379 sites in 2010 and 964 sites in 2011.

Major funding for the PMTCT programme was received from USG, EGPAF, WHO/CIDA, UNICEF/CIDA, Global Fund, CHAI and NAC. Other partners that contributed in terms of funding PMTCT activities included MSF (Holland, Belgium and Spain).

### **3.2.1.4 .3 Challenges**

There were low numbers of treatment eligible mothers initiating ART due to incompetency of some health care workers in WHO clinical staging and lack of CD4 machines at some sites.

There were inadequate community mobilization and demand generation activities in the face of such barriers as user fees. In addition, late bookings and home deliveries presented missed opportunities for PMTCT. Low male uptake was negatively affecting female uptake of PMTCT services. Furthermore, commodity insecurity was encountered with stock outs of ARVs at some sites.

Loss of follow up of HIV exposed infants was a major challenge; leading to low HIV testing rates of testing and fewer numbers going on cotrimoxazole prophylaxis.

### **3.2.1.4 .4 Recommendations**

More health workers need to be trained in WHO clinical staging and all health facilities should have WHO clinical staging flow chart. There is need to increase access to point of care machines besides the conventional CD4 machines in order to facilitate the assessment of HIV infected pregnant women in terms of their eligibility for ART.

Mother-baby pair follow up should be strengthened in order to scale up EID services. Though a rapid scale up of Early infant diagnosis has occurred, there are challenges in terms of long turn- around time of results. This often delays clinicians from taking decision related to the initiation of ART in infants.

### **3.2.1.5 HIV testing and counseling**

#### **3.2.1.5.1 Background**

The ZNASP 2006-2010 identified HIV Testing and Counseling (HTC) as an important component of the HIV national response.<sup>25</sup> Consequently, the Zimbabwe National HIV Testing and Counseling Strategic

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<sup>25</sup> Zimbabwe National HIV and AIDS Strategic Plan (ZNASP II) 2006-2010, NAC, 2006.

Plan (ZNHTCSP) 2008-2010 was launched in 2008.<sup>26</sup> Broad objectives of this strategic plan emphasized the need to increase the percentage of Zimbabwean population who knew their HIV status, from 20% to 85% by 2010; and to expand HTC services using PITC and Client- Initiated Counseling and Testing (CITC), formerly VCT. Meanwhile, there were 940 sites by 2009 that were offering HTC.

### **3.2.1.5.2 Achievements**

There have been well-developed health sector entry points offering HTC that include outpatient departments, clinical wards as well as the following services: Voluntary Counseling and Testing (VCT), Provider-Initiated Testing and Counseling (PITC), Prevention of Mother-to-Child Transmission of HIV (PMTCT), Early Infant Diagnosis (EID), TB, Sexually Transmitted Infection (STI), Family Planning (FP), Community and Home Based Care (CHBC) and Nutrition, Care and Support.<sup>27</sup>

The number of testing and counseling sites increased from 1200 in 2010 to 1390 in 2011. The expansion of HCT services was partly through PMTCT programme which managed to increase the number of comprehensive PMTCT sites. Primary Counselors (PCs) were allowed by the MoHCW Council to be trained in Rapid HIV testing from April 2011 and this resulted in a significant number of PCs trained in rapid HIV testing.

Programme data revealed that the total number of clients who received testing and counseling in Zimbabwe were 1, 653 603 in 2010 and 1832222 in 2011.<sup>28</sup>

### **3.2.1.5.3 Challenges**

Transport costs are a major bottleneck resulting in limited access to HCT in rural areas.<sup>29</sup> The situation is further aggravated by an aging fleet of vehicles for outreach HCT services. The delayed assimilation of PCs by the Health Services Board (HSB) is a hindrance to the effective delivery of HCT services in terms of staff morale.<sup>7</sup>

The percentage of the population who knew their HIV status was estimated at 50% from a recent National Behaviour Change Programme Mid Term Evaluation conducted in two provinces of Masvingo and Mashonaland East covering 6 districts per province.<sup>30</sup>

### **3.2.1.5.4 Recommendations**

Assimilation of PCs by the Health Services Board (HSB) should be prioritized to boost their morale. Community mobilization for HTC will be achieved through undertaking annual HTC campaigns in all provinces annually. HTC integration with other health sector entry points should be further strengthened. Child counseling as well as and couple counseling (especially sero-discordant couples) also needs further strengthening

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<sup>26</sup> Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support; The National HIV Testing and Strategic Plan 2008 ó 2010, MOHCW, 2008.

<sup>27</sup> Plan for the Nationwide Provision of ART 2008-2012, MOHCW, 2008.

<sup>28</sup> National Testing and Counselling Programme Database, Mar 2010; MOHCW.

<sup>29</sup> Modes of Transmission Prevention Review Report, NAC, August 2010

<sup>30</sup> L. Langhaung, R Buzdugan, J Dirawo et al An Evaluation of Zimbabwe National Behaviour Change Programme: Results of a mid-term Evaluation

### **3.2.1.6 Prevention and control of sexually transmitted infections**

#### **3.2.1.6.1 Background**

MoHCW recognizes the inextricable link between STI management and HIV prevention. The 2009 ANC sentinel surveillance report showed that women with current or past genital ulcer disease (GUD) had a higher HIV prevalence nearly three times more than those without a history of GUD. Among young ANC attendees aged 15-24 those with GUD had an HIV prevalence of 31%. Zimbabwe has a comprehensive STI prevention and control program whose main strengths lie in a well structured STI training program, full integration of STI control into Primary Health Care and other healthcare services. Meanwhile, the total number of STIs reported in 2009 were 204,819

#### **3.2.1.6.2 Achievements**

STI prevention is now part of all HIV prevention programmes and has been linked to other health sector programmes like ANC, SRH, MNCH, HTC, PMTCT, ART and Condom promotion.

#### **3.2.1.6.3 Challenges**

There were 318, 147 cases of STIs that were reported in 2011 which was an increase compared to 2009. There is no STI strategic plan to provide direction in terms of implementation of activities. In the meantime, user fees create barriers in terms of access to STI services. Stock outs of STI drugs were reported at some sites. Training of health workers in Syndromic Management remains low due to limited funds. There was inadequate awareness and knowledge among the general population of STIs and their relationship with HIV. Among cases of STIs diagnosed, there was inadequate partner contact tracing.

