Zimbabwe

UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION REPORT on HIV AND AIDS

FOLLOW-UP TO THE DECLARATION OF COMMITMENT ON HIV and AIDS

ZIMBABWE COUNTRY REPORT

Reporting Period: January 2008 to December 2009

1.0 Table of Contents

Acronyms

Acquired Immuno-deficiency Syndrome	AIDS
Antenatal Care	ANC
Antiretroviral drugs	ARVs
Antiretroviral therapy	ART
Basic Education Assistance Module	BEAM
Blood Transfusion Services Zimbabwe	BTSZ
Department for International Development	DfID
Central Statistical Office	CSO
Canadian International Development Agency	CIDA
District AIDS Coordinator	DAC
District AIDS Action Committee	DAAC
Estimation and Projection Package	EPP
Expanded Support Programme	ESP
Global Fund to Fight against AIDS, TB and Malaria	GFATM
Human Immuno-deficiency Virus	HIV
Home-based Care	HBC
Information, Education Communication	IEC
John Snow International	JSI
United Nations Joint Programme on HIV/AIDS	UNAIDS
Knowledge, Attitudes and Practice	KAP
Monitoring and Evaluation	M&E
Ministry of Education, Sport, Arts and Culture	MoEASC
Ministry of Finance	MoF
Ministry of Health and Child Welfare	MoHCW
Ministry of Labour and Social Services	MoLSS
National AIDS Council	NAC
National Action Plan for Orphans and Vulnerable Children	NAP for OVC
Opportunistic Infections	OI
Population Services International	PSI
Prevention of Mother to Child Transmission	PMTCT
Primary care counselors	PCCs
Sexually Transmitted Infections	STIs
Swedish International Development Agency	SIDA
Tuberculosis	TB
United Nations Children Fund	UNICEF
United Nations General Assembly Special Session	UNGASS
United Nations Population Fund	UNFPA
United States Agency for International Development	USAID
Voluntary Counselling and Testing	VCT
Zimbabwe AIDS Network	ZAN
Zimbabwe Business Council on HIV/AIDS	ZBCA
Zimbabwe Demographic and Health Survey	ZDHS
Zimbabwe National Family Planning Council	ZNFPC
Zimbabwe National Network for People Living with HIV	ZNNP+

2.0 Status at Glance

Zimbabwe is one of the 189 countries that have committed themselves to a comprehensive programme of national commitment and action to fight the HIV/AIDS epidemic by adopting the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS of June 2001. The Declaration of Commitment established a number of goals for the achievement of specific quantifiable and time-bound targets, including reductions in HIV infection among infants and young adults; improvement in HIV/AIDS education; health care and treatment; improvement in orphan support. During the period from January 2008 to December 2009, the country was able to conduct a performance evaluation on seventeen out of the twenty-five UNGASS indicators.

2.1 Report Writing Process

This is the fourth report that Zimbabwe is submitting to UNGASS and the lessons learnt from compilation of previous reports led to significant improvement in this report. The National AIDS Council coordinated the compilation of this report with support from the UNAIDS country office. The country setup an UNGASS Technical Working Group (TWG), composed by 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. The engaged a consultant who compiled the report. TWG created an enabling environment for the data gathering process. The TWG was chaired by. Meetings were held with the civil society and sector ministries, local and bilateral organizations as well as a desk review of available documents. The zero draft of the report was presented during the final meeting with stakeholders.

2.2 Status of HIV Epidemic

Zimbabwe is one of the countries in Sub-Saharan Africa that have been worst affected by the HIV and AIDS epidemic with a projected population of 12 million people.[1] The estimated HIV prevalence among adults 15 years and above was 14.3% according to the National HIV Estimates of 2010.[2] There were an estimated 1, 187, 822 adults and children that were living with HIV and AIDS in 2009. Meanwhile, an estimated population of 389 895 adults and children were in urgent need of antiretroviral therapy by the end of 2009.[2] above

The decline in HIV prevalence was projected to have started in the late 1990's according to the 2010 version of spectrum.[2] 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 pregnant women (15-49 years), HIV prevalence declined from 17.7% in 2006 to 16.1% in 2009.[2] In the adult population(15 years and above), using the current 2009 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 14.3% in 2009.[2] The epidemic in Zimbabwe is believed to be declining as result of prevention programmes, in particular behaviour change and Prevention of Mother to Child Transmission (PMTCT), as well as impact of mortality.[2]

1. Central Statistical Office Population Projections 2009
2. Ministry of Health and Child Welfare, Zimbabwe National HIV Estimates 2009

2.3 Response to HIV and AIDS Epidemic

Based on the Zimbabwe National and HIV AIDS Strategic Plan (ZNASP 2006-2010) that was launched in July 2006, the Government of Zimbabwe has continued to scale up the multi-sectoral response to HIV and AIDS.[3] In 2008 Mid Term Review of the ZNASP (2006-2010) was conducted[4]. Meanwhile, Government and all stakeholders have continued to urgently mobilize the required resources in order to fight the epidemic according to the strategic plan taking cognizance of the fact that response to HIV and AIDS is a national emergency.

ZNASP has universal access to care and treatment as one of the key goals of the strategic plan. In the period 2008-2009, Zimbabwe has continued to scale up access to care and treatment for HIV, AIDS and related opportunistic infections. The number of patients on ART increased from 99 408 (9 594 children) at the end of 2007 to 148 144 (13 278 children) in December 2008 and 218 589 (21 521 children) by end of December 2009. The 2009 number represents 56.1% of adults and children needing treatment. This increase reflects the efforts that the Government of Zimbabwe and partners are making in a resource constrained environment.

The number of children orphaned and made vulnerable by the impact of HIV and AIDS in Zimbabwe remains high. The approximate number of HIV and AIDS orphans in Zimbabwe in 2007 was 1 043 715, whilst estimates for 2008 and 2009 were 1 025 472 and 989 009 respectively.[2] The National Action Plan for Orphans and Other Vulnerable Children (NAP for OVC, launched 2005) continues to be the strategic guide to the care and support of orphans and vulnerable children in Zimbabwe.

Heterosexual contact is the principal mode of HIV transmission in Zimbabwe. The level of knowledge about HIV and AIDS prevention was high with 75.7% women (15-49 years) and 81.3% men (15-54 years) who knew that condoms could be used to reduce the risk of getting HIV according to the Zimbabwe Demography and Health Survey (2005/06). In the Multiple Indicator Monitoring Survey (MIMS) 2009 preliminary report, it was reported that 50.5% women of 15 to 19 years and 56.4% women of 20 to 24 years knew 2 ways of preventing HIV transmission, but there was no assessment that took place among men in the same age groups. However, the results of the ZDHS 2006/07 are not comparable to the MIMS 2009 for trend analysis since the age groups and sampling frames used were different.

Zimbabwe put in place a National Behavior Change Strategy[5] (NBCS) covering a defined period (2006-2010) in recognition of the need to move from awareness to action. This plan provides guidance to all stakeholders on their contributions to behavior change promotion using key prevention elements such as condom use, reducing multiple concurrent partners and promoting faithfulness as ways of addressing underlying causes for risk behaviors. In addition, a baseline behavior change survey was conducted in 2007-2008 and it will act as reference point in terms of the performance of the NBCS (2006-2010).

The second most important mode of HIV transmission is peri-natal and occurs when the mother passes HIV to the child during pregnancy, at birth or during breastfeeding. Included in the NBC

[3] Zimbabwe National HIV and AIDS Strategic Plan 2006-2010
[4] Zimbabwe National HIV and AIDS Strategic Plan 2006-2010 Mid Term Review, July 2009
[5] Behavior Change Baseline Survey 2007/2008

strategy are plans to reduce the incidence of HIV infection especially among youth 15-24 years of age and scale up of prevention strategies such as Prevention of Mother to Child Transmission of HIV (PMTCT).

The country was able to fund its response to HIV and AIDS through domestic and international sources of finance. Zimbabwe signed the Abuja declaration of 1998, where governments committed that a minimum of 15% of total government budget should be go towards health care for the nation. It is in the spirit of this commitment that the Zimbabwe Government (GoZ) introduced the National AIDS Trust Fund (also called AIDS Levy) which collects 3% of all taxable individual and corporate income to fund HIV and AIDS programmes. The AIDS Levy contributed 2 588[6] in 2007, 8 148 2008[7] and 5 143 108[8] in 2009.

The Government of Zimbabwe through Ministry of Finance contributed US $ 10 596 393.00 in 2007[9], US $ 354 661 in 2008 [10] and US $ 7 700 453 in 2009 towards HIV and AIDS programs.[11] The Ministry of Finance's budgeted expenditures include the National AIDS Levy.[12] These amounts reflect the GOZ commitment in terms of AIDS funding. In support of government efforts, bilateral and multilateral partners as well as international foundations contributed US $ 35 351 861.84 in 2007[9], US $ 24 987 127.00 in 2008[13] and US $ 37 796 697.00 in 2009 towards HIV and AIDS programs (basing on data collected by the time of compiling this report).[14]

The table below shows trends in achievement for specific indicators for 2005, 2007 and 2009.

[6] 3% of figure reported as disbursed by Ministry of Finance for HIV/AIDS in the year
[7] Conversion from Zimbabwe dollar currency to US dollars was based on average UNDP rate for the year 2008.
[8] NAC Annual Financial Report, 2009
[9] National AIDS Spending Assessment Report for 2006 and 2007
[10] Conversion from Zimbabwe dollar currency to US dollars was based on average UNDP rate for the year 2008
[11] Government of Zimbabwe, Ministry of Finance, Budget Estimates and Amounts Spent 2007-2009
[12] National AIDS Trust Fund is a 3% levy collected from taxable income from all sectors to mitigate the impact of HIV and AIDS and is channelled to the National AIDS Council by the Ministry of Finance
[13] Reporting on 2008 funding matrix by Bilaterals, Multilaterals and International Foundations for Zimbabwe UNGASS 2010 Report (as at reporting time)
[14] Reporting on 2009 funding matrix by Bilaterals, Multilaterals and International Foundations for Zimbabwe UNGASS 2010 Report (as at reporting time)

2.4 Table 1: Status at a glance – indicator data

National Commitment and Action	2005	2007	2009
1. Domestic and International Spending by categories and financing sources (USD).	16 200 000	54 508 408.00	79 323 462.29
2. National Composite Index (NCPI).	UNGASS 2005 Report NCPI: Annex I	See Annex 2 NCPI: Part A & B	See Annex 2: Part A & B
National Programs:	**2005**	**2007**	**2009**
3. Percentage of donated blood units screened for HIV in a quality assured manner.	100 % [NBTS]	100 % [NBTS]	100 % [NBTS]
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.	8.3% (Adults only) [MOHCW, ART data base]	26.5% [MOHCW, ART data base]	56.1% [MOHCW, ART data base]
5. Percentage of HIV positive pregnant women who received Antiretrovirals to reduce the risk of mother-to-child-transmission.	6.6% [MOHCW,PMTCT Data Base]	22.0% [MOHCW,PMTCT Data Base]	42.6% (2008) [MOHCW, PMTCT Data Base]
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV.	Not required	2.4% [MOHCW, NTBP Data Base]	4.4% (2008) [MOHCW, TB Data base]
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.	Not required	5.9%	No current data
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and know their results.	Data not available	Data not available	Data not available
9. Percentage of most-at-risk populations reached with prevention programs.	Data not available	Data not available	Data not available
10. Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child.	43% (MICS 2004)	31.2% [ZDHS]	20.9% [MIMS 2009]
11. Percentage of schools that provided life skills based HIV education in the last academic year.	Not required	100% [MoESC]	100% [MESC]

Knowledge and Behavior	2005	2007	2009
12. Current school attendance among orphans and among non-orphans aged 10-14.	Not required	**Orphans** 87.9% **Non-Orphans** 92.4% [ZDHS]	Data not available Data not available
13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention.	55.0% (both sexes, PSI)	Men 45.6% Women 43.7% [ZDHS	72.3% (Both Sexes, PSI Database 2009)
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention.	Data not available	Data not available	Data not available
15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.	8.3% [MICS 2004]	Men 4.5% Women 5.3% [ZDHS]	Men 4.5% Women 5.0% [NBBS]
16. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.	Not required	Men 14.1% Women 1.3% [ZDHS]	Men 28.3% Women 9.0% [NBCSBS]
17. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months reporting the use of a condom during the last sexual intercourse.	Not required	Male 71.1% Female 46.8% [ZDHS]	Data not available
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client.	Not required	Men 42.3% Women 38.3% [NBCSBS]	Men 42.3% Women 38.3% [NBCSBS]
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.	Not required	Data not available	Data not available
20. Percentage of injecting drug users reporting the use of a condom the last time they sexual intercourse	Not required	Data not available	Data not available
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	Not required	Data not available	Data not available

Impact	2005	2007	2009
22. Percentage of young women and men aged 15-24 who are HIV infected	17.0% [CDC/MoHCW]	13.1% [ZDHS]	5.1%
23. Percentage of most at risk populations who are HIV infected	Not required	Data not available	Data not available
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Data not available	93.1% [MOHCW, ART Database]	75.0% [Global Fund R-5 Cohort Analysis Survey]
25. Percentage of infants born to HIV infected mothers who are infected	24.0 % [MoHCW ART Database]	32.3% [MoHCW Database]	30.0% [MoHCW Database]

3.0 Overview of the AIDS Epidemic

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 14.3 %in 2009[2]. The adult HIV prevalence peaked in 1997 at 26.5% (Figure 1). Prevalence for males 15-24 peaked in 1993 at 10.6%. Similarly, in females the prevalence peaked at 26.0% in 1995 (Figures 2 and 3).[2]

In 2005, the MOHCW commissioned an epidemiological review to ascertain the decline in HIV prevalence in the country. Consequently, a report was published in November 2005 and from the gathered data from several studies there was support for the decline in HIV prevalence that had started in the late 1990's.[15] 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 attributed the decline in HIV prevalence and incidence to change in sexual behavior specifically a decrease in number of sexual partners, increased condom use and mortality.

A decline in HIV prevalence among all pregnant women (15-49 years) in 2004 was first reported by the Ministry of Health and Child Welfare. This trend continued in 2006, 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, 15-49 years. Similar trends were also observed among younger pregnant women (15-24 years) where prevalence declined from 20.8% in 2002, 17.4% in 2004, 12.5% in 2006 to 11.6% in 2009[2]. The above downward trend in HIV prevalence among women 15-24 may be depicting a concomitant decline in HIV incidence in the population.

