



UNITED NATIONS GENERAL ASSEMBLY (UNGASS) REPORT
on
HIV AND AIDS

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

ZIMBABWE COUNTRY REPORT
Reporting Period: January 2006-December 2007

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Acronyms

Antenatal Care	ANC
Antiretroviral drugs	ARVs
Antiretroviral therapy	ART
Basic Education Assistance Module	BEAM
British Department of International Development	DFID
Central Statistics Office	CSO
Canadian International Development Agency	CIDA
Demographic and Health Survey	DHS
District AIDS Coordinators	DAC
District AIDS Action Committees	DAAC
Expanded Support Programme	ESP
Global Fund to Fight AIDS, TB and Malaria	GFATM
Home-based Care	HBC
Information, Education Communication	IEC
John Snow International	JSI
Joint United Nations Programme on HIV/AIDS	UNAIDS
Knowledge, Attitudes, and Practice	KAP
Monitoring and Evaluation	M&E
Ministry of Education, Sport and Culture	MOESC
Ministry of Finance and Economic Development	MOFED
Ministry of Health and Child Welfare	MoHCW
Ministry of Public Service, Labour and Social Welfare	MoPLSW
National AIDS Council	NAC
National Blood Transfusion Services	NBTS
National Action Plan of for Orphans and Other Vulnerable Children	NAP for OVC
Opportunistic Infections	OI
Population Service 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 Population Fund	UNFPA
United States Agency for International Development	USAID
Voluntary Counselling and Testing	VCT
Zimbabwe Business Council on HIV/AIDS	ZBCA
Zimbabwe National Family Planning Council	ZNFPCC
Zimbabwe AIDS Network	ZAN

1.0 Status at Glance

Zimbabwe is one of the 189 signatories to the United Nations General Assembly Session (UNGASS), Declaration of Commitment (DOC) to fighting of HIV and AIDS through a comprehensive multi-sectoral approach. The country was able to evaluate the progress it has made on sixteen out of the twenty-five UNGASS indicators for the period January 2006 to December 2007.

1.1 Report Writing Process

The last report was produced in 2005 and lessons learnt in this process were used in the preparation of this current report of 2006-2007. The Zimbabwe National Monitoring and Evaluation Taskforce, a multi-sectoral group of Monitoring and Evaluation experts and chaired by the National AIDS Council formed the UNGASS technical working group. This technical working group with assistance from a local consultant convened meetings with Civic Society, carried out individual interviews and group discussion with sector ministries, local and bilateral organizations as well as a desk review of available documents. A final meeting with representatives met to review the zero draft of the Report (Annex 1). The report was updated and finalized in January of 2008. The preparation of this report continues to help Zimbabwe to identify gaps and allows it to prioritize program activities in the fight against the HIV and AIDS epidemic.

1.2 Status of HIV Epidemic

Zimbabwe with a projected adult (15-49 years) population of 12 million people is one of the countries in Sub-Saharan Africa that has been severely affected by the HIV and AIDS epidemic¹. According to the National HIV Estimates of 2007, the estimated HIV prevalence among adults 15-49 years is 15.6%². An estimated 1,320,739 (adults and children) were living with HIV and AIDS and of this population, an estimated 102 566 were estimated to be in urgent need of antiretroviral therapy by the end of 2007.

The country is experiencing a decline in HIV prevalence that is supposed to have started in the late 1990's. A decline was observed in both sentinel surveillance of pregnant women and in the National HIV Estimates process that models available data using the Epidemic Projection Package (EPP) and Spectrum software. Among pregnant women (15-49 years), HIV prevalence declined from 25.8% in 2004 to 17.7% in 2006. In the general population, using the current 2007 EPP and Spectrum software, HIV prevalence in Zimbabwe was estimated to be 26.5% in 2001, and therefore declined to 23.2% in 2003, and 19.4% in 2005, and to 15.6% in 2007³. The decline in HIV prevalence is attributed to a combination of mortality and a decline in HIV incidence due to behavior change.