#### **3.2.1.6.1 Recommendations**

An STI national strategic plan needs to be developed in the context of an HIV prevention strategy. Acceleration of STI education and awareness in the general population and in particular among the most at risk populations as mobile populations and people engaged in multiple and concurrent partnerships need to be strengthened. The procurement and supply of STI drugs, test kits and other consumables needs further strengthening. Training of health workers STI prevention and management should be intensified. Health and community systems should be strengthened to improve partner contact tracing.

### **3.2.1.7 Blood Safety**

#### **3.2.1.7.1 Background**

Blood safety is the most effective strategy for preventing HIV transmission. Safe blood is supplied by the National Blood Services of Zimbabwe (NBSZ), an independent non-profit organization. The NBSZ is a WHO collaborating centre for blood safety in Southern Africa. In order to prevent new HIV infections occurring through blood transfusion, quality assurance and quality improvement systems and strategies have been maintained. A 100% screening of blood for transfusion transmissible infections was maintained in 2009.

### **3.2.1.7.2 Achievement**

Zimbabwe has maintained a 100% screening of blood for transfusion transmissible infections (TTIs), including STIs in both 2010 and 2011.

### **3.2.1.7.3 Challenges**

Demand for safe blood exceeds supply. There is inadequate community mobilization and in particular among low risk groups as voluntary blood donors. A declining donor base and the absence of a donor retention strategy is further worsening the situation.

### **3.2.1.7.4 Recommendations**

There is need to intensifying awareness and education on blood donation targeting in the first instance on low risk groups. Training of service providers on facilitating blood donation strategies, including HIV testing and counseling, storage and screening techniques should be conducted. In addition, development of a national donor retention strategy should be facilitated. Laboratory technological and human resource capacity needs to be strengthened to sustain 100% screening of all donated blood. Establishment of district and provincial level blood donation programmes and storage facilities should be encouraged.

## **3.2.1.8 Post exposure prophylaxis**

### **3.2.1.8.1 Background**

In people exposed to HIV accidentally through injury with a sharp object or after rape or sexual assault, PEP services consist of counseling and risk assessment, HIV testing and counseling, provision of short term ARV based on the assessed risk and follow up post PEP service counseling. ART sites are equipped to provide PEP services.

### **3.2.1.8.2 Achievement**

The national PEP guidelines (2007) were reviewed in 2010 to ensure that they remain relevant and take cognizance of emerging issues. In the meantime, a number of healthcare workers and survivors of sexual assault have received PEP.

### **3.2.1.8.3 Challenges**

There is inadequate awareness of PEP services among most people and communities, especially in rural areas. In addition there is also low uptake of PEP services due to lack of awareness and stigma associated with HIV or rape. PEP services are not available in all health facilities due lack of qualified personnel to offer PEP. Late presentation is also a major barrier for not accessing PEP. The majority of survivors report late and will no longer be legible for PEP (e.g data from adult rape clinic indicates that only 40% (163) reported within the stipulated 72 hours.

### **3.2.1.8.4 Recommendation**

There is need to intensify education and awareness of PEP in the general population and in particular among people who are at most risk of infection by virtue of their work. Accelerated roll out of provision of PEP service to all health facilities should be considered in particular those sites offering ART and PMTCT.

Strengthening the capacity of service providers to provider PEP should be considered. Community mobilization and awareness campaigns should be conducted to create demand for PEP services and how to access and utilize them. Strengthening community-based HIV counselors including village health care

workers to provide pre-PEP counseling especially for rape and sexual abuse survivors should be promoted.

### **3.2.1.9 Life skills based HIV and AIDS Education**

#### **3.2.1.9.1 Background**

##### ***Youths in School***

The Ministry of Education, Arts, Sport and Culture (MoEASC) policy on Life Skills is that all schools should provide Life Skill based HIV and AIDS education according to Circular 16 of 1993<sup>31</sup>. Consequently, a pre-service training on life skills based HIV and AIDS education has been in existence for all student teachers since 1994. In addition, each provincial office has an Education Officer (EO) responsible for HIV and AIDS, Life Skills as well as Guidance and Counseling<sup>32</sup>. A UNESCO review of the Education Sector Response to HIV in Southern Africa<sup>33</sup> concluded that Zimbabwe has a weak education sector response.

A critical issue noted is that the HIV and AIDS Life Skills Strategic Plan for the period 2006 to 2010 developed with support from UNICEF was finalized, but was rejected by the Ministry of Education Sport and Culture. Without this strategic plan, the life skills program is running in a vacuum.

Prevention programmes for school youths are based on the HIV and AIDS Life Skills Education Syllabus<sup>34</sup> which provides different messages for each specific level from grade four (4) up to grade (7) seven. Key HIV issues covered in the Life Skills syllabus are given below;

- What is HIV and AIDS,
- Transmission and Prevention of HIV;
- Myths and misconceptions about HIV and AIDS;
- Linkages between substance abuse and HIV infection; and
- Living with and caring for PLWH

The NBCP provides for separate peer sessions for youths and has specific topics for young people. However, the focus and quality of these programs could not be ascertained.

##### ***Youths in Tertiary institutions***

The Ministry of Higher and Tertiary Education (MHTE) has a Health Education programme which encompasses reproductive health as well as HIV and AIDS. However, there is no HIV and AIDS policy for students in tertiary institutions. Most students within Zimbabwe's tertiary institutions fall between the 19-25 age groups where most are introduced to sex<sup>35</sup>. Although there are Behavior Change Facilitators (BCFs) among university students, improved collaboration between BC implementing organizations and those working within tertiary institutions may be more effective especially with issues of Multiple Concurrent Partnerships and Transactional sex among university students<sup>36</sup>. There have been prevention programmes within tertiary institutions run mainly by Students and Youths Working on Reproductive

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<sup>31</sup> UNGASS Report 2009

<sup>32</sup> Ministry of Health and Child Welfare National Adolescent Sexual and Reproductive Health Strategy 2010-2015

<sup>33</sup> SADC/UNESCO 2010, Review of the Education Sector Response to HIV and AIDS in Africa

<sup>34</sup> MoESAC HIV and AIDS Life Skills Education Primary School Syllabus Grade 4-7

<sup>35</sup> SAYWHAT Baseline Study on Access to Reproductive Health Services in Tertiary Institutions, February 2010

<sup>36</sup> Tsitsi B Masvaure. 2009. Living of Sex: Male Students and Pimping at a Zimbabwean University Campus.