Decline in HIV Prevalence

- ***Adult population 15+ years*** ⟶ ***16.1% (2007), 15.1% (2008), 14.3%(2009)***
- ***Pregnant young women 15-24years*** ⟶ ***12.5% (2006), 11.6% (2009)***

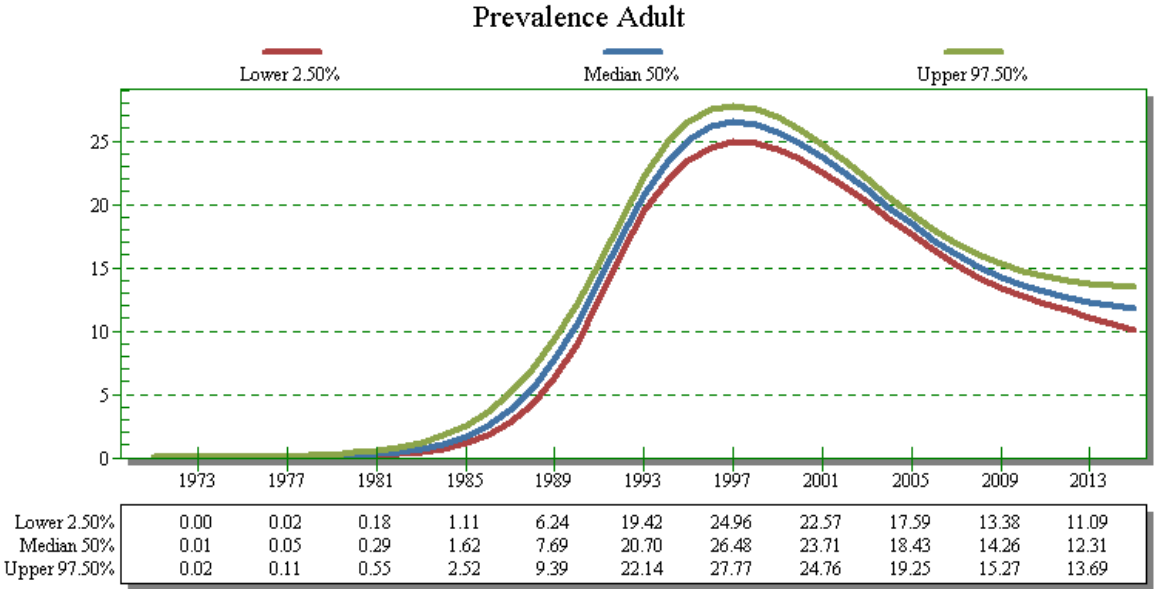
(National Survey of HIV and Syphilis Prevalence among Women Attending Antenatal Clinics in Zimbabwe, 2009)

Table 2: Adult and children HIV prevalence[2]

	2007	2008	2009
Adult prevalence (15+ years)	16.1% (15.2 – 16.9)	15.1% (14.2 – 16.0)	14.3% (13.4 – 15.3)
Prevalence males (15-24)	3.3% (2.5 – 4.7)	3.3% (2.5- 4.5)	3.2% (2.5 -4.4)
Prevalence females (15-24)	7.6% (5.9 -10.3)	7.2% (5.6 – 9.5)	6.9% (5.3 – 9.0)
Prevalence chn (0 -14)	3.3% (2.0 -4.4)	3.2% (1.9 -4.2)	3.1% (1.8 -4.1)

[15] Evidence for HIV Decline in Zimbabwe, a comprehensive review of the epidemiological data, UNAIDS 05.26E

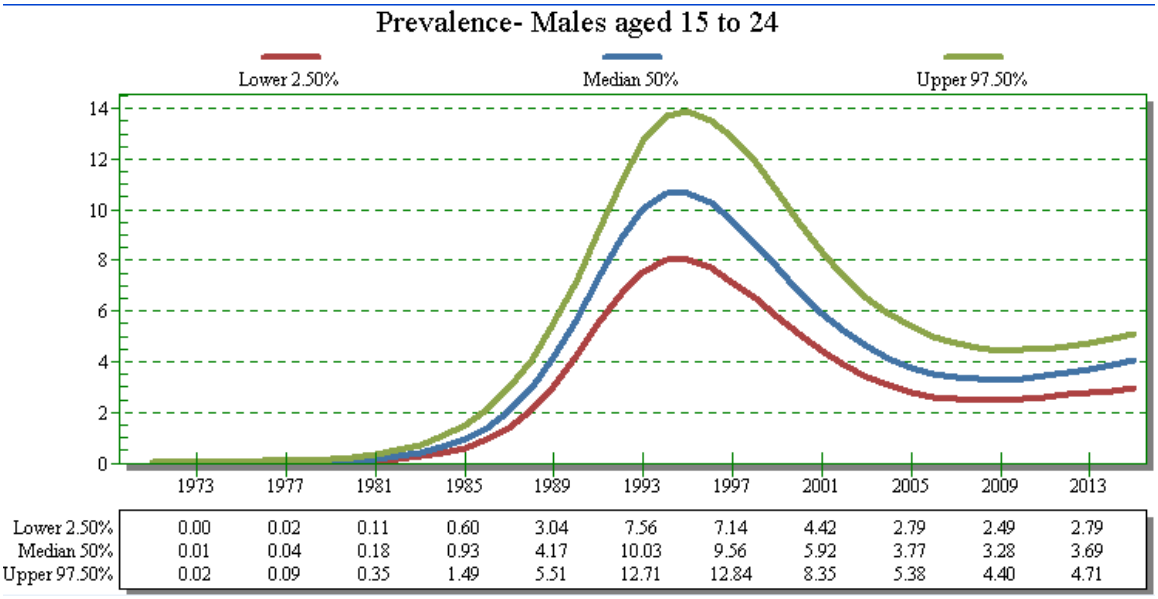
Using the 2009 version of Spectrum (Table 2), the adult HIV prevalence was 16.1 % in 2007 and has decreased to 15.1% in 2008 and decreased to 14.3% (figure 1) by the end of 2009.[2] The estimates presented on child prevalence are based on PMTCT data inputs and may underestimate prevalence due to insufficient data inputs.[2]



	1973	1977	1981	1985	1989	1993	1997	2001	2005	2009	2013
Lower 2.50%	0.00	0.02	0.18	1.11	6.24	19.42	24.96	22.57	17.59	13.38	11.09
Median 50%	0.01	0.05	0.29	1.62	7.69	20.70	26.48	23.71	18.43	14.26	12.31
Upper 97.50%	0.02	0.11	0.55	2.52	9.39	22.14	27.77	24.76	19.25	15.27	13.69

Figure 1: Trends in Adult HIV Prevalence, Zimbabwe 1970-2015. [2]

The prevalence of HIV infection peaked to 10.6% (figure 2) in 1995 among males aged 15 to 24 years.[2] In women aged 15 to 24 years, prevalence also peaked in 1995 at 26% (figure 3).[2] Declining trends in HIV prevalence have been noted in both males and females aged 15 to 24 years from 1995 to 2009.[2]



	1973	1977	1981	1985	1989	1993	1997	2001	2005	2009	2013
Lower 2.50%	0.00	0.02	0.11	0.60	3.04	7.56	7.14	4.42	2.79	2.49	2.79
Median 50%	0.01	0.04	0.18	0.93	4.17	10.03	9.56	5.92	3.77	3.28	3.69
Upper 97.50%	0.02	0.09	0.35	1.49	5.51	12.71	12.84	8.35	5.38	4.40	4.71

Figure 2: Trends in Male (15 -24) HIV Prevalence, Zimbabwe 1970-2015.[2]

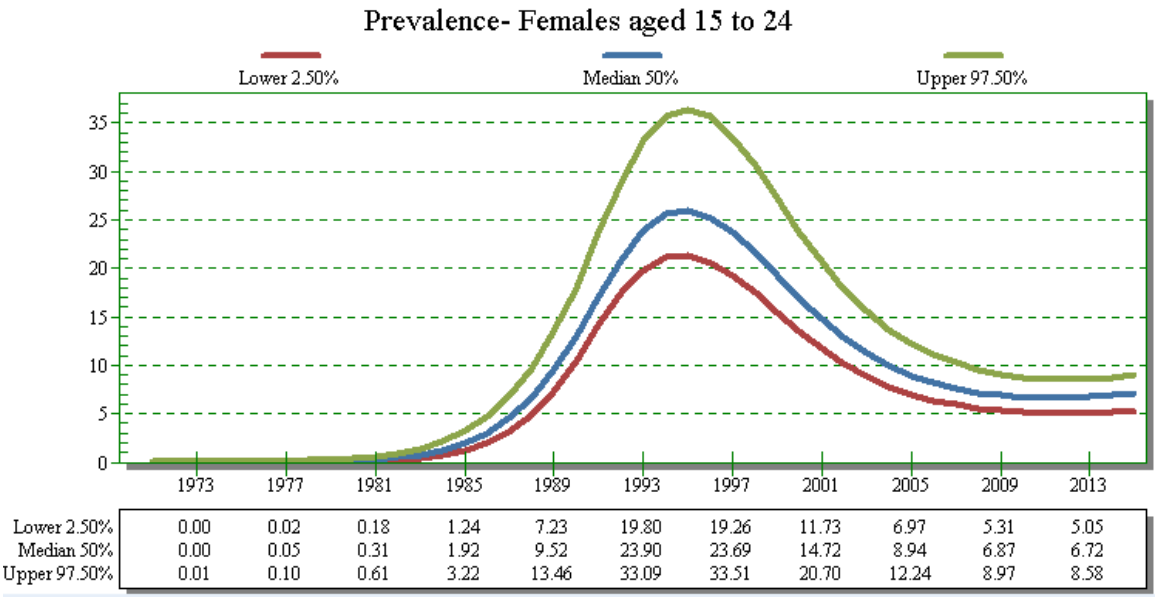


Figure 3: Trends in Female (15 -24 years) HIV Prevalence, Zimbabwe 1970-2015.[2]

It was estimated that 1 187 822 (Table 2) adults and children were living with HIV and AIDS at the end of 2009.[2] Children below 15 years that were HIV infected in 2009 were nearly ten percent at 152 189.[2] There was however a slight decrease in number of HIV infected children in 2009 reflecting increased mortality as a result of limited access to ART. The proportion of women living with HIV and AIDS remained at 60% in 2008 and 2009 respectively.

Table 3: Estimated number of people living with HIV and AIDS[2]

	2007	2008	2009
HIV Adults + Children	1 282 635 [1 172 172 – 1 405 397]	1 226 781 [1 116 389 – 1 352 221]	1 187 822 [1 077 436 – 1 311 372]
HIV Adults 15+	1 117 959 [1026 864-1 232 384]	1 068 011 [967 435-1 181 133]	1 035 633 [944 940- 1 154 464]
HIV 15+ female	667 122 [572 066-758 530]	638 677 [543 548-730 174]	619 781 [524 590-714 571]
HIV population-Children	164, 676 [101,725– 214 153]	158 770 [972492-207 185]	152 189 [92 616-199 259]

4.0 National Response to the AIDS Epidemic

4.1 Zimbabwe Policy Response

4.1.1 National and International Policies Guiding the Response

The Government of Zimbabwe has continued to demonstrate commitment and leadership on the national response to HIV and AIDS. The country still has a National AIDS Council (NAC) established by an Act of Parliament in 1999, which has a broad-based mandate to provide for measures to combat the spread of HIV. In 2008, changes were made to the inclusive 14-member NAC Board to include representation from labour, business sector and People Living with HIV (PLHIV) and increase representation of women from two to three.

The recommendations of the ZNASP MTR are providing important policy guidance to the response. The strategic recommendations include harmonization of programme area strategic plans to be in sync with the national strategic plan, strengthening coordination for and enhancing prevention efforts, improve ART commodity supply, enhance sustainability in mitigation interventions, intensify resource mobilisation and improve human resource capacity.**Error! Bookmark not defined.** These recommendations provide interim strategic guidance to the response while the country prepares for the development of a new national strategic plan.

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.
- Review of current policy, strategic documents and legislature so that these are in line with the current situations. The committee had significant input in the ZNASP MTR and it is in the process of reviewing the 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 Offenses Act and the Child Adoption Act all of which have relevance to HIV/AIDS.
- Tracking the implementation of the policies and legislation through site visits to interview beneficiaries.

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 organisations which are involved in advocacy and implementation in some programme areas. In 2008-2009 Zimbabwe saw a growth in the voice of networks of people living with HIV and AIDS.

4.1.2 Funding the Response

Various funding mechanisms enabled Zimbabwe to fund its HIV and AIDS response. The GOZ raised funds through the national budget and National AIDS Trust Fund (NATF). NATF is a 3% levy collected from taxable income from all sectors to mitigate the impact of HIV and AIDS and is channeled to NAC by the Ministry of Finance. The Government of Zimbabwe through the national

budget contributed US $ 10 596 393.00 in 2007[16], US $ 354 661 in 2008 and US $ 7 491 453 in 2009[17] towards HIV and AIDS programs. The bulk of the funds are channeled to the Ministry of Health and Child Welfare and the rest to other government ministries for their workplace programmes. The AIDS levy contributed US$8 148[7] in 2008 and US$5 143 108[8] in 2009. At least 50% of these funds were used for procurement ARVs whilst the rest goes to other programmes and administrative support for coordination. The AIDS Levy was essentially non-existent in 2007-2008 due to economic challenges the country was facing. Since dollarization of the economy in Feb 2009 Monthly income stream has been improving significantly.

The bilateral and multilateral partners as well as international foundations contributed US$35 351 861.84 in 2007, US$24 987 127.00 in 2008 and US$37 796 697.00 in 2009 towards HIV and AIDS programs[18]. These amounts may not reflect the true total financial contribution from the international sources for these years, as not all of them responded to the request for information.

In 2006 NAC was responsible for the management and disbursement of the GFTAM Round 5, which involved a total of US$60,000,000 for a period of four years from 2005 to 2009. 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 US $ 6 983 278.00 in 2007 and US $ 14 309 722.00 in 2009, leaving a funding gap in 2008[19].

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$42 million was committed for the period 2007-9, of which 50% was earmarked for care and treatment. Prevention accounted for 12% of the ESP budget, while 10% was allocated to M&E.

ESP supported activities in 16 districts of Zimbabwe with emphasis on the interdependency and mutually reinforcing effect of services and activities related to prevention, care and treatment, and mitigation with the aim to address some of the obstacles to accessing HIV/AIDS services at district level. This approach added value to existing programs, by adopting community home based care (CHBC) programs, TB treatment and PMTCT as entry points for ART, and encouraging PLWHA, including those on treatment, to become prevention activists[20]

The mitigation programme for OVC received significant funding from the Programme of Support (PoS), a pooled donor funding set up to finance implementation of the NAP for OVC. The fund The PoS committed US$84 million for 3-years funding for 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[21].

[16] National AIDS Spending Assessment Report for 2006 and 2007
[17] Government of Zimbabwe, Ministry of Finance, Budget Estimates and Amounts Spent 2007-2009
[18] Reporting on 2009 funding matrix by Bilaterals, Multilaterals and International Foundations for Zimbabwe UNGASS 2010 Report
[19] ZNASP 2006-2010 MTR, July 2009
[20] OI/ART Programme 2008 Annual Report, AIDS & TB Unit, MOHCW
[21] Programme of Support to the National Action Plan for Orphans and Vulnerable Children in Zimbabwe Annual Report, June 2009.

4.1.3 Legal and Policy Instruments

Zimbabwe has over the years crafted and passed bills that help uphold the rights of the most vulnerable people in the country. For example the Criminal Procedure and Evidence Amendment Act No. 8 of 1997 was drafted in response to the increase in numbers of cases of sexual abuse of minors. Consequently, 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. In 2007 the Government of Zimbabwe enacted the Domestic Violence Act, which criminalises all forms of violence such as psychological, physical and sexual. The Child Adoption Act (2006) allows for HIV testing in children up for adoption. The legislation to date has been aimed at protecting those who are often vulnerable in society, including women, children, orphans and people with disabilities.