¹ Central Statistics Office Projections 2007

² Ministry of Health and Child Welfare, Zimbabwe National HIV Estimates

³ The official figures from National HIV Estimates Processes for 2003 and 2005 are 24.6% and 20.1 % respectively, The EPP model recalculates values for previous years. The figures quoted in this report are based on the current 2007 EPP outputs.

1.3 Response to HIV and AIDS Epidemic

The Government of Zimbabwe has continued to scale up the multi-sectoral response to HIV and AIDS based on the Zimbabwe National and HIV AIDS Strategic Plan (ZNASP) (2006-2010) that was launched in July 2006. This plan builds on lessons learnt in implementation of the National AIDS Policy of 1999 and the National HIV and AIDS Framework (2000 -2004). The strategic plan continues to highlight HIV and AIDS as an emergency that requires Government and all stakeholders urgently mobilize the required resources in order to fight the epidemic.

Universal access to care and treatment is one of the main goals of the ZNASP. Zimbabwe continued to scale up access to care and treatment for HIV, AIDS and related opportunistic infections in the period 2006-2007. The number of people on antiretroviral therapy increased from 25 000 adults on ART at the end of 2005 to just over 60 000 adults and children in 2006 and slightly over 100 000 adults (including 10 000 children) at the end of 2007. While this number represents 38% of adults needing treatment, this increase reflects the efforts that the Government of Zimbabwe is making in a resource constrained environment.

One of the greatest negative impact of HIV and AIDS is the increase in vulnerability especially among children. It was estimated that in 2006 and 2007 there would be 1,008,542 and 975,956 HIV and AIDS orphans in Zimbabwe⁴. The National Plan of Action for Orphans and Other Vulnerable Children (NAP FOR OVC) to guide the care and support of orphans and vulnerable children in Zimbabwe was launched in 2005.

The principal mode of HIV transmission in Zimbabwean is heterosexual contact. According to the Zimbabwe Demographic and Health Survey (2005/06), the level of knowledge about HIV and AIDS is high with 75.7% women (15-49 years) and 81.3% men (15-54 years) knowing that condoms can be used to reduce the risk of getting HIV. Recognizing the need to move from awareness to action, Zimbabwe has put in place a National Behavior Change Strategy (NBCS) covering the period, 2006-2010. This plan provides guidance to all stakeholders on their contributions to behavior change promotion using key prevention elements such as condom use, reducing multiple partners and promoting faithfulness as a way of addressing root causes of risk behaviors. The second most important is perinatal transmission in which the mother passes HIV to the child during pregnancy, at birth or during breastfeeding. The NBC strategy also encompasses a plan of scale up of prevention strategies such as Prevention of Mother to Child Transmission of HIV (PMTCT) and strategies to reduce the incidence of HIV infection especially among youth 15-24 years.

The country was able to fund its response through various funding mechanisms. Zimbabwe is a signatory to the Abuja declaration of 1998, where governments committed that a minimum of 15% of government budget should be go towards health care for the nation. The Zimbabwe government raised money through the fiscus and through the National AIDS Trust Fund (NATF), a 3% levy collected from taxable income from all sectors to mitigate the impact of HIV and AIDS and is channeled to the National AIDS Council by the Ministry of Finance. The Government of Zimbabwe through Ministry of Finance contributed US \$ 14 700 000 in 2005⁵, US \$ 63,437 000.00 (Z \$ 101 500 000 000.00) in 2006 and US \$ 86 256.00 (Z\$ 345 025 716 293.71) in 2007⁶ towards

⁴Zimbabwe National HIV and AIDS Estimates 2007

⁵ Zimbabwe HIV and AIDS Subaccounts for UNAIDS, Abt Associates 2005

⁶ Government of Zimbabwe, Ministry of Finance, Budget Estimates 2005-2008

HIV and AIDS programs. These amounts reflect the Ministry of Finance's budgeted expenditures and include the National AIDS Levy. Despite several economic challenges, Zimbabwe was able to use 13.7% of the total government spending on health related expenditures in 2007. In support of government efforts, bilateral partners contributed US \$ 64 300 000.00 in 2005⁵ and US \$41,930 856.00 in 2006 towards HIV and AIDS programs⁷. The Multilaterals (UN) contributed US \$ 10 432 191.00(2005) and US \$ 24 148 770.00 (2006)⁷. Additional funding for the period under review was received from Global Fund (GFTAM) Round 5 amounting to US \$60 Million and another US\$ 50M was mobilized under the Expanded Support on Health Programs (ESP) by a consortium of partners under the chairmanship of NAC in 2007.