Health Action Team (SAYWHAT) and Sustainability, Hope, Action, Prevention Education (SHAPE) Zimbabwe. Prevention programmes in tertiary institutions focus on the following;

- Condom promotion and distribution;
- Partner reduction;
- HIV Testing and Counseling;
- Disclosure;
- Access to treatment;
- Access to PMTCT services;
- Reducing age mixing

### ***Youths out of school***

Youths out of school have been difficult to reach as they are a transient population. Youth Friendly Centres have been used to reach out of school youths with the overall coordination of ZNFPC. There were two models with one standalone multipurpose that had 22 sites supported by the GFTAM Round 1. There is also the integrated youth-friendly service provision model usually within health centres. The closure of Global Fund supported sites due to lack of funding and inadequate creative materials relevant to youths while the EC/UNFPA supported integrated sites were affected by staff turnover during the 2007/8 health sector crisis. For those centers that have remained open, some of them have been negatively affected by shortage of personnel.

As such, the intended target audiences are not receiving adequate services. Current efforts being coordinated by NAC with funding from the European Union have led to the establishment of the Zimbabwe National Young People's Network on HIV and AIDS. This is an arm of the National AIDS Council under its Youth program. It is coordinated by interns who are young people and its key role is to mainstream youth issues into the overall NAC coordinating framework. It also provides a mechanism for open dialogue and exchange between youth groups, youth serving organizations and relevant partners in the national response.

### **3.2.1.9.2 Achievements**

#### ***Youths in School***

- In 2011 boys and girls empowerment clubs were established at schools that participated in the leadership skills training that was conducted in all the country's 10 provinces.
- Participants also used the trainings as a platform to interact and share experiences on how to cope with challenges they encounter as they grow up.
- The NBCP provides for separate peer sessions for youths and has specific topics for young people.

#### ***Youths in Tertiary institutions***

- There are organisations providing HIV prevention services within tertiary institutions; and
- A National Adolescent Sexual and Reproductive Health Strategy 2010-2015 was launched and includes HIV prevention for youths in tertiary institutions.

#### ***Youths out of school***

- The Zimbabwe Young People's Network on HIV and AIDS was created and is working towards coordinating all youths activities;

### **3.2.1.9.3 Challenges**

### ***Youths in School***

- There is no HIV and AIDS Life Skills Strategic Plan;
- Challenges in reporting by schools create limitations in capturing achievements.

### ***Youths in Tertiary institutions***

- Weak coordination of activities;
- There is no Tertiary Institutions Prevention Strategy; and
- The BC programme does not include organizations working within tertiary institutions;
- Absence of data reflecting programme achievements in tertiary institutions.

### ***Youths out of school***

- The standalone model seems to be weak, more expensive and with limited coverage;
- There is no mapping of organisations providing prevention services to youths out of school;
- Programming for youths out of school is difficult as they are a transient group;
- There is no more funding for Youth Friendly corners which were being supported by the Global Fund Round 1; and
- There are no creative materials to attract youths to Youth Friendly corners.

## **3.2.1.9.4 Recommendations**

### ***Youths in School***

- There is need to develop an HIV and AIDS Life Skills Strategic Plan for youth in schools with clear targets.

### ***Youths in Tertiary institutions***

- Coordination of activities for tertiary institutions should be strengthened and a Tertiary Institutions Prevention Strategy should be developed.
- The BC programme should include organizations working within tertiary institutions.
- Data should be collected reflecting programme achievements in tertiary institutions.

### ***Youths out of school***

- There is need for innovative and cost effective models for Youth Friendly Service (YFS) provision as the standalone model has been to be weak, more expensive and with limited coverage;
- There is need to map organisations providing prevention services to youths out of school;
- There is need to mobilize funding for Youth Friendly corners which were being supported by the Global Fund Round 1; and
- There is need to provide creative materials to attract youths to Youth Friendly corners

## **3.2.1.10 Risk reduction for Most at Risk Populations (MARPS)**

### **3.2.1.10.1 Background**

MARPs<sup>37</sup> in Zimbabwe include sex workers (SWs), cross border traders, women, young people, men who have sex with men (MSM), mobile populations, truckers, internally displaced people, uniformed personnel (soldiers, police, game rangers, customs and immigration officers), prisoners, the physically challenged, survivors of rape and sexual abuse, illegal immigrants, Injecting Drug Users (IDU). The HIV prevention programs and activities aimed at reaching MARPs include the distribution of male and female condoms and Information Education Communication (IEC) materials about HIV, stigma and discrimination, behavior change, sexually transmitted infections (STIs), treatment and care, and VCT.

#### **3.2.1.10.2 Achievements**

##### ***Military***

The military have been actively involved in HIV prevention. The Military has an HIV policy and focuses on condom promotion and distribution, uptake of counseling and testing services as well as male circumcision with one of the four national sites (Manyame) being for the military.

##### ***Sex Workers***

The ZAPP/RDS Sex Work programme resulted in a number of sex workers receiving HIV testing and Counselling as well as treatment for STIs. In addition sex workers received condoms through the ZAPP/RDS Sex Work programme. According to programme data from ZAPP/RDS 65% of workers reported using condoms in their last sexual encounter. A size estimate survey was conducted in Manicaland.

#### **3.2.1.10.3 Challenges**

The restrictive policy and legal framework makes it difficult to carry out size estimation and implement intervention programmes for MARPs (Sex workers and MSM) in Zimbabwe.

#### **3.2.1.10.4 Recommendations**

There is need to conduct size estimates for MARPs (sex workers and MSM) to establish their contribution to the HIV and AIDS burden in Zimbabwe.

### **3.2.2 Treatment and Care**

#### **3.2.2.1 Antiretroviral Therapy**

##### **3.2.2.1.1 Background**

The ART programme was launched by the MoHCW in 2004. Following this, the GoZ made expansion of ART services a priority. ART access was scaled up from 5 learning sites in April 2004 to 337 sites with 219 409 (55% coverage) HIV infected patients (adults and children) on ART by December 2009.<sup>38</sup> Expansion of ART services was guided by a number of strategic plans, guidelines and review documents from 2004 to 2009.<sup>39,40,41,42,43,44,45,46,47,48</sup>

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<sup>37</sup> The groups discussed above who are captured in the NARF

<sup>38</sup> The National OI/ART Programme Annual Report 2009

<sup>39</sup> Plan for the Nationwide Provision of ART 2005-2007, MOHCW, 2004.