4.1.4 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. Nonetheless, these policy and regulatory guidelines are unclear in terms of protecting sub-populations such as men having sex with men (MSM), intravenous drug users (IDU) and commercial sex workers (CSW). Hence, 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 organisations 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 Zimbabwe National HIV and AIDS Strategic Policy 2006-2010, one of the guiding principles is that the needs of vulnerable populations including mobile and migrant populations should be prioritized and addressed. A major highlight of the ESP is the support to the International Office of Migration (IOM) for purposes of mitigating the impact of HIV and AIDS and providing humanitarian assistance to migrant workers in the agricultural, mining, uniformed services, construction and transport industries, as well as cross-border traders and mobile and vulnerable populations (MVPs)[22].

[22] IOM Programme Report, March 2009

IOM provided HIV/AIDS services to a total of 1 073 572 of most-at-risk populations (MARPS) in 2009.[23] HIV Testing and Counseling in 2009 was provided to 8 143 MARPs by the organization[23]. According to IOM, their definition of MARPs includes sex workers, men who have sex with men, cross-border drivers, internally displaced persons and migrants. IOM further stated that they did not have injecting drug users among their MARPs.[23] The organization has continued to partner with government and other organizations and implemented programs mostly at border posts to reduce vulnerability.

The major serious consequence of the AIDS epidemic has been the increased number of children who have been orphaned or whose social economic vulnerability has been caused by illness of a parent or other adult in the family. According to the HIV Estimates 2009, the number of orphans has declined from 1 060 396 in 2007 to 1 030 400 in 2009. The GOZ came up with an idea of Basic Education Assistance Module (BEAM) in 2001 as an early response to mitigate the effects of orphan-hood. This program provides school and examination fees assistance to OVC in order to ensure that vulnerable children do not drop out of school and was implemented through the then MoPSLSW (now MoLSS).

4.1.5 Macroeconomic policies

A number of the macroeconomic policies that Zimbabwe has adopted in the last two years have a contribution to mitigation of the effects of HIV and AIDS. The National Economic Development Priority Program (NEDPP) of 2005-2007 was replaced by the Zimbabwe Economic Development Strategy (ZEDS) 2007-2008 developed to stimulate economic growth and reduce poverty. However, before ZEDS was launched, it was replaced by the Short Term Economic Recovery Plan (STERP I)[24] in 2009 which covered the period from February 2009 to December 2009. This strategic economic framework was then followed by a medium term (3 years) economic recovery plan (STERP II) that will cover the period 2010 to 2012.[25] STERP II seeks to achieve sustainable, balanced and robust economic growth and development, oriented towards poverty reduction and the integration of previously marginalized groups of people[26]. This strategy also looks at ways of revitalizing the health sector in order for Zimbabwe to meet its regional and global targets, especially those related to reduction of the burden and impact of HIV and AIDS.

4.2 HIV Programmes

4.2.1 HIV Prevention Programmes

Prevention of new HIV infections remains the cornerstone of the national response. In the absence of a national prevention strategy, the National Behavioral Change Strategy (NBCS) 2006-2010 was developed to consolidate HIV prevention and accelerate the country's goal to reduce the HIV prevalence to less than 10% by 2010 , in line with the MDGs. Given the current HIV prevalence rates (14.3% among adults), Zimbabwe has faired comparatively well. The NBCS is to guides systematic and strategic programming in the area of promoting behavioral change in terms of

[23] IOM Programme Database, March 2010
[24] Short Term Emergency Recovery Programme (STERP 1), Min. of Finance, GOZ, March 2009
[25] The Three Year Macro – Economic Policy and Budget Framework: 2010 – 2012 (STERP 2), Ministry of Finance, GOZ, December 2009

preventing HIV transmission. The hope is that the ZNASP and the NBCS will guide and strengthen the implementation of HIV prevention from a multi-sectoral perspective.

The NBCS covering the period 2006 – 2010 has the following four key outcome areas:

- Enabling environment for behavioral change through increased leadership and gender-equality as well as reduced stigma associated with PLWHA
- Increased adoption of safer sexual behavior and risk reduction
- Increased utilization of HIV prevention services and
- Improved national and sub-national institutional frameworks to address behavior change.

In 2007, behavior change promotion was launched within 16 ESP funded districts. Furthermore, the program "Engendering HIV prevention" was commenced in 10 European Commission funded districts in 2007. District action plans were then developed for the 26 districts. This Created an enabling environment mainly through community leaders' involvement and gender equality were some of the main activities. Meaningful Involvement of People openly living with HIV and AIDS (MIPA) was undertaken in order reduce stigma. In the district structures, professionals meeting these criteria are being assimilated into key positions. Adoption of safer sexual behaviours, risk reduction and increased utilization of HIV prevention services (Testing and Counselling including post test support, PMTCT and PEP) are the aims of this strategy.

4.2.2 Health Sector Response

The health sector in Zimbabwe includes organized public and private health services (health promotion, disease prevention, diagnosis, treatment and care). Non- governmental organizations, community groups, professional associations, pharmaceutical industry teaching institutions also contribute the healthcare system. Zimbabwe has a diverse health sector that is composed of the following health institutions

- State funded public health institutions
- Private-not-for-profit including mission health institutions run by Faith based organizations
- Private-for-profit health facilities
- Allopathic practitioners (Traditional and Alternative medicine).

Records from the Health Professions Council for the year 2009 indicated that there were approximately 2 800 registered health institutions in the public sector clinics and hospitals, private general and specialist practices, industrial, mining and agricultural clinics, hospitals and pharmacies, mission clinics and hospitals, emergency rooms and trauma centers, ambulance services, x-ray service facilities and laboratories among others.

4.2.3 Provision of safe blood and blood products

The donation of blood is governed by the Anatomical Donations and Post-Mortem Examinations Act, Chapter 15:01 whose administration falls under the MoHCW. All blood used in Zimbabwe is provided by the National Blood Services of Zimbabwe (NBSZ), an independent private registered non-profit organization. The NBSZ has the sole responsibility and mandate for collecting and distributing blood and blood products in the country. The purpose of the NBSZ is to provide adequate blood and blood products that are safe and free from microbial contamination by HIV, Hepatitis B and C viruses and syphilis. Blood is collected, processed and distributed in Harare and

Bulawayo and at satellite stations in Mutare, Gweru, and Masvingo. However all blood testing for HIV and other pathogens is centralized to the Harare laboratory. The NBSZ has been designated a WHO collaborating centre for Southern Africa. It also attained ISO certification in 2007. The NBSZ reported a low HIV sero-positivity rate of 0.50% (0.60 in females and 0.43 in males) in donated blood in 2006, 0.33% and 0.50% in 2007 and 2008 respectively[27].

In an effort to encourage rational use of blood and reduce the risk of transmission of HIV and other blood-borne infectious agents the NBSZ with the support of the National AIDS Council (NAC) has developed a guideline document "Prescribing Blood, 2005". Similar guidelines are also contained in the Essential Drug List in Zimbabwe (ELDIZ). The main strategic priority is to sustain the current high standards of blood safety. This entails maintaining stringent donor selection procedures as new donors are continuously recruited, and adopting the latest testing technologies (MoHCW, 2006).

4.2.4 Antiretroviral Therapy

The MOHCW introduced the OI/ART programme in April 2004 and 'Plan for the Nationwide Provision of ART' was finalized in December 2004 covering the period (2005-2007)[28]. [20.] As part of its strategy to scale-up OI/ART services towards universal access in 2010, the MOHCW commissioned a review of the OI/ART programme[29]. According to the 'Review of the National HIV and AIDS Treatment and Care Programme (OI/ART) 2004-2007, ART coverage increased from about 5,000 to over 100,000 (29%) by December 2007. Findings of this review contributed immensely to the development of the 'Plan for the Nationwide Provision of Antiretroviral Therapy 2008-2012.[30] A number of key players support the implementation of the policy and strategies espoused by the national pharmaceutical body, NatPharm. In particular UNICEF, United States Government (USG), Clinton Foundation, and NAC procure the ARV drugs. Once the drugs are procured and arrive in the country, NatPharm delegates the distribution of the drugs to MoHCW AIDS and TB Logistics Sub-Unit (LSU), which was set up by the JSI/DELIVER project.

The numbers of adults and children accessing ART were 148 144 (39.7%) in December 2008 and 215 109 (56.8%) in November 2009.[31] Guiding the scale up of paediatric ART is the detailed plan for Pediatric HIV and AIDS care that was finalized in the last quarter of 2006. Meanwhile, the number of children accessing ART was 8 627 (24.8%) in 2007, 13 287 (38.7%) in 2008 and 20 003 (57.1%) in 2009.[32] The trend observed above was mainly attributed to the scale up and decentralization of the OI/ART programme associated with an increase in OI/ART initiation and follow up as well as training of healthcare workers.[33] Generally, funding gaps have been a hindrance in terms of Zimbabwe achieving universal access to OI/ART.

The Government made efforts to subsidize local manufacture of ARVs through provision of foreign currency for purchase of raw materials and waiver of duty on raw materials for local production of ARVs and imported ARVs in 2008. Consequently, the supply of ARVs has improved in 2009 with minimal number of sites experiencing drug stock outs.

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[27] National Blood Services Zimbabwe, Annual Report, 2008
[28] Plan for the Nationwide Provision of ART 2005-2007, MOHCW, 2004
[29] Review of the National HIV and AIDS Treatment and Care Programme (OI/ART) 2004 – 2007, MOHCW, 2008
[30] Plan for the Nationwide Provision of Antiretroviral Therapy, 2008 – 2012, MOHCW, 2008
[31] Coverage Based on 'Ministry of Health and Child Welfare, Zimbabwe National HIV Estimates 2009
[32] OI/ART Database, AIDS and TB Unit, MOHCW, March 2010
[33] Paediatric HIV Care Strategic Plan for 2006-2010, MOHCW, 2006

If the 2009 WHO recommendations are to be considered in terms of CD4 (< 350) threshold for commencing ART, it is estimated that the number of patients in need of ART will dramatically increase. [2] For example in 2009, using the less than 350 CD4 criteria adult patients in need of ART increased from 317 894 to 500 857. [2] Thus, financial gaps in terms of the funding of the OI/ART programme will widen. This calls for comprehensive planning and resource mobilisation between MOHCW and partners before implementation of the new WHO recommendations.

4.2.5 Prevention of mother to child transmission of HIV (PMTCT)

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.[34] The country has demonstrated high level commitment in developing and utilising policy guidelines on and the expansion of the PMTCT programme. A multi-sectoral national PMTCT Partnership Forum (PPF) was established to improve coordination of the programme. The existing national PMTCT protocols were amended in 2008 in line with the WHO recommendations (revised 2006).[35] The revised treatment guidelines were distributed to all Provincial Medical Directors, City Health Directors, ZACH, ZINA, ZIMA and other relevant implementing partners.

As a result of the efforts made to expand the PMTCT programme, the country has seen an increase in uptake of PMTCT by pregnant women. Figure 6 below shows the comparison of the PMTCT programme performance over 5 years; 2004-2008.[36]

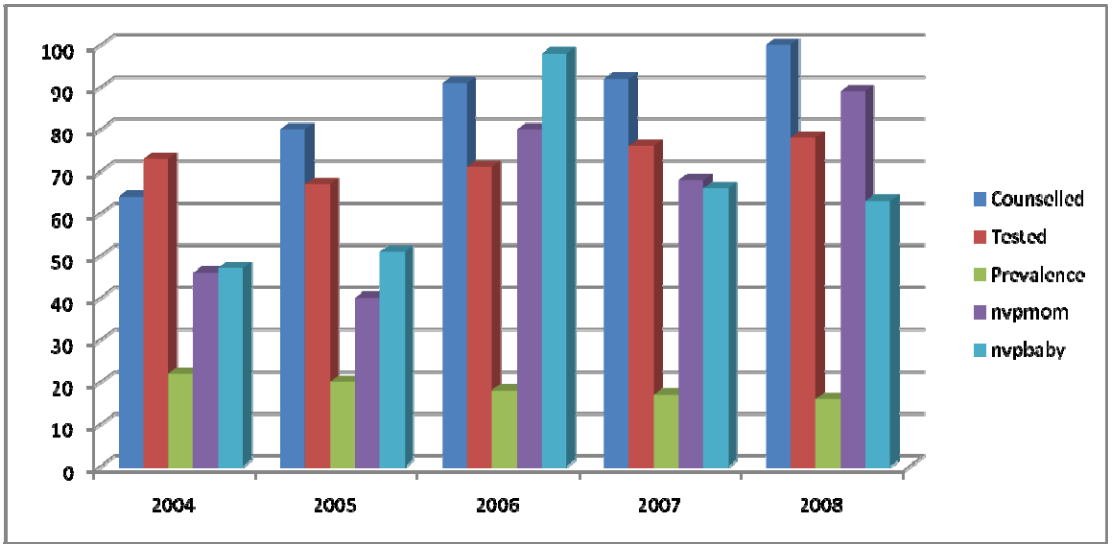

Figure 6: Data from the National PMTCT programme Database (estimated to be 80% complete). [27]

Until recently, the comprehensive PMTCT services were based on the single dose Nevirapine (sdNVP) to reduce mother-to-child transmission (MTCT). By December 2008 the country had

[34] PMTCT and Paediatric HIV Prevention, Treatment and Care National Plan, 2006 – 2010, MOHCW, 2006
[35] Module 9: More Efficacious ARV Prophylaxis of Mother to Child Transmission (PMTCT), MOHCW, 2008.
[36] PMTCT Programme 2008 Annual Report, AIDS & TB Unit, MOHCW

started rolling out a multiple dose PMTCT regimen[37]. Comprehensive PMTCT sites increased from 710 in December 2007 to 920 in December 2008 and 960 in 2009. Consequently, PMTCT coverage increased from 22% in 2007 to 42.6% in 2008.

Early HIV infant diagnosis was introduced in 2008 using the HIV DNA PCR testing at the National Medical Reference Laboratory.[38]

In 2008, 76 Primary Care Counselors were trained on PMTCT, counseling and infant feeding. More needs to be done to train primary counselors and cadres certified to perform rapid testing to strengthen the PMTCT program.

In promoting optimal and safer infant feeding practices, 6,797 infants exposed to HIV were provided with alternative feeding in 2008. The MoHCW nutrition department and ZVITAMBO conducted campaigns on exclusive breast feeding to encourage both HIV positive and negative women to stick to this practice. The PMTCT and reproductive health departments worked in collaboration with PPF partners to revise the ANC card to include information on HTC including HIV status so as to enhance tracking of children born to HIV infected mothers.

It acknowledged that the PMTCT program besides strengthening current strategies needs to adopt, adapt and implement the 2009 WHO rapid advice on PMTCT and feeding practices for 'HIV Exposed Infants.'