⁷UNAIDS Resource tracking report, 2007

1.4: Table 1 - Status at a glance indicators

NATIONAL COMMITMENT and ACTION

1. Amount of national funds disbursed on HIV/AIDS → **US\$ 63 437.00⁸ (2006) and US\$ 86 256.00⁹ (2007)** (*Zimbabwe HIV and AIDS Subaccounts for UNAIDS Report for 2007*)
2. National Composite Policy Index → **Refer to NCPI-A&B**

NATIONAL Programs

3. Percentage of donated blood units screened for HIV in a quality assured manner
100% (2006) and 100% (2007) (*National Blood Transmission Services*)
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.
8% (2005), 17.8% (2006) and 38% (2007) (*MOHCW Programme Data*)
5. Percentage of HIV positive pregnant women who received antiretroviral to reduce the risk of mother to child transmission. **40% (2005), 60% (2006) and 67% (September 2007)** (*MOHCW Programme Data*)
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV
(Not available see narrative)
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months who know their results. **6.6% women and 6.6% men** (*ZDHS 2005/06*)
8. Percentage of most at risk populations that have received an HIV result in the last 12 months and who know their results. **(Not available)**
9. Percentage of most –at-risk populations reached with HIV prevention Programs
(Not available)
10. Percentage of orphaned and vulnerable children aged 0-17 years whose households received free basic external support in caring for the child
31.2% received at least one type of external assistance (ZDHS 2005/06)
39.0% received BEAM (Ministry of Public Service Labour and Social Welfare (2006))
11 % received BEAM (Ministry of Public Service Labour and Social Welfare (2007))¹⁰
11. Percentage of schools that provided life skills-based HIV education in the last academic year
100% (2006) and 100% (2007) (*Ministry of Education Sports and Culture. Department of Policy and Planning*)

KNOWLEDGE and BEHAVIOUR

12. Current school attendance among orphans and among non-orphans aged 10-14 years*
87.9 % current school attendance among orphans (ZDHS 2005/06)
92.4% current school attendance among non-orphans (ZDHS 2005/06)
13. Percentage of young women and men aged 15-24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.*
43.7% women and 45.6% men (ZDHS 2005/06)
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 **Not available**
15. Percentage of young women and men aged 15-24 years who had sexual intercourse before the age of 15.

⁸ Conversion of Zim Dollar was 1USD= Z\$ 1 600 (UN Rate 2006)

⁹ Conversion of Zim Dollar was 1USD= Z\$ 4 000 000 (UN Rate 2007)

¹⁰ Beam assistance is given to school going children in the age group 6-18 years.

A total of 350 722 out of an expected 906 000 children benefited in 2006 and in 2007 the ratio was 93 941 out of 837 428 children.

5.3% women and 4.5% men (ZDHS 2005/06)

16. Percentage of women and men aged 15-49 years who had sexual intercourse with more than one partner in the last 12 months. *1.3% women and 14.1 % men (ZDHS 2005/06)*
17. Percentage of women and men aged 15-49 years who had more than one sexual partner in the last 12 months who reported using a condom during their last sexual act.
46.7% women 70.5% men (ZDHS 2005/06)
18. Percentage of female and male sex workers reporting the use of condom on their most recent client.
3.8 % men (ZDHS 2005/06)
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner
(Not available)
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse. *(Not available)*
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected *(Not available)*