<sup>40</sup> Guidelines for Antiretroviral Therapy in Zimbabwe, MoHCW, 2005.

<sup>41</sup> Zimbabwe National HIV and AIDS Strategic Plan 2006-2010.

<sup>42</sup> Paediatric HIV Care Strategic Plan for 2006-2010, MOHCW, 2006.

### 3.2.2.1.2 Achievements

Meanwhile, there was almost doubling in terms of HIV infected clients in need of ART after MoHCW

Year	Initiating Sites	Follow up Site	Total Number of ART Sites
2010	128	382	510
2011	141	449	590

adopted the new CD4 thresholds from the 2010 WHO recommendations for clients eligible to be initiated on ART.<sup>49, 50</sup> Nevertheless, ART coverage increased from 55% (326 241 adults and children; 28149 children at a coverage of 31.5%) in 2010 to 79.7 % (436181 adults; children 40140 at a coverage of 46.1%) by December 2011.<sup>11</sup> This success was underpinned by linkages between the ART and health sector programmes like HTC, PMTCT,SRH,ANC and NTP (TB/HIV) among others. In addition, there was further decentralization of ART services (see table 6 below) and an increased number of health workers were trained in both Paediatric and Adult ART components.<sup>51</sup>

**Table 7: Number of ART Initiating and Follow-up Sites 2011**

Percentage of adults and children with HIV known to be on treatment 12 months after initiating antiretroviral therapy was 85.7 % according to the NAC October 2009 Cohort data that was analysed in 2010. This data shows that the ART programme was performing well with regards to patient retention.

In line with 2010 WHO ART recommendations of transitioning patients to less toxic regimens, ART programme started implementation of new regimens by allowing clinicians to substitute Zidovudine for Stavudine among children and substitute Tenofovir for Stavudine among adolescents and adults from April 2011 onwards. By December 2011, about 78% (target 100% for 2011) children had been transitioned to the Zidovudine based regimen whilst about 9.5% (target 20% for 2011) of adults and adolescents had been transitioned to Tenofovir based regimen.<sup>52</sup>

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<sup>43</sup> Guidelines for Antiretroviral Therapy in Zimbabwe, MoHCW, 2007.

<sup>44</sup> Review of the National HIV and AIDS Treatment and Care Programme (OI/ART) 2004 . 2007, MOHCW, 2008.

<sup>45</sup> Coverage Based on Ministry of Health and Child Welfare, Zimbabwe National HIV Estimates 2009

<sup>46</sup> Plan for the Nationwide Provision of Antiretroviral Therapy, 2008 . 2012, MOHCW, 2008.

<sup>47</sup> Zimbabwe National HIV and AIDS Strategic Plan 2006-2010 Mid Term Review, July 2009

<sup>48</sup> OI/ART Database, AIDS and TB Unit, MOHCW, March 2012.

<sup>49</sup> Guidelines for Antiretroviral Therapy in Zimbabwe, MoHCW, 2010.

<sup>50</sup> HIV Estimates for Zimbabwe, MoHCW, June 2010.

<sup>51</sup> ART Inventory Reports and M& E Reports for Dec 2010 and Dec 2011, AIDS and TB Unit MoHCW.

<sup>52</sup> Directorate of Pharmacy Services Update. Presentation at TB/HIV Joint Partnership Forum by LSU Manager, MoHCW, 1<sup>st</sup> March 2012.

The main sources of funding for the ART programme between 2010 and 2011 were NATF, Global Fund, USG, ESP and Clinton Foundation. Other partners that have supported the ART programme directly include MSF (Holland, Belgium and Spain).

### **3.2.2.1.3 Challenges**

Challenges for the ART programme between 2010 and 2011 were high staff attrition, limited financial resources, inadequate and constant breakdown of CD4, biochemistry, hematology machines. In addition, there were inadequate related consumables and reagents for the lab machines. Another constrain for the ART programme was poor reporting of M & E to the national office.

### **3.2.2.1.4 Recommendations**

The ART programme should endeavor to achieve universal access guided by targets in ZNASP 2011-2015 and international commitments made by all countries who attended the UN General Assembly high level meeting on AIDS held at UN headquarters in June 2011.

## **3.2.2.2 TB and HIV Collaborative Activities**

### **3.2.2.2.1 Background**

Zimbabwe is ranked among high burden countries for both TB and HIV.<sup>53</sup> The incidence of new TB cases was 633 per 100 000 in 2010 compared to 97 per 100 000 in 1990.<sup>54</sup> Associated with the resurgence of TB which has been devastating Zimbabwe is the onset of the HIV epidemic.

The Strategic Plan for Provision of Antiretroviral Therapy (2008-2012), National Tuberculosis Strategic Plan (2009-2013), National Guidelines for TB/HIV Co-management (2010) and National TB Control Guidelines are among the documents that have been used by NTP and ART programmes to plan TB/HIV collaborative activities focusing on the following areas:

- Establishing mechanisms for collaboration between TB and HIV programmes.
- Decreasing burden of TB in people living with HIV
- Decreasing burden of HIV in TB patients.

By 2009, about 18 % of TB/HIV patients were accessing ART.

### **3.2.2.2.2 Achievements**

Among the TB/HIV collaborative that have been accomplished is the establishment of TB/HIV committees at national, provincial and district levels. National TB/HIV committees have been engaged in

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<sup>53</sup> TB control 2011, WHO

<sup>54</sup> TB control 2011, WHO

developing strategies for reducing TB burden among PLHIV that focus on infection control, intensified TB case finding and finding ways of implementing IPT.<sup>55</sup> In addition, TB/HIV partnership forum meetings have been held on a regular basis where there is an exchange of ideas with other players in the civil society.<sup>56</sup>

In terms of decreasing the burden of HIV among TB patients, there has been a move towards achievement of universal access to HIV testing between 2008 and 2010 (85% TB patients tested for HIV in 2011).<sup>57</sup> Similarly, the same trend has been observed for TB/HIV patients put on CPT. Modest improvements, were noted regarding the proportion of estimated incident TB patients commenced on ART.