4.2.6 TB and HIV Collaborative Activities

Zimbabwe ranks 17th of 22 countries that the WHO has designated high burden; countries that together report 80% of the total number of TB cases in the world.[39] New TB cases (incidence rate) in Zimbabwe in 2007 were 782 per 100 000 people per year, compared to 97/ 100 000 in 1990. The reason for the resurgence of TB is the onset of HIV/AIDS pandemic which has been devastating in Zimbabwe and other Sub-Saharan African countries.[40]

The National TB Control Strategy is harmonized with regional and global plans with the following strategic implementation approaches:[41]

- Dots expansion and enhancement.
- Addressing TB/HIV, MDR-TB and other challenges
- Contributing to health systems strengthening
- Greater involvement of all health care providers
- Engagement of people with TB.
- Enabling and promoting operational research

It is estimated that 70% of all TB patients are co-infected with HIV, but there is no routine surveillance among TB patients. There is therefore need to enhance collaboration between TB and HIV/AIDS programmes. According to the Zimbabwe National Tuberculosis Programme Control

[37] Module 9: More Efficacious ARV Prophylaxis of Mother to Child Transmission (PMTCT), MOHCW, 2008
[38] PMTCT Programme 2008 Annual Report, AIDS & TB Unit, MOHCW
[39] TB control 2009, Epidemiology strategy & Financing – WHO
[40] TB-HIV Guidelines, AIDS and TB Unit, MOHCW, 2009
[41] Zimbabwe National TB Control Programme Guidelines, MOHCW, 2007

Guidelines (2007), the goals of TB/HIV activities are to:

- Establish mechanisms for collaboration between TB and HIV/AIDS programmes.
- Decrease burden of TB in people living with HIV.AIDS
- Decrease burden of HIV in TB patients.

At most sites, there is an increase in the number of TB patients being offered HIV testing and counseling.[42] The implementation of provider initiated testing and counseling in health care settings started in July of 2007 in 10 learning sites. It is encouraged that all TB patients are offered an HIV test while suspect TB cases will also be able to access HIV testing. Tools to capture this data were pilot tested in 2007. The number of TB/HIV patients that received HIV testing were 7373 (10.2%) in 2007 and 9371 (13.2%) in 2008.

Among TB/HIV co-infected patients 5 824 (8.1%) in 2007 and 7 566 (10.7%) 2008 received cotrimoxazole prophylaxis. Thus, there was a slight increase in TB/HIV patients being offered cotrimoxazole prophylaxis between 2007 and 2008. The number of TB/HIV dually infected patients who were commenced on ART were 1 727(2.4%) in 2007 and 2 999(4.3%) in 2008.[42] TB patients who are HIV positive are being given priority in the commencement of ART. Documentation and reporting of such activities need to be strengthened from 2010 onwards, since the current TB registers have a section where details on ART are captured. Furthermore, the Zimbabwe National TB Control Guidelines of 2007 and the Zimbabwe National TB-HIV Guidelines of 2009 have clear indications on when to start ART in TB-HIV co-infected patients.

Currently, of concern is the prevalent lack of diagnostic services for TB (sputum examination and CXR) which may lead to a delay in treatment of TB and initiation of ART. The country needs to consider the policy of INH preventive treatment (IPT) in TB/HIV dually infected patients.

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.

According to the Strategic Plan for the Nationwide Provision of Antiretroviral Therapy 2008-2012, the strategic framework for TB/HIV co-infection will be to increase access of TB patients to ART (and vice versa) by strengthening TB/HIV collaborative activities[30]. Furthermore, these activities include establishing collaborative TB/HIV committees at different levels (district, provincial and national) of health delivery system and conducting joint training for HIV and TB at all levels. The other activities planned include intensifying TB case finding among people with HIV infection, strengthen or establish infection control measure in health care settings and to develop a national policy on INH Preventive Therapy (IPT).

4.2.7 HIV Testing and Counseling Services

The ZNASP and the Health sector HIV Prevention Strategic Framework have both identified HIV Testing and Counseling (HTC) as an important component of the national response. The Zimbabwe National HIV Testing and Counselling Strategic Plan (ZNHTCSP) 2008-2010 was launched in

[42] National TB Programme Database, AIDS and TB Unit, MOHCW, 2007

2008.[43] Broad objectives of this strategic plan emphasize the need to increase the percentage of Zimbabwean population who know their HIV status, from 20% to 85% by 2010; and to expand HTC services using PITC and Client- Initiated Counselling and Testing (CITC), formerly VCT.[43]

The ZDHS of 2005/06 reported that 5.9% women and men (15-49years) had been tested and received their HIV results in the 12 months prior to the survey. The country has set a target to increase the percentage of people who know their status from 20% in 2007 to 85% by 2010 in line with Millennium Development Goals (MDG).

A variety of HCT materials and guidelines for trainings and guidance were developed between 2008 and 2009. Some of these materials include the national HCT training manual for health workers; Zimbabwe National Guidelines for HCT in Children (2008), A Training Course for Counselors on HCT for Children (2008); and PICT and HCT training manuals. This resulted in capacity development of service providers in PITC, HTC for children, and rapid HIV testing.

In an effort to increase testing and counseling coverage, the MOHCW has adopted a four delivery models, namely[43]:

- Integrated model within the public health institutions
- Stand alone model manned by NGOs,
- Private sector workplace model
- Mobile outreach services conducted by NGOs.

Geographic coverage of testing and counseling services expanded to reach all populations during the period 2006-2007. The number of stand-alone and integrated testing and counseling sites increased from 547 sites in 2006 to 649 at the end of 2007. HCT services were further decentralized and expanded through the PMTCT program in which more than 920 health facilities were actively providing HCT services by the end of 2008.[36]

The number of clinics registered to provide testing and counseling in combination with mobile service delivery increased over the year. Estimates in terms of centers providing HCT by the end of 2009 were as follows; 27 VCT centers managed by NGOs, 502 HCT service delivery points integrated with health services, and approximately 1,000 counseling and referral-only service delivery points. There were also HCT services provided through mobile outreach, workplace programs, and family planning clinics. PSI noted that quality counseling and testing services were maintained in urban areas with centers indicating that a counselor meets between 8 and 12 clients per day which is the accepted counselor client ratio. The HIV testing and counseling services have expanded to rural areas. Mobile counseling and testing units visit rural sites through outreach.

The total number of clients who received testing and counselling in Zimbabwe were 579 767 (314 464 public sector, 265 303 PSI) in 2007; 1 035 168 (769 125 public sector, 266 043 PSI) in 2008, and 1 071 740 (710 385 public sector, 361 355 PSI) in 2009[44]. In addition to HTC, clients receive information on behavior change, referrals for care, treatment and psychosocial support. An analysis of VCT attendees by sex suggests that CITC (formerly VCT) in 2008 showed that women were in the majority by 30%. VCT services reach the whole country through networks with various

[43] Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support; The National HIV Testing and Strategic Plan 2008 – 2010, MOHCW, 2008.
[44] Testing and Counselling National Programme Database, Mar 2010; MOHCW

stakeholders and outreach programs.[45] Comprehensive and quality care is guaranteed through a strong referral system for other medical conditions such as STI, TB and family planning.

In Zimbabwe, there is no law that denies any group or person access to medical or social services as a result of their political, sexual of any other affiliation. Sex workers, men who have sex with men (MSM), intravenous drug users, prisoners and mobile populations such as the army and those in the transport sector have access to testing and counseling services. Program data from the IOM shows that a sizeable number of commercial sex workers and migrant (or mobile) populations accessed testing and counseling services from designated public health facilities supported by IOM.[23] In the 2009, a total of 8 143 clients accessed counseling and testing services out of 1 073 572 MARPs reached by IOM prevention programmes.[23] There is need however for size estimates to cover MARPs because programme data is not generalizable. Data from MSM and IDU groups is not easily accessible due to the individuals' inability to publicly acknowledge their practices as a result of these activities being considered as illegal or socially unacceptable.

HIV testing kits are distributed to health facilities through the integrated USAID funded Delivery Team Top-Up (DTTU) distribution system[19]. NatPharm has a full supply of HIV testing kits. From 2008, they have introduced the Delivery Team Topping-Up System, where each facility HIV testing and counseling site is visited bi-monthly to replenish stocks. This system has reduced stock-outs of testing kits at facilities. Previously testing sites used to collect their supplies from NatPharm and this exacerbated the problem of stock-outs due to lack of transport and time to travel. The aim is to have 'zero' stock-out rate. Current delivery rate to facilities can be pegged at 95%. PSI supported New Start centers reported '0' stock-out rates as well in 2008. However, there were some stock outs reported in during the last quarter of 2009 as a result of an increased number of clients accessing testing and counseling services. Urgent measures were taken to improve the supply of HIV test kits during the last quarter of 2009.

Referral tracking between VCT and post test support services has been improved through the New Start network but needs further strengthening especially for mobile VCT services. Overall, the VCT program had a consistent increase in the number of individuals pre- and post-test counseled and HIV tested. Male participation continues to be lower than female participation and programs need to focus on encouraging males to get counseled and tested.

4.2.8 Orphans and Vulnerable Children

Zimbabwe continues to have a huge burden of Orphaned and Vulnerable Children. National HIV/AIDS Estimates 2010 estimated HIV/AIDS orphans to be 923 862 in 2007, 923 477 in 2008 and 903 564 in 2009[2]. The Government developed a National Action Plan for Orphans and Vulnerable Children (NAP for OVC) through the Ministry of Public Service Labor and Social Services in 2005 to increase reach to OVC with basic services.[46] The NPA aims to reach 25% of orphans and other vulnerable children through various interventions, including educational, medical, legal, and psychosocial assistance, in line with the UNGASS goals 65, 66 and 67 which directly target OVC.[46]

[45] National AIDS Council (NAC) Annual Report 2008
[46] Programme of Support to the National Action Plan for Orphans and Vulnerable Children in Zimbabwe Annual Report, June 2009.

Since commencement of implementation of the NAP for OVC program in 2007 and the initiation of the Program of Support, systems have been developed to directly provide children with basic services through the efforts of 33 civil society organizations working with over 155 sub-grantees. [15.] However, there are many other civil society organisations implementing programmes for OVC outside the mainstream funding mechanism of the PoS. A significant number of children have benefited from the educational support provided through the PoS and through other NGO funding. Some provide block-grants to schools, a system which has an advantage of eliminating stigma and discrimination of OVC as well as bringing about community development.[46] The Basic Education Assistance Module (BEAM) had an impact in providing block grants for tuition, levies, building fund, and examination fees up until 2007. It ceased to provide the necessary school education fund as a result of hyperinflation which (in 2008) rendered contributions irrelevant.[47] The BEAM programme was resuscitated in 2009 and 517 315 out of 625 000 OVC were assisted.[47] The NAP-OVC programme managed to help 393 197 OVCs in 2009 and this constituted about 30% of the target group.[48] Meanwhile, the thrust of the National Orphan Care Policy is to strengthen the community care method through extended families.

Table 3 below shows some of the achievements made on some of the key OVC indicators from 2006 to 2009.[49]

Table 3: Selected achievements for some key OVC indicators

Selected Indicators	2006	2007	2008	2009
Number of new OVC provided with school-related assistance	752	3 102	249 207	219 874
Number of new OVC provided with food or nutrition assistance support	65 248	459 495	237 666	812 250
Number of new children headed household provided with shelter/ housing assistance	203	3 772	220	17 310
Number of new OVC assisted to obtain birth certificates	-	-	2 713	3 131
Number of new OVC receiving psychosocial support	-	-	68990	131 924
Number of new children headed household assisted with livelihood projects	-	-	16 187	16 985
Number of new reported cases of child abuse	157	5 794	2 217	21 432

Source: NAC Annual Monitoring and Evaluation Report, 2009.

4.2.9 Life skills based HIV and AIDS education in schools

The MoEASC policy on Life skills based HIV and AIDS education in schools (Circular 16 of 1993) is that all schools should provide life skills based HIV and AIDS education to pupils in schools. Consequently a pre-service training on life skills based HIV and AIDS education has been introduced for all student teachers since 1994. Most colleges allocate 1 to 2 hours weekly and make sure that every student teacher goes through the program. All teachers' Colleges have either a full time coordinator or a team of trained lecturers to teach the subject. An integrated training package

[47] BEAM Programme Database, MoLSS, March 2010
[48] NAP OVC Programme Database, MoLSS, March 2010.
[49] National AIDS Council OVC Core Output Indicator Database, March 2010.

was introduced in 2005 focusing on the issue including learner-centered HIV and AIDS participatory methodologies so that every teacher who is trained is able to support both the cognitive and psychosocial needs of children.

The Ministry of education hopes that all teachers (100%) give lectures on life skills HIV and AIDS education about 2 hours a week. However, this may not be the reality. Hence, the need to carry out regular school based surveys to ascertain whether life skills based HIV and AIDS education is being carried out as well as checking on the quality of the education provided.

A total of 2,471,605 school pupils were exposed to life skills HIV and AIDS education in 2006 through school based programs. A total of 22,790 school based peer educators were trained in 2006. No statistics are available on the project for 2007, 2008 and 2009.[50] An HIV and AIDS Life Skills Strategic Plan for the period 2006 to 2010 was developed and finalized in 2008 with support from UNICEF, but was nor endorsed by the MoEASC. Hence, there is no strategic plan guiding HIV and AIDS Life Skills in schools.[19]

The remaining challenges are weak coordination of youth programs and absence of focal persons to focus on implementation of HIV prevention activities in tertiary institutions. There is also need to create a network for the institutions to exchange information and experiences.[19] Nevertheless, there are a number of organizations working with in-school youths such as UNESCO, Saywhat, SHAPE Zimbabwe, and Students' Partnership Worldwide.

4.2.10 Male Circumcision

Male circumcision was identified in the ZNASP as one potential service-based HIV prevention intervention strategy. Research was proposed to assess feasibility and acceptability of large scale male circumcision and pilot the initiative in some selected geographical areas.[19] Zimbabwe is mostly a non-circumcising country but has traditionally circumcising ethnic and religious communities such as the Xhosa, VaRemba, Chewa, Tshangani, Tonga (parts) and Moslems. The ZDHS (2006) noted self reported MC prevalence at 10%.

A male circumcision situation analysis (feasibility and acceptability) was conducted and findings were disseminated during MC stakeholders meeting in 2008. A Steering committee and three technical working groups were created at the same meeting. A tool to assess the readiness of a health facility to introduce or expand provision of male circumcision services as part of a comprehensive HIV prevention program and a draft MC policy were developed. A national training of trainers (TOT) was conducted for 18 national trainers comprising surgeons, nurses and counselors.

The MC strategy received a boost in November 2009 when the MC Policy was launched as a component of the overall HIV/AIDS prevention strategy. As of December 2009, 2800 men recruited through the HIV counseling and testing sites (mainly PSI) were circumcised. Latent demand can be described as very high as most males have volunteered to be circumcised when offered through HCT centers. MC surgery is conducted by medical doctors, using sterilized pre-packed MC kits and guided by the minimum standards operating procedures (SOPs) for safe male circumcision developed for Zimbabwe. There is a back up service to address complicated cases and any adverse events that may occur.

[50] Data provided by MoEASC Head Office in data gathering process for this report

4.3 Knowledge and Behaviour

4.3.1 Behavior Change and Communication (BCC).

Zimbabwe, in the absence of a comprehensive prevention strategy, has a National Behavior Change Strategy 2006-2010 whose main objective is reducing sexual transmission of HIV.[5] Focus of the BC strategy is to address the behaviour-related key drivers and underlying factors of the HIV and AIDS epidemic in Zimbabwe such as multiple concurrent sexual partnerships, age-different sexual relations and long term discordant couples.[5] The strategy provides a streamlined approach to addressing issues of leadership at all levels, gender imbalances and stigma associated with HIV as well as specific cultural practices.