IMPACT

22. Percentage of young women and men aged 15-24 years of age who are HIV infected*
(Target: 25% reduction in most affected countries by 2005; 25% reduction globally by 2010)→
19.9% in 2002 ; 17.4% in 2004 ; 13.1% in 2006
{ *National Survey of HIV and Syphilis Prevalence Among Women Attending Antenatal Clinics in Zimbabwe, 2006* }
23. Percentage of most at risk populations who are known to be HIV infected
Not available see narrative
24. Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy → *92.7 % (2006) (ART Programme Data, MOHCW)*
25. Percentage of infants born to HIV infected mothers who are infected
(Target: 20% reduction by 2005; 50% reduction by 2010) → Not available**

2.0 Overview of the AIDS Epidemic

Decline in HIV Prevalence

- *Estimated Adult HIV Prevalence (15-49 years)* —→ *19.4% (2005) 15.6% (2007) {2007 National HIV Estimate Report}*
- *Percentage of HIV-Positive Among ANC Attendees women 15-24years* —→ *17.4% (2004) 13.1% (2006) {National Survey of HIV and Syphilis Prevalence Among Women Attending Antenatal Clinics in Zimbabwe, 2006}*

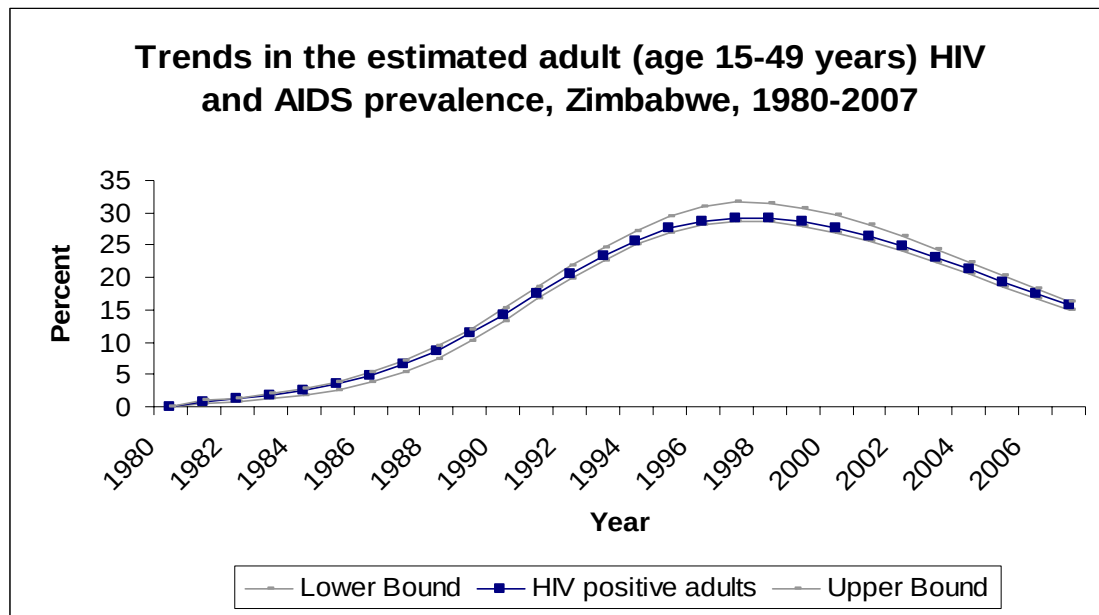


Table 1: Zimbabwe National HIV Estimates 2007

Estimated number of people living with HIV and AIDS in Zimbabwe at the end of 2007		
	Estimated Number	Upper and Lower Bounds
Total (adults and children)	1,320,739	1,252,299 - 1,384,440
Adults (15-49)	1,085,671	
Women (15-49)	651,402	
Children (0-14)	132,938	124,235 - 142,059
Adult Prevalence (15-49)	15.6%	14.9% - 16.3%