The following development partners have been instrumental in providing technical and financial support to the National TB Programme between 2008 and 2009: GFTAM, CDC, WHO, TB-CAP, PSI and MSF (Belgium, Holland and Spain).

**Table 8: Progress in care and treatment of TB/HIV co-infection.**

Indicator	2008*	2009*	2010**
% /# of TB cases tested for HIV	45(18,310)	76 (35,886)	88 (40,714)
% /# of HIV positive TB cases	76 (18,310)	79 (28,507)	77 (31,538)
%/# of HIV positive TB cases put on CPT	79 (12,402)	74 (20,993)	87 (27,569)
%/# of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	10 (4,630)	18 (8,658)	23 (13,999)

\* öGlobal TB Control 2010ö by WHO reported the following estimated incident cases of TB/HIV; 43,000 in 2008 and 48,000 in 2009

\*\*ö Global TB Control 2011ö by WHO reported an estimated 60,000 incident cases of TB/HIV for 2010.

### 3.2.2.2.3 Challenges

Collaboration between the ART and TB programs still remain weak despite efforts to integrate activities. Meanwhile, TB infection control guidelines have not yet been finalized. Moreover, there were limited

<sup>55</sup> TB /HIV M & E Reports 2010 to 2011

<sup>56</sup> TB/HIV Partnership Forum Minutes 2010 to 2011.

<sup>57</sup> NTP Database, AIDS and TB Unit, MoHCW, March 2012

funds for procurement of Gene Xpert machines that would increase TB detection among patients with smear negative samples. In addition, there has been delayed adoption and adapting of WHO recommendations on IPT. Hence, there were no clients recorded in the database as having received IPT between and 2010 and 2011. ART coverage among incident TB/HIV cases is still very low taking into cognizance the fact that a significant number of health workers have been trained in TB/HIV collaborative activities. Due to the slow rate of implementation of M& E tools that can capture the ART data on TB/HIV clients promptly, figures for ART among TB patients are only reported late on the TB outcomes report.

#### **3.2.2.2.4 Recommendations**

Collaboration between NTP and ART programmes needs to be further strengthened so that activities that significantly reduce the burden of TB among PLHIV and the burden of HIV among TB patients can be promptly implemented. In addition, NTP and ART programmes need to collaborate in terms of implementation of the new M& E tools that can promptly capture CPT & ART data.

### **3.2.3 Support and Mitigation**

#### **3.2.3.1 Orphans and Vulnerable Children**

##### **3.2.3.1.1 Background**

About 1 million (National HIV Estimates 2010) children in Zimbabwe have lost one or both parents due to HIV and AIDS and related causes. Recent analyses indicate that over two-thirds of all children in Zimbabwe live below the food poverty line (ZIMVAC, 2010; and PASS, 2003) and are unable to access basic services such as health and education. The Government developed a National Action Plan for Orphans and Vulnerable Children (NAP for OVC) through the Ministry of Labor and Social Services in 2004 to increase reach to OVC with basic services.<sup>15</sup> The NAP-OVC programme managed to help 393 197 OVCs in 2009 and this constituted about 30% of the target group.

##### **3.2.3.1.2 Achievements**

NAP 1 managed to reach out to about 440 000 children with basic services (including food, medication, and psychosocial support) in 2010. The NAP 1 (2004 ó 2010) was superseded by NAP 2 (2011 ó 2015). NAP 2 aims to reach out to about 250 000 household with cash transfers by 2015 annually in addition to paying school fees for about 550000 primary school children and 200,000 secondary school children through BEAM annually. Between 2010 and 2011 there was successful documentation of OVC and their needs at village level in the OVC village/area register. Furthermore there was operationalization of ward

level child protection committees to deal with child protection issues and refer to relevant stakeholders for further assistance.

Under NAP 2 intervention moved from the individual child approach of NAP 1 to the family centered approach in 2011 therefore resulting in more children being catered for in programming.

**Table 9: Summary of BEAM beneficiaries 2010-2011.**

Year	Primary			Secondary			Grand Total
	Girls	Boys	Total	Girls	Boys	Total	
2010	270 201	267 393	537 594	98 591	98 405	196 996	734 594
2011	205 021	199 992	405 013	54 746	59 308	114 054	519 067

The funding sources for the NAP for OVC programme include the Government, Donors (Australia, the European Union, Germany, Netherlands, New Zealand, Sweden and the United Kingdom) and Global Fund. This multiple funding mechanism had a greater impact since efforts at both coordination and implementation were at the highest level.

### 3.2.3.1.3 Challenges

The high number of orphans and vulnerable children has resulted in available funding not meeting all the children's requirements. Limited number of vehicles in provinces and districts has resulted in some cases of child abuse being attended late. The lack of data bases on some special groups of children such as street children has resulted in poor budgeting. Staff attrition in Government Ministries has resulted in high professional to client ratio and also impacting on timeliness and quality of service for children especially those in need of probation services.

### 3.2.3.1.4 Recommendations

There is need for intensive resource mobilization to ensure that all children have access to basic social support including education and health. There is need for government to initiate staff retention schemes for critical staff.

### 3.2.3.2 Nutrition

#### 3.2.3.2.1 Background

Nutritional health is essential for PLHIV to get the most out of the period of asymptomatic infection, in order to mount an effective immune response to fight opportunistic infections and to optimize benefits of ART. The association of malnutrition with opportunistic infections which is further aggravated by HIV



and AIDS is a significant factor among adults but more severe among children. Furthermore, poor nutrition in children is associated with risk of children's faltered growth, impaired mental development and even death. The GoZ has supported therapeutic and supplementary feeding of children and adults living with HIV who suffer from severe and moderate acute malnutrition respectively.<sup>58</sup>

### **3.2.3.2.2 Achievements**

Therapeutic foods were procured and distributed via the Nutrition Unit of MoHCW to the malnourished children including those that were HIV infected. Health workers were trained in community management of acute malnutrition activities.

### **3.2.2.3.3 Challenges**

Environmental factors and low food production are associated with food and nutrition insecurity at household level. In addition, there is lack of a national strategy or policy addressing food and nutrition insecurity in vulnerable households with PLHIV. There is insufficient programmatic data on nutrition and other related interventions (e.g. food distribution) to ensure quality and comprehensive nutrition programming, decision-making and advocacy. Furthermore, unsustainable supply chain for nutritional commodities has been observed.