The BC component is being implemented in 16 districts with ESP support and a further 10 districts with European Commission (EC) support. The component is supported and coordinated at national level by UNFPA in collaboration with the NAC, which is responsible for the National BC Program, and implemented at district level by 8 NGOs contracted by UNFPA.[5] The key aspects of the National BC Strategy are creation of an enabling environment and adoption of safer sexual behaviors and reduction of risk behaviors through community mobilization and interpersonal communication. Model used includes community assessment, working through community leaders and BC facilitators (selected from community opinion leaders) and promoting community dialogue.

4.3.2 Interventions for Out-of-School Youths

HIV prevention interventions for youths out of school have been supported by Global Fund. Services are provided through Youth Friendly Corners and Centers. However, according to the ZNASP MTR, most of these centers are facing sustainability challenges.[19] Through European Union funding, the country has established a Young People's Network, which provides a platform for advocacy by young people.[51]

4.3.3 Condom Distribution and Social Marketing

The main objective of the ZNASP 2006 -2010 under condom distribution is to make more widely available both re-branded public sector and socially marketed condoms in rural and remote areas. Condom promotion and distribution is spearheaded by both the public sector (MoHCW and Zimbabwe National Family Planning Council (ZNFPC)) and civil society (Population Services International (PSI)). The National Female Condom Strategy 2006 to 2010 was developed and is currently being implemented.[19]

NAC in collaboration with partners secured and distributed 100 female and 1000 male genital models for condom education and demonstrations in 2008.[19] Under this strategy the ZNFPC's Depot Holders and Community Based Distributors program was strengthened through capacity development with technical support from DFID and UNFPA. The establishment of CBD is supposed to be 800, but not all posts were filled in 2008 and 2009. The limited staffing levels are a constraint in terms of condom distribution to underserved areas and new settlements.

[51] National AIDS Council Annual Report, 2009

In terms of condom distribution (see figure 8) there has been a gradual increase in number distributed over the years. The numbers of male condoms distributed were 86 562 348 in 2007, 95 463 490 in 2008 and 89 956 552 in 2009.[52] Female condoms distributed (see figure 9) were 3 557 476 in 2007, 5 276 705 in 2008 and 4 491 916 in 2009.[52] The targets set in the National Female Condom Strategy 2006 to 2010 highlight that 2.4 million, 2.5 million and 2.8 million should have been distributed from 2006 to 2008 respectively. Thus, the 2008 total of 4,678,212 female condoms distributed surpassed the set target. Female condom distribution increased 31% in the social sector, 7% in the public sector and 23% overall according to the NAC Annual Report 2008. Compared to 2007, both male and female condoms distributed rose in 2008 and 2009. However, even though condom distribution has increased from 2007 to 2009, the target set by the ZNASP of 150 million condoms per year was not attained.[19]

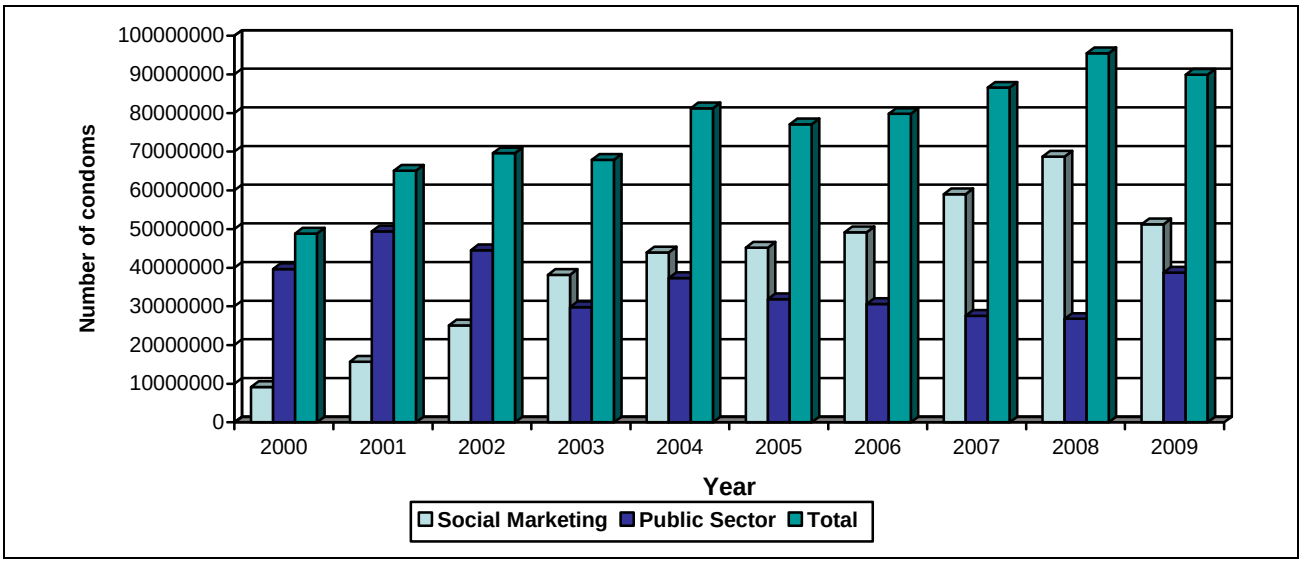

Figure 8: Male condoms consumption and distribution by year.

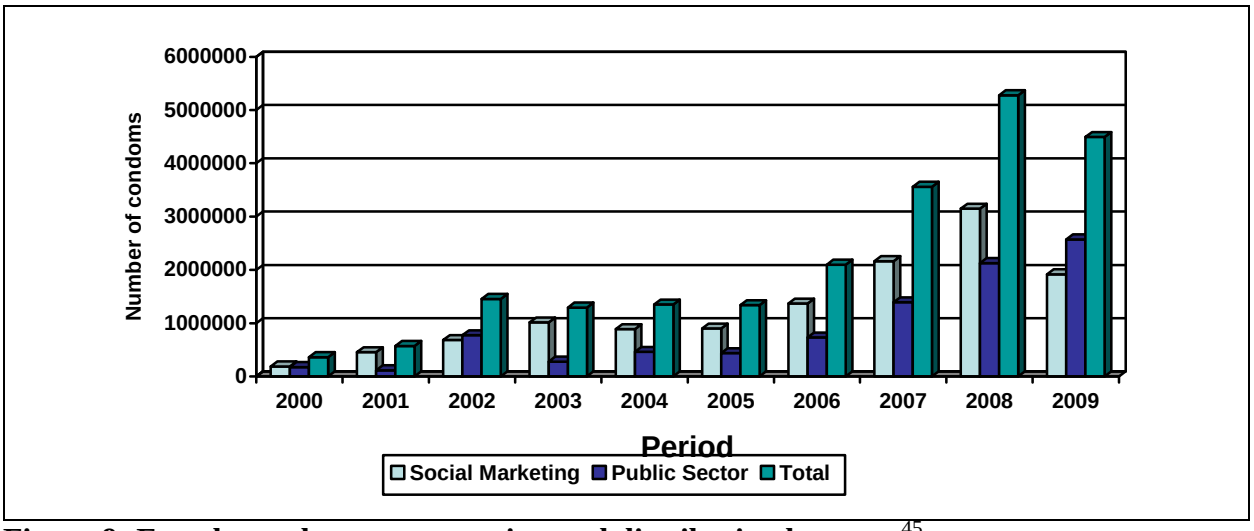

Figure 9: Female condoms consumption and distribution by year. [45]

[52] Condom Distribution Database, AIDS and TB Unit, MOHCW, March 2010.

Condom procurement and supply is done by ZNFPC, JSI, and Crown Agents which carry out systematic forecast of condom consumption needs. All procured commodities are assessed for quality by the Medical Council of Zimbabwe and all commodities that fail the test are destroyed. Distribution of commodities is through a Delivery Team Topping-Up System (DTTU), where visits are made bi-monthly to health facilities for replenishment of commodities according to consumption data. The country is working towards increasing the procurement and supply condoms of both socially marketed and public sector distributed condoms towards the targets in the ZNASP.[19]

4.3.4 Most at Risk Populations (MARPs)

MARPs 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).[4] 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.[19]

A general decline in the numbers accessing the High Risk Group (HRG) program for commercial sex workers, truck a driver, cross border traders and small-scale miners was noted in the NAC 2008 Annual Report.[45] This trend could be attributed to the economic downturn that was experienced in 2008. Nevertheless, an increase in number of MARPs reached by HRG program activities was recorded for fishermen and prisoners accessing HCT. VCT, HIV and STI prevention services, treatment and care, IEC and HBC were among the new prevention programs were actively implemented in prisons in 2008 with the aim of improving the HIV/AIDS services among prisoners.[45]

A needs assessment study on mobile and migrant populations' access to HIV/AIDS prevention and treatment and care services in Zimbabwe was conducted in 2008. As a follow-up to the study, NAC with support from UNFPA, UNAIDS, and International Organization for Migration (IOM) convened a national consultative meeting on HIV prevention in sex work settings to deliberate and reach a consensus on the best way forward regarding the integration of sex work into comprehensive HIV and AIDS programming within the Zimbabwean context.

An assessment of patterns, meeting points, behaviors and size estimates of Men who have Sex with Men are yet to be carried out in Zimbabwe. The findings will be used to develop HIV/AIDS public health interventions for the population sub-group.[53]

4.2.5 Impact

HIV prevalence has been on the decline in the general population and among the young people aged 15-24 years. The decline has been attributed to the various HIV and AIDS interventions being implemented in the country as well as mortality. HIV prevalence among women (15-24) attending ANC was 19.9% in 2002, 17.0% in 2004 and 12.5 % in 2006 and 11.6% in 2009. This signifies 41.7% decline over a period of 7 years. According to the 2010 HIV estimates, HIV prevalence

[53] NAC/UNAIDS Know Your Epidemic (KYE) Concept Note, 2008

among young women 15-24 years of age was 3.3% in 2007, 3.3% in 2008 and 3.2% in 2009. Among young men (15-24) HIV prevalence was 7.6% in 2007, 7.2% in 2008 and 6.9% in 2009.[54]

The antiretroviral therapy programme is increasing survival of infected individuals, despite the large percentage of ART patients dropping out of treatment programmes in selected sites. The percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART was 75% in the 2009 Cohort Analysis carried out in 22 districts that were supported by Global Fund round 5.[55] Most of the 25% of patients no longer on ART were due to loss to follow up.[55]

The percentage of infants born to HIV infected mothers that were infected were estimated using spectrum at 32.3% in 2007, 31.1% in 2008 and 30% in 2009. The high percentage of infected infants could be attributed to breastfeeding which extends to 20 months (according to ZDHS 2005/06) and not too effective PMTCT regimen (single dose Nevirapine)[2]. The marginal decline in infection rates could be due to increase in PMTCT services uptake between 2007 and 2009.

5.0 Best Practices

5.1 Leadership and political commitment

The Government of Zimbabwe continues to demonstrate a strong political commitment to respond to the HIV and AIDS epidemic. The country has held national commemorations of the World AIDS Day annually at all levels national to district level. Each year the head of state has made state of the nation address on HIV/AIDS and featured HIV/AIDS in other period addresses. In the Behaviour Change (BC) programme there is high involvement of traditional, opinion leaders, political leaders, business persons and religious leaders in promoting open dialogue and speaking against risky behaviors and negative cultural practices that fuel HIV infection. As a result, there were reports of a reduction in practices that may fuel the HIV and AIDS epidemic.[19]

5.2 Testing and counseling

The Provider Initiated Testing and Counselling (PITC) has led to a dramatic increase in clients tested for HIV. This has been achieved through a large number of healthcare workers trained and health facilities providing testing and counseling services.[44]

5.3 Decentralization of HIV and AIDS Services

Most HIV and AIDS services have been decetralised to clinics thus improving access and coverage to services in both urban and rural settings. Increase in the number of sites offering HTC, PMTCT and OI/ART is linked to a decentralized strategy.[20]

5.4 Family Approach to HIV and AIDS Services

The family approach to HIV and AIDS Services creates linkages and increases entry points for services like VCT, PMTCT, OI/ART & TB/HIV. Under the PMTCT Programme for example, there were a number of male partners that were subsequently tested for HIV after their female counterparts booked for maternity and underwent PITC.[20]

[54] National Survey of HIV and Syphilis Prevalence Among Women Attending Antenatal Clinics in Zimbabwe, MOHCW, 2009

[55] ART Data Verification & Cohort Analysis in 22 districts, Global Fund Round 5 Zimbabwe (1-6 November, 2009)

6.0 Major challenges facing Zimbabwe's HIV and AIDS Response

6.1 Economic environment

The country received limited donor funding in the period 2007-2009 and this affected the coverage of most HIV and AIDS preventive, treatment and care programmes. The inflationary pressures arising from the drought, low economic growth, high fuel prices on the international market, sanctions and high HIV and AIDS disease burden have negatively affected the effective response to HIV and AIDS in Zimbabwe.[19] Consequently, the economic challenges encountered in the period 2000-2008 led to poverty, unemployment and international migration among the general population to levels that were unprecedented. [13] Most women then engaged in cross border trading exposing themselves to sexual and other forms of abuse during the course of their work.[19]

6.2 Human resources challenges

Many health facilities in Zimbabwe were seriously and chronically short of staff as a result of low remuneration not commensurate with the prevailing economic conditions in 2008. [13] This was also coupled with massive exodus of staff to neighboring Southern African countries and abroad. The challenges associated with staff attrition in the health sector have impacted on the quality and coverage of HIV and AIDS health programs.[19] The shortage of equipment also made work in the health sector non-conducive leading to low morale.[19]

6.3 Limited Funding for the national HIV/AIDS response

The global and local economic meltdown; politically-induced tension, anxiety, and uncertainty in the country; and less than optimal external donor support especially to the public sector contributed to the inadequate funding needed for the national response in 2008 and 2009.[19] For example, many PLHIV eligible for ART were on the waiting list for ART in 2008 and 2009.[19] This is severely hindering the implementation of the ZNASP and achievement of UNGASS targets. Thus, there is need for domestic and international resource mobilization to cover the existing funding gaps.

6.4 Weakened Health System

The economic challenges that the country has gone through over the years have severely dented the country's health system. The country's health facilities are riling under severe shortage of essential supplies such as lab equipment, reagents, drugs, HIV and HBC test kits. Health facilities are suffering from frequent breakdowns of essential lab equipment such as CD4 machines, hematology and chemistry machines which are essential for provision of quality HIV/AIDS service. Hospitals have poor transport and communication facilities making referral of patients a challenge.[20]

7.0 Support from the Country's Development Partners

7.1 Key Support Received

During the last 3 years, Expanded Support Program (ESP), Program of Support (PoS), US Government (USG), GFATM, and some bilateral agencies have made significant contributions to the national HIV/AIDS response.[19] The ESP and PoS are both basket funding by a group of development partners.