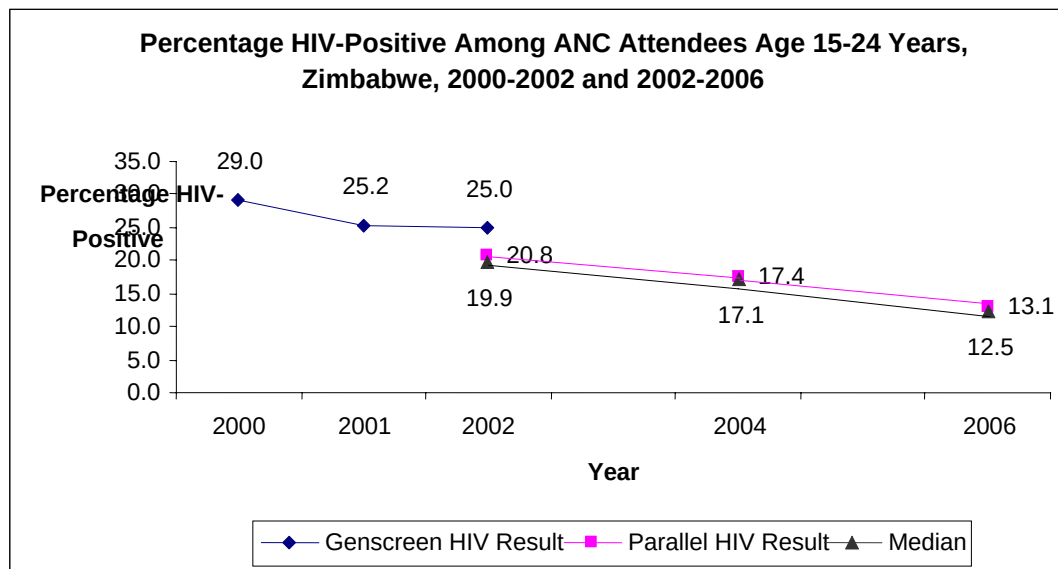
Zimbabwe is experiencing a declining generalized HIV epidemic. In the general population, using the current 2007 EPP and Spectrum software, HIV prevalence in Zimbabwe was estimated to be 26.5% in 2001, and therefore declined to 23.2% in 2003, and 19.4% in 2005, and to 15.6% in 2007³.

An epidemiological review commissioned by the MOHCW, Zimbabwe and published in November 2005 gathered data from several studies that supported that the decline in HIV prevalence had

started in the late 1990's¹¹. This decline was further supported by data from the Zimbabwe Demographic and Health Survey of 2005/06 that showed HIV prevalence was 18.1% in the general population (15-49 years). The main conclusions of the epidemiological review were that, a decrease in incidence mainly due to a change in sexual behavior specifically a decrease in number of sexual partners and reported condom use and mortality, have contributed to decline in HIV prevalence.

An estimated 1,320,739 (1,252,299 - 1,384,440) Zimbabweans were living with HIV and AIDS at the end of 2007. Among the estimated 1,085,671 people age 15 to 49 years living with HIV and AIDS, 60.0% were women. Among children age 0-14 years, an estimated 132,938 (124,235-142,059) were living with HIV and AIDS.

Figure 1: Trends among Pregnant Women



The Ministry of Health and Child Welfare first reported a decline in HIV prevalence among all pregnant women (15-49 years), in 2004. This declining trend continued in 2006, with prevalence decreasing from 25.7% in 2002, 21.3% in 2004 to 17.7% in 2006 among antenatal clinic attendees, 15-49 years. Although there is no direct method to estimate HIV incidence from the ANC survey data, prevalence trends among women 15-24 years of age can be used as a proxy to estimate incidence since these women are likely to be only recently exposed and infected with HIV. Similar trends were also observed among younger pregnant women (15-24 years) where prevalence declined from 20.8% in 2002, 17.4% in 2004 to 13.1% in 2006. This decline in HIV prevalence among the 15-24 year age further supports the theory that HIV incidence is going down .