### **3.2.2.3.4 Recommendations**

Health sector capacity to address nutrition challenges among severely and moderately affected adults and children living with HIV will be further strengthened through trainings. To address severe cases of malnutrition in PLHIV and in particular children provision of therapeutic foods will be prioritized.

Households should be empowered and capacitated to become self reliant on food, through sustainable food production systems that take into account factors such as climate, geography, socio-economic systems and national legal framework for food production and investment. Collaboration between Ministry of Agriculture and civil society organizations will be vital in securing household food security.

Communities will be mobilized and educated on food and nutrition issues. Advocacy, educational and awareness materials will be developed, produced in languages most people can understand and disseminated countrywide. Service providers will be trained to provide nutritional counseling at household level.

### **3.2.2.4 Community Home Based Care (CHBC)**

#### **3.2.2.4.1 Background**

Community and home-based care (CHBC) is an integral component of the continuum of care and support. Services provided in Zimbabwe include palliative care, nursing care, counseling and psychosocial support, spiritual support, and nutrition and referral services. Provision of these services is premised on

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<sup>58</sup> MOHCW (2010) Guidelines on Dietary Management for PLHIV (2010) and MOHCW Policy Statement on Infant Feeding and HIV as well as Infant Feeding Guidelines for Health Workers were developed in 1999.

the partnership between government, civil society organizations, support groups of PLHIV and the communities themselves. The number of people receiving CHBC increased from 489,000 in 2008 to 697,000 at the end of 2009.

The nature of community CHBC service has evolved overtime given the impacts of ART on patients that were previously bed ridden are now ambulant. Consequently, new services have emerged based on demand such as promoting treatment adherence, addressing issues of stigma and providing social protection, and strengthening capacity of households to initiate and implement sustainable livelihoods.

#### **3.2.2.4 .2 Achievements**

CHBC kits were procured and distributed to the communities. Besides supporting the bedridden, activities aimed at promoting treatment adherence for PLHIV clients on ART and TB treatments and strengthening capacity of households to initiate and implement sustainable livelihoods were carried out. Trainings were conducted for CHBC providers

#### **3.2.2.4 .3 Challenges**

CHBC service providers have limited skills and experience. There is lack of standards and quality assurance for CHBC services. Inconsistent supply of CHBC kits and other supplies also pose challenges to the programme. In addition, there are weak referral and M& E systems of CHBC services.

#### **3.2.2.4 .4 Recommendations**

Community systems will be strengthened to support CHBC service delivery. Procurement and distribution of CHBC supplies to communities will be improved and service providers trained in its management. In improving efficiency and effectiveness of CHBC service delivery motorcycles will be considered and procured. A review of the CHBC monitoring tools will be conducted annually to ensure their continued relevance and practicality.

## 4.0 Best Practices

### 4.1 Leadership and political commitment

There was further strengthening of political commitment to respond to the HIV and AIDS epidemic between 2010 and 2011. Most of the Head of State addresses have had HIV and AIDS components. The head of State and Government, His Excellency, the President has each year made state of the nation address on HIV and AIDS and featured the topic during other state occasions. Meanwhile, commemorations for the World AIDS Day have been held annually at all levels including districts. The Head of State supported the Zimbabwe HIV conference held in September 2011 as he officially opened the event. The formation of Zimbabwe Parliamentarians against HIV and AIDS for the fight against HIV and AIDS was also supported by the President in 2011. The President's strong and exemplary leadership qualities on HIV issues have been cascaded to various levels of Government and the community at large as evidenced by high involvement of traditional, opinion leaders, political leaders including parliamentarians,<sup>59</sup> business persons and religious leaders in promoting open dialogue and speaking against risky behaviors and negative cultural practices that fuel HIV infection. Consequently, there are reports of reduction of risky sexual behavior.<sup>60</sup> In addition the GoZ has shown leadership by supporting

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<sup>59</sup> A platform for Parliamentarians called ZIPA to fight HIV/AIDS was formed in 2011 and launched by the President in 2012.

<sup>60</sup> L. Langhaung, R Buzdugan, J Dirawo et al An Evaluation of Zimbabwe National Behaviour Change Programme: Results of a mid-term Evaluation

NATF and providing funds directly from the national budget for HIV programming (e.g. US\$15 million was provided for BEAM).

#### **4.2 National AIDS Trust Fund (NATF)**

Funds collected via NATF which is 3% of all taxable income have been increasing over the years.<sup>61</sup> As a result, there is evidence of significant improvement in the percentage contribution of NATF in HIV programming between 2010 and 2011. About 50% of funds collected through NATF have been used for the procurement of ARVs. In addition, NATF funds have been used for procurement of HIV test kits, CD4 machines, Biochemistry machines and Laboratory consumables in support of HIV programmes.

The percentage contribution of NATF towards procurement of ARVs for the national cohort of PLHIV on ART between 2010 and 2011 stood at 24%. In the meantime, contributions from other sources were as follows: USG 22%, ESP 18%, GF 35% and CHAI 1%.

#### **4.3 Public Health Approach to HIV Programming**

The ART Programme continued with treatment guidelines that encourage the use of a single 1<sup>st</sup> line ART regimen. Clients who fail first line ART are also switched to a single 2<sup>nd</sup> line ART regimen. This approach results in simplification and reduction of costs related to procurement and supply of ARVs in the public health sector. A similar approach has been taken for choosing a single regimen for MER used in the PMTCT programme. In line with the public health approach, ART and PMTCT services have been integrated into Sexual and Reproductive health programme. Consequently, there has been further decentralization and geographic expansion of ART and PMTCT services to more sites.