The ESP contributed US$50 million in the 3-year period of the project. This funding supported ART in 16 districts, prevention programmes, coordination as well as retention scheme for health workers involved in the ART program.[19] The PoS contributed US$84 million in 3-years funding for the National Action Plan (NAP) for OVC, supporting OVC with education, healthcare, birth registration HIV/AIDS prevention and treatment.[19]

The GFATM and the ESP have been the main source of funding for many districts; the funding is enabling these districts to outperform other districts especially those receiving support from GoZ only. The GFATM Round 8 awarded a 5-year (2009-2013) US$296 million grant for the HIV/AIDS response in Zimbabwe for interventions in all areas of the response and for building the capacity of NGOs.[9] Human resources are critical to the success of the project and about 7% of the grant provides funds to meet the cost of some essential staff for the project. With this funding ZNASP 2006-2010 modest target of US$65 million was surpassed.[19] However, this remains far short of the country's resource needs in relation to the size of epidemic and ability the economy to sustain the response.[9]

7.2 Actions that need to be taken by Development Partners to ensure Achievement of UNGASS targets.

Development partners need to work with the GOZ in identifying funding gaps for HIV/AIDS programmes. Following this, coordinated mobilization of resources should be undertaken by the development partners on behalf of the GOZ. Meanwhile, Development partners should prioritize the human resource component when mobilizing for financial resources.[19]

When it comes to HIV/AIDS programmes implementation, the Development Partners need to work with the GOZ in a coordinated way so that there is no duplication of activities and setting up of parallel structures.[19] Examples of HIV/AIDS funding programmes by Development partners that are well managed are GFTAM, ESP and PoS.

Generally, Development partners will improve the possibility of attaining UNGASS targets by covering financial gaps, channeling resources in a streamlined way and implementing coordinated activities at site level through collaboration with the GOZ.

8.0 Monitoring and Evaluation Environment

8.1 Overview of the current Monitoring and Evaluation (M&E) System

Monitoring and Evaluation is an integral part of the national response on HIV and AIDS in Zimbabwe. The framework of the "three ones" principles has been operationalised giving the National AIDS Council (NAC) the mandate to coordinate and maintain the one national M&E system. Most national programs and partner projects are linked to the national system.[13] A multi-sectoral and multi-disciplinary National M&E Advisory Group (MEAG) is in place which provides technical advice in the development and operationalisation of the national M&E system. A national M&E plan was developed in 2009 in accordance with the "Three Ones" principle.[19] The plan enables Zimbabwe to systematically monitor implementation of the national HIV/AIDS strategic plan and gauge progress towards the achievement of both national targets and international commitments in the fight against HIV and AIDS.

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. There are important surveys that the country has not been able to regularly conduct including school-based surveys, high–risk group surveys, Young Adult Survey (YAS) and Behaviour Surveillance Survey (BSS).[56]

8.2 Challenges faced in the implementation of a comprehensive M&E System and remedial actions planned to overcome challenges

8.2.1 Human Resource Shortages

The human resource situation was critical in 2008 due to the economic challenges. Consequently, staff was moving from the public to the NGO sector internally and abroad. In 2009, with the modest improvements in the economy the situation has somewhat stabilized. However, there is need to train more M& E programme officers in the government, civil and private sectors. The health sector retention scheme needs further strengthening. Incentives and support for staff involved in data validation at district level should be improved.[56]

8.2.2 Low reporting rates by implementing partners

Just over 50% of implementing organizations were submitting National Activity Report Forms (NARF) on monthly basis to NAC Districts Offices in 2008. This improved to 70% in 2009. Thus the challenge is to achieve 100% in registration and reporting by implementers.[51]

8.2.3 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 capacity to develop and maintain M&E

[56] HIV and AIDS National M&E Plan, 2008-2010

systems at primary data collection levels and delays in reporting by implementers. The health sector data is affected by lack of training and supervision among staff collecting and capturing data. Some sectors do not have sufficient M&E tools to guide and facilitate collection of indicator data. Generally, there is low capacity for data triangulation, validation and verification in the country.[51]

8.2.4 Harmonization of sector and national M & E systems

There are some sector M&E systems that are yet to be fully harmonized with the national M&E system, for example, the business sector, private medical practitioners and selected government ministries and departments which are not reporting on their workplace programmes. Furthermore, multilaterals and bilaterals are not reporting to the national M&E system. There is need to strengthen harmonization with these sectors.[56]

8.2.5 Equipment and funding for M & E activities[56]

There is need to strengthen capacity of sites by implementing partners (MOHCW, Local Private & NGOs) and NAC through provision of computers, printers, printer cartridges & stationery for M & E.

8.2.6 Lack of Communication for M & E Activities

Improve communication through provision of transport (motorbikes), telephone, fax, broadband internet connectivity, radios, satellite phones and cell phones. Broad bandwidth connectivity is needed at provincial and district levels.[56] There is a need for an M&E Communication Strategy.[19]

9. Recommendations

1. There is a need to conduct a thorough and comprehensive national M&E system assessment to ascertain the functionality of the national M&E System at all levels using the 12 components criteria,[56]
2. There is need to carryout a Know Your Epidemic /Response and size estimation study,[53]
3. The country needs to enhance the use of evidence and results–based approaches in the planning process including planning for the ZNASP 11 to be developed covering 2011-2015,[53]
4. There is need to undertake a Size estimation and Behavioral Surveillance study survey for Most-at–Risk Populations to collect key outcome indicators for them,[53]
5. There is need to collect Private Sector and Workplace baseline data to plan and monitor the stages of development of HIV and AIDS Workplace Programs,[19]

ANNEX 1: Financing Sources and National Funding Matrix.

Domestic & International AIDS Spending by Categories** and Financing Sources 2008 and 2009 UNGASS 2010, INDICATOR NUMBER 1**

Aids Spending Category/ Year	*Grand Total*	Domestic Total	Private	Public	International Total	Bilateral	Multilateral	GFATM	ESP
Year 2008	**26 484 932**	**397 673**	43 012	* 354 661	**26 087 259**	9 172 655	49 474	** -	16 865 130
Year 2009	**54 147 723**	**16 351 026**	8 650 573	7 700 453	**37 796 697**	7 215 513	87 547	14 309 722	16 183 915
Total	**80 632 655**	**16 748 699**	*** **8 693 585**	**8 055 114**	**63 883 956**	**16 388 168**	**137 021**	**14 309 722**	**33 049 045**

***** UN monthly Exchange rate ** No resources disbursed to Zimbabwe. *** Estimate AIDS Spending based on ZBCA members.

**** Categories: - Prevention, Care & Treatment, Orphans & Vulnerable Children, Program Management and Administration, Human Resources, Enabling Environment and Research.

Financing sources	AIDS Spending Categories								
	Total	**Prevention**	**Care and Support**	**Orphans and Vulnerable children**	**Program Management and Administration**	**Human resources**	**Social protection and Social Services**	**Enabling Environment**	**Research**
Year: 2008 Grand Total (Domestic and International)	**26 484 932**								
DOMESTIC **(Total/category)**	**397 673**	**9 886**	**3 853**		**6 763**	**19 300**	**12 130**	**1 020**	
PUBLIC: **a) Government**	***344 721**								
b) Parastatal	**9 940**	3 640			3 600	1 300	380	1 020	
PRIVATE:	**43 012**	6 246	3 853		3 163	18 000	11 750		
INTERNATIONAL **Total/category**	**26 087 259**	**2 184 523**	**3 433 000**			**2 691 112**		**913 494**	
BILATERAI	**9 172 655**	2 179 523	3 433 000			2 670 132		890 000	
MULTILATERALS	**49 474**	5 000				20 980		23 494	
Global Fund	**-**								
Expanded Support Programme	***16 865 130**								

Year: 2009 **Grand Total**	**54 147 723**								
DOMESTIC **Total/category**	**16 351 026**	**3 788 925**	**4 256 267**	**1 244 000**	**3 435 600**	**1 613 573**	**941 961**		
PUBLIC (total) **a) Government** **b) Parastatals** **PRIVATE:**	**7 491 453** ***1 070700** **6 629 753** **8 650 573**	2 572981 1 215 944	2 146767 2 109500	124 000 1 120000	367 141 3 068 459	860 241 753 332	558 623 383 338		
INTERNATIONAL **Total/category**	**37 796 697**	**1 555 731**	**5 863 388**	**105 000**	**80 170**	**5 254 717**	**1 702 535**	**223 799**	**114 486**
BILATERAL **MULTILATERALS** **Global Fund** **Expanded Support Programme**	**7 215 513** **87 547** **14 309 722 (6 816 918)** ***16 183 915**	807 513 43 073 705 145	2 207000 3 656 388	105 000	80 170	3 426 000 20 980 1 807 737	1 421 500 281 035	10 000 213 799	 23 494 90 992

***Breakdown according to spending categories not given

ANNEX 2: National Composite Policy Index (NPCPI) Part A & Part B.

National Composite Policy Index (NCPI) questionnaire

Part A: [To be administered to government Officials]

1. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?
   (Multisectoral strategies should include, but are not limited to those developed by Ministries such as the ones listed under 1.2)

Yes √	No	Not applicable (N/A)

Period covered: *[2006 - 2010]*

IF NO or NOT APPLICABLE, briefly explain why.

IF YES, complete questions 1.1 through 1.10; IF NO, go to question 2.

1.1 How long has the country had a multisectoral strategy?

Number of years: *[10 years]*

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

Sectors	Included in strategy		Earmarked budget	
Health	Yes √	No	Yes √	No
Education	Yes √	No	Yes √	No
Labour	Yes √	No	Yes √	No
Transportation	Yes √	No	Yes √	No
Military/Police	Yes √	No	Yes √	No
Women	Yes √	No	Yes √	No
Young people	Yes √	No	Yes √	No
Other* *[write in]* **Public service**	Yes √	No	Yes √	No

*Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

IF NO *earmarked budget for some or all of the above sectors*, explain what funding is used to ensure implementation of their HIV specific activities?

1.3 Does the multisectoral strategy address the following target populations, settings and cross cutting issues?

Target populations	
a. Women and girls	a. Yes √ No
b. Young women/young men	b. Yes √ No
c. Injecting drug users	c. Yes No √
d. Men who have sex with men	d. Yes √ No
e. Sex workers	e. Yes √ No

f. Orphans and other vulnerable children	f. Yes √	No
g. Other Specific vulnerable subpopulations*	g. Yes	No
Settings		
h. Workplace	h. Yes √	No
i. Schools	i. Yes √	No
j. Prisons	j. Yes √	No
Cross cutting issues		
k. HIV and poverty	k. Yes √	No
l. Human rights protections	l. Yes √	No
m. Involvement of people living with HIV	m. Yes √	No
n. Addressing stigma and discrimination	n. Yes √	No
o. Gender and empowerment and/or gender equality	o. Yes √	No

1.4 Were target populations identified through a needs assessment?

Yes √	No

Year: **2005**

*Sub-populations other that injecting drug users, men who have sex with men and sex workers, that have been locally identified as being at higher risk of HIV transmission (e.g. clients of sex workers, cross border migrants, migrant workers, internally displaced people , refugees, prisoners).

IF NO, explain how were target populations identified?

1.5 What are the identified target populations for HIV programmes in the country?

Vulnerable groups:

- In and out of school youths
- Youths in tertiary Institutions
- Prisoners
- Farm workers
- Single mothers
- Men having sex with men
- Orphans and Vulnerable children
-

1.6 Does the multisectoral strategy include an operational plan?

Yes √	No

1.7 Does the multisectoral strategy or operational plan include?

a. Formal programme goals?	Yes √	No
b. Clear targets or milestones?	Yes √	No
c. Detailed costs for each programmatic area?	Yes √	No
d. An indication of funding sources or support programme implementation?	Yes √	No
e. A monitoring and evaluation framework?	Yes √	No

1.8 Has the country ensured "full involvement and participation" of civil society*in the development of multisectoral strategy?

Active involvement √	Moderate involvement	No involvement

IF *active involvement,* briefly explain how this was organised

- Planning workshop for four days which involved NANGO and Zimbabwe AIDS Network.
- They were requested to make their partners participate.
- The group was multisectoral to input into the ZNASP. The group comprised of all sectors (Legislators, Chiefs, Faith Based Organisations, and Politicians).
-

*Civil society includes among others: networks of people living with HIV, women's organisations, young people's organisations, faith based organisations, AIDS service organisations, community-based organisations, organisations of key affected groups (including men who have sex with other men, sex workers, injecting drug users, migrants, refugees/displaced populations, prisoners), worker's organisations, human rights organisations, etc. For the purpose of the NCPI, the private sector is considered separately.

IF NO or MODERATE involvement, briefly explain why this was the case.
N/A

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals)?

Yes √	No

1.10 Have external development partners aligned and harmonised their HIV-related programmes to the national multisectoral strategy?

Yes, all partners √	Yes, some partners	No
IF SOME or NO, briefly explain for which areas there is no alignment/harmonisation and why N/A		

2.0 Has the country integrated HIV into its general development plans such as in (a) National Development Plan; (b) Common Country Assessment/UN Development Assistance Framework; (c) Poverty Reduction Strategy: and (d) sector-wide approach?

Yes √	No	N/A

2.1 IF YES, in which specific development plan(s) is support for HIV integrated?

a. National Development plan Short Term Emergency Recovery Plan 2, Medium Term Plan	Yes √	No	N/A
b. Common country Assessment/UN Development Assistance Framework	Yes √	No	N/A

c. Poverty Reduction Strategy	Yes √	No	N/A
d. Sector-wide approach	Yes √	No	N/A
e. Other *[write in]*	Yes	No	N/A

2.2 ***IF YES,*** which specific HIV-related areas are included in one or more of the development plans?

HIV-related areas included in development plan(s)		
HIV prevention	Yes √	No
Treatment of opportunistic infections	Yes √	No
Antiretroviral Treatment	Yes √	No
Care and support (including social security or other schemes)	Yes √	No
HIV impact alleviation	Yes √	No
Reduction of *gende*r inequalities as they relate to HIV prevention/treatment, care and / or support	Yes √	No
Reduction of income inequalities as they relate to HIV prevention/treatment, care and / or support	Yes √	No
Reduction of stigma and discrimination	Yes √	No
Women's economic empowerment (e.g. access to credit, access to land , training)	Yes √	No
Other: *[write in]*	Yes	No

3.0 Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes √	No	N/A

3.1 IF YES, to what extent has it informed resource allocation decisions?

Low					High
0	1	2	3	4√	5

Comment:

The budget spent on care and treatment is high although some funds are from Donor agencies like Expanded Support Programme (ESP) and Global Fund (GF)
Other funds are from the 50% of AIDS levy.

4. Does the country have a strategy of addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes √	No

4.1 IF YES, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

Behavioural Change communication	Yes √	No
Condom provision	Yes √	No
HIV testing and counselling	Yes √	No
Sexually transmitted infection services	Yes √	No
Antiretroviral treatment	Yes √	No
Care and support	Yes √	No
Other: *[Male circumcision; PEP]*	Yes√	No

IF HIV testing and counselling is *provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if HIV testing is voluntary or mandatory etc):

HIV testing and counselling is Voluntary in the defence forces.

5. Does the country have non-discrimination laws or regulations which specify protections for most at-risk populations or other vulnerable sub populations?

Yes √	No

5.1 ***IF YES***, for which subpopulations?

a. Women	Yes √	No
b. Young people	Yes √	No
c. Injecting drug users	Yes	No √
d. Men who have sex with men	Yes	No√
e. Sex workers	Yes	No √
f. Prison inmates	Yes	No √
g. Migrants/mobile populations	Yes	No√
h. Other *[People living with disabilities]*	Yes √	No

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

- Child Protection Act
- Domestic Violence Act

Briefly comment on the degree to which these laws are currently implemented:
These structures are in place to make sure there is implementation in different programme areas.