¹¹ Evidence for HIV Decline in Zimbabwe, a comprehensive review of the epidemiological data, UNAIDS 05.26E

3.0 Zimbabwe's Response

3.1 National and International Policies Guiding the Response

The Zimbabwe Government has continued to demonstrate its commitment and leadership through ratification of international and regional agreements, the establishment, implementation and review of national policies on HIV and AIDS. Regionally and internationally, Zimbabwe is a signatory to several commitments to improve the HIV and AIDS response towards universal access to comprehensive prevention, treatment, care and support by 2010. These commitments include the following:

- Millennium Development Goals particularly Goal 6 that seeks to halt and reverse the spread of the HIV and AIDS epidemic by 2015 (2000)
- Maseru Declaration on HIV and AIDS (2003)
- The Gleneagles G8 Universal Access Targets (2005)
- Brazzaville Commitment on Universal Access (2006).
- The African Union's Abuja Call for Accelerated Action (2006)
- SADC Strategic Framework on HIV and AIDS (2006)

Zimbabwe has sought to improve coordination in HIV and AIDS responses at all levels by strengthening the three ones, namely, one strategic plan, one monitoring and evaluation system and one coordinating authority. The National AIDS Council which was formed through an act of parliament SI 16 of 1999 continued to coordinate the government's response to HIV and AIDS through a multi-sectoral approach. Early responses to the HIV and AIDS Epidemic include; two five year Medium Term Plan 1(MTP1) of 1989 and MTP2 of 1994. These were followed by the National HIV and AIDS Policy of 1999 and the development of the first National HIV and AIDS Strategic Framework (2000-2004) to provide guidance on implementation of a multisectoral HIV and AIDS response. This first strategic framework was extended and reviewed in 2005 resulting in the development of the current Zimbabwe National HIV and AIDS Strategic Plan, 2006 – 2010 (ZNASP). This plan provides a policy and strategic framework for operationalising the “Three Ones” principle and overall guidance to all HIV and AIDS interventions implemented by stakeholders, Government, civil society, the private sector and development partners in Zimbabwe. The ZNASP is also aligned to all regional and international commitments listed above.

As a demonstration of political commitment to the fight against HIV and AIDS, the government of Zimbabwe established high level fora, the parliamentary portfolio committee on Health in 2005, and the Cabinet Social Services Action Committee (SSACC). The Parliamentary Portfolio Committee on Health is a multi-party committee with three main functions. These are:

- Budget function 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.
- Legislative function, where the committee reviews current policy, strategic documents and legislature so that these are in line with the current situations. The committee had significant input in the current ZNASP document 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 Offences Act and the Child Adoption Act.

- Over-sight function where the Portfolio Committee tracks the implementation of the policies and legislation through site visits to interview beneficiaries.

In addition to the political commitment which has been demonstrated through policy and national strategic frameworks, an enabling environment has also been created for HIV and AIDS advocacy. The Expanded Theme Group for HIV and AIDS, now called the National Partnership Forum are very active policy, advocacy and coordinating bodies. The Zimbabwe AIDS Network (ZAN) represents up to 400 civil society organisations that are involved in HIV and AIDS implementation and advocacy.

The formation of the National AIDS Council to coordinate HIV and AIDS programs in Zimbabwe in 1999 has resulted in a more efficient system of coordinating the 3 “ones” in Zimbabwe. The NAC Board oversees overall policy and decision while the NAC secretariat oversees implementation of the board decisions. Under this arrangement, the national HIV and AIDS strategic framework is implemented through a multi-sectoral institutional structure which is coordinated by the NAC. The government of Zimbabwe has decentralized its health delivery and HIV and AIDS response structures with a focus on a district service delivery approach. The NAC head office is the overall administrator of the national Aids levy. It disburses funds to local structures for coordination and implementation of HIV and AIDS interventions. The NAC has established decentralized local coordinating structures down to grassroots. These coordinating bodies are called AIDS Action Committees and they are represented in all the administrative levels including Provincial, District, Ward and Village levels.

3.2 Funding the Response

The country was able to fund its response through various funding mechanisms. The Zimbabwe government raised money through the fiscus and additional money was collected through the National AIDS Trust Fund (NATF), 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 Ministry of Finance contributed US \$ 14 700 000 in 2005¹², US \$ 63,437 000.00 (Z\$ 101 500 000 000.00) in 2006 and US \$ 86 256.00 (Z\$ 345 025 716 293.71) in 2007¹³ towards HIV and AIDS Programs. In 2006, the NAC was tasked to manage and disburse GFTAM Round 5, US\$ 60 M to 22 of the 65 districts for the purpose of maintaining and strengthening health service delivery and mitigating the impact of HIV and AIDS. This funding will be disbursed over three years up to the end of 2008. In 2006, the Country Coordinating Mechanism (CCM) applied for GFATM Round 6 grant support for strengthening human resource and procurement and supply chain management (PSM) capacity under the HIV and AIDS disease component. This application was not successful.