#### **4.4 SRH and HIV integration**

HIV and AIDS cannot remain a vertical program; hence there is a need to integrate the HIV response with other programs. This is an approach that Zimbabwe has adopted and within the elimination of new HIV infections among children by 2015 agenda, PMTCT programming has taken steps to emphasize implementation of a comprehensive approach to Elimination of Mother to Child Transmission of HIV (eMTCT) that puts the client at the centre and focuses on the 4 prongs;

- Prong 1: reduce infections in women by 50%
- Prong 2: meet unmet family planning needs
- Prong 3: <5% vertical transmission rate
- Prong 4: reduce HIV-related maternal, newborn and child mortality

In pursuit of strengthening prong 2, Zimbabwe has conducted a rapid assessment of SRH and HIV linkages and a report is available. To take into account some of the recommendations, a SRH and HIV Integration Officer has been appointed to the MoHCW. As a best practice in this respect, the PMTCT training has been modified to adopt the Integrated Management of Adult Illnesses and Integrated Management of Pregnancy and Childbirth (IMAI/IMPAC) approach which places the care of an HIV positive mother and her HIV exposed baby in the context of pregnancy, labor and delivery, and postnatal care. Ultimately health care workers trained in this approach will know how to manage pregnancy, labor and delivery, and postnatal conditions in addition to being able to manage the HIV positive mother and

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<sup>61</sup> NAC Annual Reports 2009, 2010 and 2011.

her baby. In recognition of these country efforts, the Permanent Secretary of Health made a "best practice presentation" at the International Conference on AIDS and STIs in Addis Ababa in December 2011.

#### **4.5 Role of Primary Counselor in HIV Programming**

The role of the primary counselor cadre has been significant to HIV programmes in the context of an ever increasing burden of HIV and a static staff establishment in the public health sector. The primary counselor cadre has helped the health system to cope with the workload. A significant development occurred in April 2011 when primary counselors were allowed to perform HIV rapid testing if they receive the appropriate training. This has resulted in reduction in waiting time for HTC services at those sites where there are PCs trained in rapid HIV testing. This has further strengthened task shifting and task sharing in the health sector.

#### **4.6 HIV Testing and Counseling (HTC) Campaigns**

The HTC programme conducted provincial campaigns that resulted in massive uptake of testing and counseling services in Mashonaland West, Mashonaland Central, Mashonaland East and Manicaland between 2010 and 2012. This entailed HTC outreach activities 10 days prior to the commemoration of the World AIDS Day. Communities were noted to have responded to these campaigns favorably as evidenced by the large numbers of clients who visited clinics in the provinces where the campaigns took place afterwards.<sup>62</sup>

#### **4.7 Community mobilization through Traditional Circumcisers in Male Circumcision (MC) Programme**

There was collaboration between the MC programme and traditional circumcisers in massive community mobilization in those communities that are traditionally circumcising. Consequently, large numbers of clients were circumcised by health workers between 2010 and 2011.<sup>63</sup>

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<sup>62</sup> In the provinces where the campaigns took place there was a more than 5% increase in annual HTC figures based on the HTC Programme database, MoHCW.

<sup>63</sup> About 1200 clients were circumcised by Health Workers in Chiredzi in 2010 and 2300 in 2011 following community mobilization by Traditional Circumcisers based on the Male Circumcision database, MoHCW.

## **5.0 Major Challenges and Remedial actions**

### **5.1 Weak TB/ART Integration**

The integration of TB and ART activities has been weak between 2010 and 2011 resulting in missed opportunities in terms of ART initiation among TB and HIV clients. For example, ART coverage was at 55% among eligible HIV infected clients whilst an estimated 23% of estimated TB and HIV clients were on ART in 2010. Aggravating the situation is the fact that there has been slow roll out of M & E tools for tracking provision of ART among TB and HIV clients. To address this challenge, NTP and ART programmes need to further strengthen TB and HIV collaboration by quickly rolling out M & E tools for tracking provision of ART to TB and HIV clients. In addition, there is need to conduct more TB and HIV trainings in the context of Basic Integrated HIV Training as well as TB and HIV training. Both programmes should conduct joint support and supervision visits to sites to monitor and evaluate TB and HIV collaborative activities.

### **5.2 Human Resources Shortages**

Staff shortages were mainly due to high staff turnover which were further worsened by the fact that posts continued to be frozen in the public health sector between 2010 and 2011. Moreover, the staff establishment was last reviewed in the early 1980s. Meanwhile, the country's population has almost doubled since the early 1980s whilst the staff establishment has remained static resulting in further workload among health workers. Further increasing the workload among health workers are HIV related

ailments which are linked to the top 5 causes of consultations in the health sector. There is need for more funds to be allocated to the health sector according to the Abuja Declaration so that there will be resources to improve the working conditions of health workers. If adequate resources are mobilized staff establishment will be reviewed, vacant posts will be filled and subsequently new posts created.

Global Fund Round 5 which supported a lot of staff in the health sector came to an end in June 2010.

### **5.3 Inadequate Funding for the national HIV/AIDS response**

Funding gaps have led the national ART programme to adopt and implement targets for 2010 and 2011 below universal coverage in terms of ART provision in adults and children. Gaps in terms of funding were further widened when Zimbabwe adopted the 2010 WHO ART guidelines in terms of CD4 thresholds for initiating ART in both adults and children resulting in the doubling of the number in need of ART. In addition, adoption of the TDF based regimen (twice as expensive compared to D4T based regimen) recommended by WHO in 2010 in adults broadened the gap in terms of funding. Consequently, a phased approach was taken in terms of transitioning adults from D4T to TDF based regimens due to limited funds. The pending expiry of Global Fund Round 8 in 2014 presents further resource challenges in future. There is need to broaden the tax base by ensuring that the informal sector contributes to the AIDS levy. Besides resource mobilization for domestic funding, there is need to resource mobilize from international partners to fill the gaps that have been identified in terms of HIV programming.

### **5.4 Lack of an Integrated Database for HIV Programmes**

There was no integrated database for tracking clients' referrals across all Health Sector programmes. As a result, clients are often lost across health sector programmes. Besides resource mobilizing to fund an integrated database to track clients' referrals, programme managers in the health sector should be firmly committed to make the patient tracking system a success.

## 6.0 Support from the Country's Development Partners

### 6.1 Key Support Received

The major sources of international funding for HIV programming from 2009 to 2011 were Global Fund, UN Agencies, bilateral (including USG, Expanded Support Programme, DFiD, European Commission), International NGOs (Not-for-Profit Organizations) and other multilaterals as shown in table 9 below.