- Domestic violence Act
- Child protection committees at district level
- Victim friendly courts in place.

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most at risk populations or other vulnerable sub populations?

Yes √	No

6.1 ***IF YES***, for which subpopulations?

a. Women	Yes	No √
b. Young people	Yes	No √
c. Injecting drug users	Yes √	No
d. Men who have sex with men	Yes √	No
e. Sex workers	Yes √	No
f. Prison inmates	Yes √	No
g. Migrants/mobile populations	Yes√	No
h. Other *[People living with disabilities]*	Yes	No √

IF YES, briefly describe the content of these laws, regulations or policies

Homosexuality
Loitering
Sodomy

Briefly comment of how they pose barriers
It becomes difficult for sex workers to come up in the open because of the strict laws, they fear being prosecuted

7.0 Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes √	No

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes √	No

7.2 Have the estimates of the size of the main target populations been updated?

Yes	No √

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs √	Estimates of current needs only	No

7.4 Is HIV programme coverage being monitored?

Yes √	No

(a) ***IF YES***, is coverage monitored by sex (male, female)?

Yes √	No

(b) ***IF YES***, is coverage monitored by population groups?

Yes √	No

IF YES, for which population groups?

- ART Ages 0-4, 5-14 and 15+
- PMTCT Ages 0-6 weeks, 6 weeks – 18 months and 18 months – 2 years
- VCT Ages 0 – 4, 5–15, 15-24, 25–30, 31–49 and 50+

Briefly explain how this information is used:

- Resource mobilisation
- Planning
- Programming
- Advocacy
- Reporting
- Monitoring

(c) Is coverage monitored by geographical area?

Yes √	No

IF YES, at which geographical levels (provincial, district, others)?

District, Provincial and National levels

Briefly explain how this information is used:

- Resource mobilisation
- Planning
- Programming
- Advocacy
- Reporting
- Monitoring

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes √	No

Overall, how would you rate strategy planning efforts in the HIV programmes in 2009?

2009 Very Poor Excellent										
0	1	2	3	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

- Grants received from Global Fund
- ART scale up
- Increased coverage of ART sites. The country now has 280 sites from the 70 it had in 2007.
- Adoption of the male circumcision initiative in 2008**.**

What are the remaining challenges in this area?

- Disbursement of funds from partners was inconsistent such that some of the funds could not be spent.
- Change of currency which resulted in most funds set aside in Zimbabwean dollars not being used.
- Human resources loss due to brain drain.
- High inflation

ii POLITICAL SUPPORT

Strong political support includes: government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings; allocations of national budgets to support HIV programmes, and effective use of government and civil society organisations to support HIV programmes.

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

President/Head of government	Yes √	No
Other high officials	Yes √	No
Other officials in regions and/or districts	Yes √	No

2.0 Does the country have an officially recognised national multisectoral AIDS coordination body (i.e. a National AIDS Council or equivalent)?

Yes √	No

IF NO, briefly explain why not and how AIDS programmes are being managed:

N/A

2.1 IF YES, when was it created?

Year: **1999**

2.1 IF YES, who is the Chair?

Name:	Position/Title
Reverend Doctor M. Kuchera	**Reverend**

2.3 IF YES, does the national multisectoral AIDS coordination body:

Have terms of reference?		Yes √	No
Have active government leadership and participation?		Yes √	No
Have a defined membership?		Yes √	No
IFYES, how many members?	*[14]*		
Include civil society representatives?		Yes √	No
IF YES, how many?	*[2]*		
Include people living with HIV?		Yes√	No
IF YES, how many?	*[2]*		
Include the private sector?		Yes√	No
Have an action plan?		Yes √	No
Have a functional Secretariat?		Yes √	No
Meet at least quarterly?		Yes √	No
Review action on policy decisions regularly?		Yes √	No
Actively promote policy decisions?		Yes √	No
Provide opportunity for civil society to influence decision making?		Yes √	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?		Yes √	No

3. Does the country have a mechanism to promote interaction between government, civil society organisations and private sector for implementing HIV strategies/programmes?

Yes√	No	N/A

IF YES, briefly describe the main achievements:

- Promotion of multisectoral approach
- Came up with a shared vision
- Coordinating funding in terms of Expanded Support Programme (ESP) and Global Fund (GF)
- Convince donors to support HIV and AIDS programmes
- BC programmes running in different districts
- National Action Plan for OVC.

Briefly describe the main challenges:

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

Percentage: *[write in]*

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organisations for the implementation of HIV –related activities?

Information on priority needs	Yes√	No
Technical guidance	Yes√	No
Procurement and distribution of drugs or other supplies	Yes√	No
Coordination with other implementing partners	Yes√	No
Capacity Building	Yes√	No
Other: [*write in]*	Yes√	No

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

6.1 IF YES, were the policies and amended to be consistent with National AIDS Control policies?

Yes√	No

IF YES, name and describe how the policies/laws were amended:

Statutory Instrument No. 192 of 2002 was amended which indicates that HIV and AIDS must be mainstreamed in all labour issues.

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

- Legal provision and protection with regards to sex work.
- Men having sex with men.
- Legal provisions on human rights issues with special mention on homosexuality.

Overall, how would you rate the political support for the HIV programme in 2009?										
Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9√	10

Since 2007, what have been key achievements in this area:

- HIV and AIDS syllabus in the Agricultural Education colleges.
- HIV and AIDS now on curriculum in primary schools.
- Parliamentary committee on HIV and AIDS.
- Implementation of workplace programmes in Tertiary Institutions.
- Male circumcision adopted in July 2008.

What are remaining challenges in this area? • There is no budget allocation for HIV and AIDS from the fiscus.

iii. PREVENTION

1. Does the country have a policy or strategy that promotes information education and communication (IEC) on HIV to the general population?

Yes√	No	N/A

1.1 IF YES, what key messages are explicitly promoted?

✓ Check for key message explicitly promoted

a. Be sexually abstinent	Yes
b. Delay sexual debut	Yes
c. Be faithful	Yes
d. Reduce the number of sexual partners	Yes
e. Use condoms consistently	Yes
f. Engage in safe(r) sex	Yes
g. Avoid commercial sex	No
h. Abstain from injecting drugs	N/A
i. Use clean needles and syringes	Yes
j. Fight against violence against women	Yes
k. Greater acceptance and involvement of people living with HIV	Yes
l. Greater involvement of men in reproductive health programmes	Yes
m. Males to get circumcised under medical supervision	Yes
n. Know your HIV status	Yes
o. Prevent Mother to Child Transmission of HIV	Yes
Other : *[write in]*	

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes√	No

2.0 Does the country have a policy or strategy promoting HIV related reproductive and sexual health education for young people?

Yes√	No	N/A

2.1 Is HIV education part of the curriculum?

Primary schools?	Yes√	No
Secondary schools?	Yes√	No

Teacher training?	Yes√	No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes√	No

2.3 Does the country have an HIV education strategy for the out of school young people?

Yes√	No

3.0 Does the country have a policy or strategy to promote information education and communication and other preventive health interventions for most-at-risk or other vulnerable sub-populations?

IF NO, briefly explain: N/A

3.1 IF YES, which populations and what elements of HIV prevention do the policy/strategy address? Check which specific populations and elements are included in the policy/strategy

	IDU*	MSM*	Sex Workers	Clients of sex workers	Prison inmates	Other populations * *[write in]*
Targeted information on risk reduction and HIV education			√		√	
Stigma and discrimination reduction						
Condom promotion						
HIV testing and counselling						
Reproductive health including sexually transmitted infections prevention and treatment						
Vulnerability reduction (e.g income generation)	N/A	N/A		N/A	N/A	
Drug substitution therapy		N/A	N/A	N/A	N/A	
Needle and syringe exchange		N/A	N/A	N/A	N/A	

*IDU = injecting drug user
*MSM = men who have sex with men

Overall, how would you rate policy efforts in support of the HIV prevention in 2009?										
2009 Excellent									Very	Poor
0	1	2	3	4	5	6	7	8	9√	

10
Since 2007, what have been key achievements in this area: • Materials on HIV flighted on television • Positive reporting by the media • Reduction in sex partners • Increased uptake of condoms *What are remaining challenges in this area?* • Consistent and correct use of condoms • Prevention difficult to measure

4. Has the country identified specific needs for HIV prevention programmes?

Yes √	No

IF NO, how are HIV prevention programmes being scaled up? N/A

4.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	Agree √	Don't agree	N/A
Universal precautions in health care settings	Agree √	Don't agree	N/A
Prevention of mother to child transmission of HIV	Agree √	Don't agree	N/A
IEC* on risk reduction	Agree √	Don't agree	N/A
IEC* on stigma and discrimination reduction	Agree √	Don't agree	N/A
Condom promotion	Agree √	Don't agree	N/A
HIV testing and counselling	Agree √	Don't agree	N/A
Harm reduction for injecting drug users	Agree	Don't agree	N/A √
Risk reduction for men who have sex with men	Agree	Don't agree	N/A √
Risk reduction for sex workers	Agree √	Don't agree	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	Agree √	Don't agree	N/A
School-based HIV education of young people	Agree√	Don't agree	N/A
HIV prevention for out-of-school young people	Agree√	Don't agree	N/A
HIV prevention in the workplace	Agree √	Don't agree	N/A
Other: *[write in]*	Agree	Don't agree	N/A

Overall, how would you rate policy efforts in support of the HIV prevention in 2009?										
Very poor										Excellent
0	1	2	3	4	5	6	7	8	9√	10
Since 2007, what have been key achievements in this area: • More people disclosing their positive status • Male circumcision										

- More women are on PMTCT

What are remaining challenges in this area?

- Inadequate resources – Behaviour change programme is only covering 26 districts out of the possible 66.
- Scaling up of prevention programmes in all districts.

*IEC = Information, Education, Communication

IV TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care and home and community-based care).

Yes √	No

1.1 ***IF YES***, does it address barriers for women?

Yes √	No

1.2 ***IF YES,*** does it address barriers for most-at-risk populations?

Yes √	No

2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes √	No

IF YES, how were these determined?

- Needs assessment
- HIV and AIDS estimates

IF NO, how are HIV treatment, care and support services being scaled up?

2.1 To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support services	The majority of people in need have access		
Antiretroviral therapy	Agree √	Don't agree	N/A
Nutritional Care	Agree √	Don't agree	N/A
Paediatric AIDS treatment	Agree √	Don't agree	N/A
Sexually transmitted infection management	Agree √	Don't agree	N/A
Psychosocial support for people living with HIV and their families	Agree √	Don't agree	N/A
Home based care	Agree √	Don't agree	N/A
Palliative care and treatment of common HIV-related	Agree √	Don't agree	N/A

infections			
HIV testing and counselling for TB patients	Agree √	Don't agree	N/A
TB screening for HIV infected people	Agree √	Don't agree	N/A
TB prevention therapy for HIV infected people	Agree √	Don't agree	N/A
TB infection control in HIV treatment and care facilities	Agree √	Don't agree	N/A
Cotrimoxazole prophylaxis (e.g occupational exposures to HIV, rape)	Agree √	Don't agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree √	Don't agree	N/A
HIV care and support in the workplace (Including alternative working arrangements)	Agree √	Don't agree	N/A
Other: *[support for infected children]*	Agree √	Don't agree	N/A

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes √	No

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms and substitution drugs?

Yes √	No

IF YES, for which commodities?

- Condoms
- ARVs

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?										
Very poor										Excellent
0	1	2	3	4	5	6	7 √	8	9	10

Since 2007, what have been key achievements in this area:

- Decentralisation of ART.
- Establishment of follow-up sites.
- Improvement in availability of drugs.
- Secured support from multilateral agencies to scale up treatment and care.

What are remaining challenges in this area?

- There are still a number of people in need of ART who are not getting them.
- Delays in initiation of ART patients
- Training of Nurses to initiate patients on ART.
- Decentralisation to be done further.
- Inadequate equipment if hospitals.

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes √	No	N/A

5.1 ***IF YES***, is there an operational definition for the orphans and vulnerable children in the country children?

Yes √	No

5.2 ***IF YES,*** does the country have a national action plan specifically for orphans and vulnerable children?

Yes √	No

5.3 ***IF YES,*** does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes √	No

IF YES, what percentage or orphans and vulnerable children is being reached? 24.57%

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?										
Very poor										Excellent
0	1	2	3 √	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

- Pulled funding in terms of programme of Support (PoS)
- Revitalisation of BEAM in 2009
- Increased number of children reached

What are remaining challenges in this area?

- Coordination gap within the coordinating Ministry especially in sub-national levels.
- Inadequate funding
- Most children are infected and they are not taken care of in this context.

IV MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M & E) plan?

Yes √	In progress	No

IF NO, briefly describe the challenges: N/A

1.1 ***IF YES,*** years covered: *[2010 - 2012]*

1.2 ***IF YES***, was the M & E plan endorsed by key partners in M & E?

Yes √	No

1.3 ***IF YES,*** was the M & E plan developed in consultation with civil society, including people living with HIV?

Yes √	No

1.4 IF YES, have the key partners aligned and harmonised their M & E requirements (including indicators) with the national M & E plan?

Yes, all partners	Yes, most partners √	Yes, but only some partners	No

IF YES, but only some partners or IF NO, briefly describe what the issues are:

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	Yes√	No
IF YES, does it address:		
Routine programme monitoring	Yes√	No
Behavioural surveys	Yes√	No
HIV surveillance	Yes√	No
Evaluation/research studies	Yes√	No
a well defined standardised set of indicators	Yes√	No
Guidelines on tools for data collection	Yes√	No
a strategy for assessing data quality (i.e. validity, reliability)	Yes√	No
a data analysis strategy	Yes√	No
a data dissemination and use strategy	Yes√	No

3. Is there a budget for implementation of the M & E plan?

Yes	In progress	No √

3.1 ***IF YES,*** what percentage of the total HIV programme funding is budgeted for M & E activities?

3.2 ***IF YES,*** has full funding been secured?

Yes	No√

IF NO, briefly describe the challenges: • Budget • Training • Tools N/A

3.3 IF YES, are M & E expenditures being monitored?

Yes√	No

4. Are M & E priorities determined through a national M & E system assessment?

Yes√	No

IF YES, briefly describe how often a national M & E assessment is conducted and what the assessment involves:

IF NO, briefly describe how priorities for M & E are determined:

5.0 Is there a functional national M & E Unit?

Yes√	In progress	No

IF NO, what are the main obstacles to establishing a functional M & E Unit?

5.1 IF YES, is the national M & E Unit based:

In the National AIDS Commission (or equivalent)?	Yes√	No
In the Ministry of Health?	Yes√	No
Elsewhere? *[Partners]*	Yes√	No

5.2 IF YES, how many and what type of professional staff are working in the national M & E Unit?

Number of permanent staff:		
Position:	Full time/Part time	Since when?
Position:	Full time/Part time	Since when?
[Add as many as needed]		

5.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M & E data/reports to the M & E unit for inclusion in the national M & E system.

Yes	No

IF YES, briefly describe the data-sharing mechanisms:

What are the major challenges?