The United Nations contributed a total of US \$ in 2005 and US \$ 24148 770.00 in 2006 in support of the national strategic framework. Most of the funding from the UN supported mitigation (US \$ 18 518 405.00) followed by capacity building (US \$ 3 192 100.00).

In November 2006, a consortium of partners, namely CIDA, DFID, Norwegian Aid, Irish Aid and SIDA came together under the chairmanship of NAC, mobilized and pooled resources for purposes

¹² Zimbabwe HIV and AIDS Subaccounts for UNAIDS, Abt Associates 2005

¹³ Government of Zimbabwe, Ministry of Finance, Budget Estimates 2005-2008

of supporting the implementation of HIV and AIDS Programs with at least 50% of the total ESP budget going towards ART. The objectives of the Expanded Support on Health Programs (ESP) were to support:

- The integration of the recently developed national BC strategy into district HIV and AIDS responses, largely through the strengthening of involvement of traditional and religious leadership.
- The mobilization of communities and their leaders for normative and behavioural change, to complement and stimulate demand for the envisaged scaling up of essential service-based prevention programs, such as counseling and testing, PMTCT, treatment of sexually transmitted diseases and condom social marketing in rural areas through funding from other channels.
- Scale up HIV and AIDS services for migrant/mobile and vulnerable populations in Zimbabwe.

The ESP supported activities in 26 districts of Zimbabwe with emphasis on the interdependency and mutually reinforcing effect of services and activities related to prevention, care and treatment, and mitigation in an effort to address some of the obstacles to accessing HIV/AIDS services at district level. This approach added value to existing programs, by using 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. As at the end of 2007, the ESP had mobilized about US\$50 million and US\$16.5 million was committed to the first of the three year period, 2007-2009. These funds complemented resources available from the Government of Zimbabwe through Ministry of Finance, the GFTAM, the United States Government, the European Commission and other funding sources for HIV and AIDS programs.

3.3 Legal and Policy Instruments

Zimbabwe has put in place policies that create an enabling environment for mitigating the impact of HIV and AIDS. The government ratified several ILO conventions including Occupational Safety and Health Convention 1981 (No. 155) and Occupational Health Services Convention, 1985 (No. 161). The document covers the prevention and management of HIV in the work place and is meant to ensure non-discrimination of HIV-infected employees. In 1998, the government of Zimbabwe gazetted the Government Labour Relations statutory instrument (SI) 202 to guide HIV and AIDS response in the workplace. This was followed by the National HIV and AIDS Policy(1999-2004) which has adopted all the 12 International Human Rights Guidelines on HIV/AIDS and has documented the key public health principles, namely, confidentiality, blood transmission, promotion of marital integrity, reduction of STI infection, condoms and care for people with AIDS.

Realising the increase in number of cases of sexual abuse among minors, the Government crafted the Criminal Procedure and Evidence Amendment Act No. 8 of 1997. This resulted in the creation of Victims Friendly Courts to allow sexually abused minors to testify freely without fear. Related to this, is the Criminal Procedure and Evidence Amendment Act and the Sexual Offences Act of 2000 that criminalize the wilful transmission of HIV and AIDS even between husband and wife. Additionally, it provides for a stiffer penalty of 20 years for rapists convicted of raping and infecting their victims with HIV and AIDS. In 2007 the Government of Zimbabwe enacted the Domestic Violence Act, which criminalises all forms of violence, sexual, psychological and physical. The Child

Adoption Act (2006) allows for HIV testing in children up for adoption. The legislation to date has been aimed at protecting women and children, orphans and vulnerable children and disabled people.