**Table 10: International Sources of HIV Funding**

<b>International Sources of HIV Funding</b>			
	<b>2009</b>	<b>2010</b>	<b>2011</b>
Bilaterals	24,868,885	15,388,067	33,113,031
UN Agencies	7,452,677	17,972,300	27,240,021
Global Fund	8,545,029	66,042,408	26,233,338
For-Profit Institutions	7,617,170	30,005	0.00
Development Banks	259,044	30,000	0.00
Not-for-Profit Organizations	4,516,155	13,577,964	11,471,751
Other Multilaterals	1,028,398	658,280	16,528,578



<b>Total International HIV Funding</b>	<b>54,287,358</b>	<b>113,699,024</b>	<b>114,586,719</b>
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Meanwhile, there was a significant increase in support received from the Global Fund which was explained by the fact that Global Fund Round 5 funds were utilized to implement activities in 2009 followed by the Global Fund Round 8 Phase 1 (GF R8 P1) between 2010 and 2011. GF R8 P1 funds were used for the HIV programmes in Zimbabwe for interventions in all areas of HIV response and for building the capacity of NGOs. Human resources are critical to the success of the HIV response, hence a component of the GF funds were utilized for staff retention. However, funding remained far short of the country's resource needs in relation to the magnitude of the epidemic and capacity of the economy to sustain the response.

USG funded critical components of the HIV prevention programmes that included HIV testing and counseling (HTC), PMTCT, Condoms and Male Circumcision. Funds were further committed to the procurement of ARVs for 59 000 clients in 2010 and 80 000 clients in 2011. Besides supporting the supply chain management for the procurement and supply of HIV commodities, the USG also supported retention schemes for key staff.

The ESP contributed US\$47 million in the 3-year period (2009 -2011). This funding supported the following numbers of ART clients: 48 000 in 2009; 60 000 in 2010 and 80 000 in 2011. In addition, the ESP funding supported prevention programmes, coordination and retention scheme for health workers involved in HIV programmes.

UN agencies supported all components of the HIV response and funding increased between 2009 and 2011. International NGOs like EGPFAF, CHAI, MSF (Belgium, Holland and Spain), PSI and others played important roles in funding HIV response between 2009 and 2011.

The Programme of Support (PoS) for NAP 1 contributed US\$35 million in 2010 whilst NAP contributed US\$16,600,000 million in 2011. The funding was used for supporting cash transfers for vulnerable households as well as assisting OVC with education, healthcare, birth registration, HIV and AIDS prevention, treatment.<sup>64</sup>

## **6.2 Actions that need to be taken by Development Partners to ensure Achievement of UNGASS targets.**

Development partners need to work with the GOZ guided by the Zimbabwe National AIDS Strategic Plan ZNASP 2011-2015 and other national strategic plans in identifying funding gaps for HIV and AIDS programmes. Following this, development partners need to align themselves behind the objectives of ZNASP 2011-2015 and undertake coordinated mobilization of resources in collaboration with the GoZ. Development partners need to coordinate, simplify procedures and share information to avoid duplication according to the Paris declaration on AID effectiveness (2005) and the Accra Agenda for Action (2008).

<sup>64</sup> NAP-OVC Programme Database, MoLSW

Furthermore, the focus by development partners should be on delivering measurable impact results in terms of the HIV epidemic in Zimbabwe. To achieve this, a monitoring system to assess progress and ensure that donors and GoZ hold each other accountable for their commitments should be put in place. Additionally, development partners should build capacity of Zimbabwe to manage her own future regarding HIV response.

## **7.0 Monitoring and Evaluation Environment**

### **7.1 Overview of the current Monitoring and Evaluation (M&E) System**

The country subscribes to the "three ones" principle which entails; one national strategic plan, one national coordinating body and one national M&E system. The national M&E system is coordinated and maintained by the National AIDS Council (NAC). In addition, the M & E system is an integral part of the national response on HIV and AIDS as it provides a platform for systematic monitoring and evaluation of the strategic goals ZNASP 2011 - 2015. NAC with support from the multi-sectoral National Research, Monitoring and Evaluation Advisory Group (NRMEAG) developed the National Monitoring and Evaluation plan in 2011. The M&E plan guides all stakeholders in effective measurement of inputs, outputs, outcomes, and impact of ZNASP 2011 - 2015. Furthermore, the plan enables Zimbabwe to periodically monitor implementation and measure progress towards the achievement of both national targets and international commitments in the national response to HIV and AIDS.

Besides the routine programme monitoring, several population surveys form part of the national M&E system to provide a tracking system for outcome and impact indicators. The surveys periodically conducted in Zimbabwe include Antenatal Clinic Sentinel Surveillance, Behavioral Surveillance, Demographic Health Surveys (DHS), Census, Special Health Facility surveys and other national level programme-based surveys.

### **7.2 Achievements**

The country managed to conduct the Demographic Health Survey (DHS) in 2010 ó 2011 whose results will be published in 2012. Other surveys such as the National AIDS Spending Assessment (NASA)

survey for 2010, Early Warning Indicator (EWI) survey and high-risk group surveys (Prisons study) were also conducted in 2011. In addition the following achievements were made in 2011:

- Capacity building of NAC and Implementers in Data verification (Routine Data Quality Assessment), monitoring and evaluation of HIV and AIDS programmes, operational research and data analysis.
- Institutionalization of ART Cohort Studies.
- Development of HIV and AIDS national research priorities.
- Adoption and institutionalization of Routine Data Quality Assessment (RDQA).
- An improvement in the reporting rate by partners from 72% in 2010 and 83% in 2011.

### **7.3 Challenges and Remedial Actions**

#### **7.3.1 Absence of M & E structures and personnel in other sectors**

The public, private and civil society has no M & E structures and qualified personnel to carry out M & E duties. There is need to train more M & E officers in the government, civil and private sectors. The health sector needs to train the existing Health Information Officers so that they assume M & E duties, since they work with health information.

#### **7.3.2 Reporting rates by implementing partners below planned target**

Reporting by partners is not at the expected level of 100%. There is need for a legislation to foster mandatory registration and reporting by implementing partners.

#### **7.3.3 Quality of data collected in programme monitoring**

The challenges faced in data quality are incompleteness due to low reporting rates and inconsistencies in reporting by implementers. Lack of M & E capacity by implementers to interpret indicators and overwhelming workload for health staff has negatively compromised the quality of data. The health sector data is affected by lack of training and supervision among staff collecting and capturing data. There is need to train health staff in M & E in order to improve quality of reports.