6. Is there a national M & E Committee or Working Group that meets regularly to coordinate M & E activities?

No	Yes, but meets irregularly	Yes, meets regularly√

6.1 Does it include representation from civil society?

Yes	No

IF YES, briefly describe who the representatives from civil society are and what their role is

7. Is there a central national database with HIV-related data?

Yes√	No

7.1 ***IF YES,*** briefly describe the national database and who manage it. *[write in]*

7.2 ***IF YES,*** does it include information about the content, target population and geographical coverage of HIV services as well as their implementing organisations?

a. Yes all of the above
b. Yes, but only some of the above.
c. No, none of the above

7.3 Is there a functional* Health Information System?

	Yes	No
At national level		
At sub-national level(s) ***IF YES,*** at what level(s) *[write in]*		

*(*regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analysed and used at different levels)*

8. Does the country publish at least once a year an M & E report on HIV and on, including HIV surveillance data?

Yes	No√

9. To what extend are M & E data used.

9.1 In developing/revising the national AIDS strategy?

Low					High
0	1	2	3√	4	5

Provide a specific example:

- Targets
- Resource allocation
- Planning

What are the main challenges, if any?

- Capacity
- Data quality
- Data dissemination

9.2 For resource allocation?

Low				High	
0	1	2	3	4	5

Provide a specific example:

What are the main challenges, if any?

9.3 For programme improvement?

Low				High	
0	1	2	3√	4	5

Provide specific example:

What are the main challenges; if any?

10. Is there a plan for increasing human capacity in M & E at national, sub-national and service-delivery levels?

a. Yes √ *[write in]*

b. Yes, but only addressing some levels.

c. No

10.1 In the last year, was training in M & E conducted

At national level?	Yes	No
IF YES, Number trained: *[write in]*		
At sub national level?	Yes	No
IF YES, Number trained: *write in]*		
At Service delivery level including civil society?	Yes	No

IF YES, Number trained:*[write in]*

10.2 Were other M & E capacity-building activities conducted other than training?

Yes	No

IF YES, describe what types of activities: *[write in]*

Overall, how would you rate the M & E efforts of the HIV programme in 2009?
Very Poor Excellent
0 1 2 3 4 5 6 7 8 9 10
Since 2007, what have been key achievements in this area: • ART M & E developed • Civil society training • Private sector M & E system *What are remaining challenges in this area?* • Data analysis plans • Dissemination

National Composite Policy Index (NCPI) questionnaire

Part B
[To be administered to representatives from civil society organisations, bilateral agencies, and UN organisations]

1. HUMAN RIGHTS

2. **Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health etc)**

Yes √	No

National HIV and AIDS Policy

1.1 IF YES, specify if HIV is specifically mentioned and how or if this is a general non-discriminatory provision

[write in]

2. Does the country have non-discriminatory laws or regulations which specify protection for most at risk populations and other vulnerable subpopulations?

Yes √	No

2.1 IF YES, for which populations?

i. Women	Yes √	No
j. Young people	Yes √	No
k. Injecting drug users	Yes	No
l. Men who have sex with men	Yes	No
m. Sex workers	Yes	No
n. Prison inmates	Yes	No
o. Migrants/mobile populations	Yes√	No
p. Other *[write in]*	Yes √	No

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Briefly describe the content of these laws:

Briefly comment on the degree to which they are currently implemented

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

Yes √	No

3.1 IF YES, for which subpopulations?

a. Women	Yes	No
b. Young people	Yes	No
c. Injecting drug users	Yes√	No
d. Men who have sex with men	Yes√	No

e. Sex workers	Yes√	No
f. Prison inmates	Yes√	No
g. Migrants/mobile populations	Yes	No
h. Other *[write in]*	Yes	No

IF YES, briefly describe the content of these laws, regulations or policies

- Social Offences Act – Sodomy laws
- Criminalisation of sex workers – miscellaneous Act
- Policy on non distribution of condoms in prisons/schools

Briefly comment on how they pose barriers

- Practices affect mobile populations
- Fear of accessing treatment, care and support and testing due to stigma and discrimination.
- Criminalisation of same sex relationships prevents people from accessing proper protective methods, information, treatment care and support.
- Prisoners fuel the spread of HIV.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes √	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most at risk-populations an d/or other vulnerable subpopulations?

Yes	No√

IF YES, briefly describe this mechanism:

6.0 Has the Government, through political and financial support, involved people living with HIV, most-at risk-populations and/or other vulnerable subpopulations in government HIV-policy design and programme implementation?

Yes	No

IF YES, briefly describe some examples:

(Need for follow-up) There seem to be some involvement at different levels (MIPA Officers etc)

But in future there is need to be up scaled involvement as their voice is not heard.

7. Does the country have a policy of free services for the following?

f. HIV prevention services	Yes √	No
g. Antiretroviral treatment	Yes √	No
h. HIV-related care and support interventions	Yes √	No

IF YES, given resource constrains, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

- People are placed on waiting list for long periods as there are limited supply if drugs.
- Inaccessibility to health centres due to transport costs.
- Under resourced people being charged.
- Administration fees which are not affordable

8. Does the country have a policy to ensure equal access to HIV prevention, treatment, care and support?

Yes √	No

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnant and childbirth?

Yes √	No

9. Does the country have a policy to ensure equal access for most at-risk-populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes	No √

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, and termination)?

Yes √	No

11. Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by national/local ethical review committees?

Yes √	No

11.1 IF YES, does the ethical review committee include representatives of civil society including people living with HIV?

Yes	No √

IF YES, describe the approach and effectiveness of this review committee:

12. Does the country have the following human rights monitoring and enforcement mechanisms?

- Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs and ombudspersons which consider HIV related issues within their work.

Yes	No √

- Focal points within governmental health and other departments to monitor HIV related human rights abuses and HIV related discrimination in areas such as housing and employment

Yes	No √

- Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes	No √

IF YES, on any of the above questions, describe some examples:

13. In the last 2 years, have members of the judiciary (including labour courts/employment tribunals) been trained/sensitised to HIV and human rights issues that may come up in the context of their work?

Yes	No √

14. Are the following legal support services available in the country?

- Legal aid systems for HIV casework

Yes	No √

- Private sector firms or university based centres to provide free or reduced cost legal services to people living with HIV.

Yes	No √

- Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes √	No

15. Are there programmes in place to reduce HIV related stigma and discrimination?

Yes √	No

IF YES, what types of programmes?

Media	Yes √	No
School education	Yes √	No
Personalities regularly speaking out	Yes	No√
Other *[write in]* Training at Community level	Yes √	No

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relations to HIV in 2009?										
Very poor										Excellent
0	1	2	3	4√	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

- Policy formed in 1999

What are the remaining challenges in this area?

- Policy has not been translated into laws and regulations

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2009?										
Very Poor										Excellent
0	1	2	3	4√	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

- The World AIDS Campaign on Universal access and all.

What are the remaining challenges in this area?

ii CIVIL SOCIETY* PARTICIPATION

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

Low					High
0	1	2	3√	4	5

Comments and examples:

- Civil society has been involved in policy and strategy formulations and there has been consultations e.g. Zimbabwe National AIDS Strategic Plan (ZNASP) and Behaviour change strategy
- Loosing momentum in as far as political leadership is concerned.

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current plan (e.g. attending planning meetings and reviewing drafts)?

Low					High
0	1	2	3	4√	5

Comments and examples:

- There is room for improvement in budgeting process.
- 50% of National AIDS Trust Funds was pushed to go for ART allocation
- Both government and civil society need to be proactive

3. To what extent have civil society representatives been involved in the planning and budgeting process of the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts?

a. The national AIDS strategy

Low					High
0	1	2	3	4√	5

b. The national AIDS budget?

Low					High
0	1	2√	3	4	5

c. National AIDS reports?

Low					High
0	1	2	3	4√	5

*civil society include among others: networks of people living with HIV, women's organisations, young people's organisations, faith based organisations, AIDS service organisations, community-based organisations, organisations of key affected groups (including men who have sex with men, injecting drug users, sex workers, migrants, refugees/displaced populations, prisoners) workers organisations, human rights organisations etc. For the purpose of the NCPI, the private sector is considered separately

Comments and examples:

- CBOs, ZNNP+ have been accessing these funds.
- Civil society is included in National AIDS strategy

4. To what extent is civil society included in the monitoring and evaluation (M & E) of the HIV response?

   a. Developing the national M & E plan?

Low					High
0	1	2	3	4√	5

   b. Participating in the national M & E committee/working group responsible for coordination of M & E activities?

Low					High
0	1	2	3	4√	5

   c. M & E efforts at local level?

Low					High
0	1	2	3√	4	5

Comments and examples:
- Need to build capacity of CBOs in terms of reporting for M & E.

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organisations (e.g networks of people living with HIV, organisations of sex workers, faith based organisations)?

Low					High
0	1	2	3√	4	5

Comments and examples:

- Legal framework prohibits other sectors such as MSM, sex workers and representation at NAC by PLWHIV
- There is room for improvement.

6. To what extent is civil society able to access?

a. adequate financial support to implement its HIV activities

Low					High
0	1	2√	3	4	5

b. adequate technical support to implement its HIV activities?

Low					High
0	1	2√	3	4	5

Comments and examples:

During the period under review, it was a resource limited period.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention of youth	<25%	25 – 50%	51 – 75%√	>75%
Prevention for most-at-risk-populations: Injecting drug users	<25% √	25-50%	51-75%	>75%√
Men who have sex with men	<25%	25-50%	51-75%	>75%√
Sex workers	< 25%	25-50%	51-75%	>75%√
Testing and Counselling	<25%	25 – 50%	51 – 75%√	>75%
Reduction of stigma and discrimination	<25%	25 – 50%	51 – 75%√	>75%
Clinical services (ART/OI)*	<25%	25 – 50%√	51 – 75%	>75%
Home-based care	<25%	25 – 50%	51 – 75%	>75%√
Programmes for OVC	<25%	25 – 50%	51 – 75%√	>75%

**ART = Antiretroviral Therapy; OT – Opportunistic Infections*
***OVC = Orphans and other vulnerable children*

Overall, how would you rate the efforts to increase civil society participation in 2009?										
Very Poor										Excellent
0	1	2	3	4√	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

Representation in the NAC Board

What are the remaining challenges in this area?

- Legal framework
- Resource allocation
- Coordination of civil society

iii. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes √	No

IF YES, how were these specific needs determined?

- Review of BC
- Review of National Strategic Framework
- M & E data collected

IF NO, how are HIV prevention programmes being scaled up?

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	Agree √	Don't agree	N/A
Universal precautions in health care settings	Agree √	Don't agree	N/A
Prevention of mother to child transmission of HIV	Agree √	Don't agree	N/A
IEC* on risk reduction	Agree √	Don't agree	N/A
IEC* on stigma and discrimination reduction	Agree √	Don't agree	N/A
Condom promotion	Agree √	Don't agree	N/A
HIV testing and counselling	Agree √	Don't agree	N/A
Harm reduction for injecting drug users	Agree	Don't agree	N/A √
Risk reduction for men who have sex with men	Agree	Don't agree√	N/A
Risk reduction for sex workers	Agree	Don't agree√	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	Agree √	Don't agree	N/A
School-based HIV education of young people	Agree√	Don't agree	N/A
HIV prevention for out-of-school young people	Agree	Don't agree√	N/A
HIV prevention in the workplace	Agree √	Don't agree	N/A
Other: *[write in]*	Agree	Don't agree	N/A

*IEC = Information, education, communication

Overall, how would you rate the efforts in the implementation of HIV prevention programme in 2009?

Very Poor										Excellent
0	1	2	3	4	5	6√	7	8	9	10

Since 2007, what have been key achievements in this area:

- Reduction in prevalence 15.6% to 13.7%

What are remaining challenges in this area?

- Move efforts to reach Millennium Development Goals (MDGs)

IV TREATMENT, CARE AND SUPPORT

1. Has the country identified specific needs for HIV treatment, care and support services?

Yes √	No

IF YES, how were these specific needs determined?

- HBC from WHO guidelines
- Treatment, care and support – International and National guidelines and standard s and national surveys/assessments

IF NO, how are HIV treatment, care and support services being scaled-up?

1.1 To what extent have HIV treatment, care and support services been implemented?

HIV treatment, care and support services	The majority of people in need have access		
Antiretroviral therapy	Agree	Don't agree√	N/A
Nutritional Care	Agree	Don't agree√	N/A
Paediatric AIDS treatment	Agree	Don't agree√	N/A
Sexually transmitted infection management	Agree √	Don't agree	N/A
Psychosocial support for people living with HIV and their families	Agree √	Don't agree	N/A
Home based care	Agree √	Don't agree	N/A
Palliative care and treatment of common HIV-related infections	Agree	Don't agree√	N/A
HIV testing and counselling for TB patients	Agree √	Don't agree	N/A
TB screening for HIV infected people	Agree	Don't agree√	N/A
TB prevention therapy for HIV infected people	Agree	Don't agree√	N/A
TB infection control in HIV treatment and care facilities	Agree	Don't agree√	N/A
Cotrimoxazole prophylaxis (e.g occupational exposures to HIV, rape)	Agree √	Don't agree	N/A
Post-exposure prophylaxis (e.g occupational exposures to HIV rape)	Agree	Don't agree√	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace.	Agree	Don't agree√	N/A

HIV care and support in the workplace (Including alternative working arrangements)	Agree	Don't agree√	N/A
Other: *[Diagnostic/Laboratory testing for ART, CD4 count machines very limited]*	Agree	Don't agree√	N/A

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?										
Very Poor										Excellent
0	1	2	3	4	5√	6	7	8	9	10

Since 2007, what have been key achievements in this area:

- Availability of drugs
- HBC service provision gone up
- Support from government leaders
- Zimbabwe has given a great amount of domestic funds to HIV treatment and care more than other countries
- IEC material literature is more widely available
- Policy guidelines developed e.g. Nutrition, OI/ART guidelines

What are remaining challenges in this area?

- Human resources and infrastructure for health
- Laboratory testing should be continuous not once off.
- Issues of stigma and discrimination.
- Quality of service
- Access of treatment for people in rural areas.
- Expiring drugs due to supply management systems and bureaucracy.
- Corruption when it comes to drug
- Lack of accountability
- Dynamics involved in HIV and AIDS in children and youths

2. Does the country have a policy or strategy to address the additional HIV related needs of orphans and other vulnerable children?

Yes√ **NAP for OVC**	No	N/A

2.1 ***IF YES***, is there an operational definition for orphans and vulnerable children in the country

Yes √	No

2.2 ***IF YES,*** does the country have a national action plan specifically for orphans and vulnerable children?

Yes √	No

2.3 ***IF YES,*** does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes √	No

IF YES, what percentage or orphans and vulnerable children is being reached?

- the figure is estimated at 1.3 million children but the percentage reached is not known.

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?										
Very Poor										Excellent
0	1	2	3 √	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

- The NAP for OVC is still in operation and it is being implemented.
- Children are now being considered with regards to programming.
- There is slight improvement in Child Protection participation and PSS

What are remaining challenges in this area?

- Need to scale up on child protection.
- Need to mainstream gender when dealing with orphans and other vulnerable children.
- Need to scale up on child participation with regards to reproductive health, life skills education
- Interventions targeting OVC need to be holistic
- Paediatric treatment is not being accessed by many children due to factors such as lack of child participation and the quality of service.