3.4 Human Rights and Vulnerable Populations

Zimbabwe's National HIV and AIDS Policy of 2000 and the SI 202 of 1998 have clear sections that prohibit discrimination of HIV positive people. For example, 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 committees. However, these policy and regulatory documents are not explicit in protecting sub-populations such as intravenous drug users (IDU), men having sex with men (MSM) and commercial sex workers have no legal status in Zimbabwe. The Sodomy Act however, protects non-consenting men who are forced to have anal sex. However, whilst sex work and homosexuality is illegal in Zimbabwe, these have not been denied access to services as a result of a specific law or policy.

Failure by countries to identify the key drivers of the HIV epidemic and to recognize key groups that may be driving the epidemic provides a weakening of the country's effective response to HIV and AIDS. In line with global trends, the SADC region countries including Zimbabwe met in Maputo in October 2007. The focus of the meeting was to encourage countries to conduct a situation analysis with regards to commercial sex work and to come up with a plan of action. Zimbabwe presented preliminary findings of a qualitative situation analysis conducted in 12 research sites in 2006¹⁴. The main findings were that girls as young as 12 years old were engaged in commercial sex work and that they were highly mobile as a way ensuring anonymity and concealing source of income from families. Women engaged in commercial sex work due to structural reasons (poverty, macroeconomic conditions) and personal causes (fashionable clothes and cell-phones). The report identified small projects that were already working with commercial sex workers such as Cave Adlem in Harare, PSI condom sales projects in Chimanimani and peer led sex workers' groups at Gutu Mission and Masvingo Hospitals. However the report noted that there were several programmatic weaknesses including limited funding and lack of confidentiality in service provider settings. In line with the current ZNASP of 2006-2010, that recognizes commercial sex workers as a vulnerable group, Zimbabwe has already started working on a plan of action that is scheduled to be reviewed at a national consultative meeting in March 2008.

Despite the current lack of legal frameworks for targeting prevention activities among high risk groups such as MSM and IDU, Zimbabwe has exercised a degree of liberalism as evidenced by the presence of a formal body of Gays and Lesbians Association of Zimbabwe (GALZ). This organization represents gays and lesbians living in Zimbabwe. However, the country still needs to put in place targeted programs such as condom promotion and other prevention strategies in order to curb the spread of the HIV Epidemic.

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

¹⁴ Situation Analysis of Female Sex Workers and HIV in Zimbabwe. IOM, UNFPA, UNAIDS and NAC unpublished report 2007.

services, construction and transport industries, as well as cross-border traders and mobile and vulnerable populations (MVPs). In 2005, with assistance from 20 humanitarian partner organizations, IOM assisted a total of a 454,952 individuals requiring emergency assistance. This support continued in the period 2006-2007 and increased to cover 63 districts¹⁵. The organization has continued to partner with government and other organizations and implemented programs at border posts to reduce vulnerability. The Southern Africa Development Cooperation (SADC) Unit on HIV and AIDS initiated a joint project with IOM called the one border stop between Zambia and Zimbabwe in 2006. This project aims at reducing the time spent by truck drivers at border towns hence reducing vulnerability. Other activities at border posts include a health facility at Beitbridge Border Post called Reception and Support Centre (RSC) that started in May 2006. To enhance its ability to respond to migrant and mobile population need for counseling and testing services, IOM Zimbabwe entered into a Cooperation agreement with PSI Zimbabwe for the provision of mobile/outreach HIV counseling and testing services for mobile populations at the Zimbabwe/South Africa border town in July 2006.

One of the major negative outcomes of the AIDS epidemic has been the increased number of children who have been orphaned or whose social economic vulnerability has been increased because of an illness of a parent or other adult in the family. The MoPSLSW estimates that the number of orphans has risen from 980 000 in 2005, to 1.3M in 2007. One of the early responses to mitigate the effects of orphan-hood was the conceptualization of the Basic Education Assistance Module (BEAM) in 2001. This program through the MoPSLSW, provides school and examination fees assistance to OVCs in order to ensure that vulnerable children do not drop out of school.

The launch of the National Action Plan for Orphans and Other Vulnerable Children (NAP for OVC) by the Vice President in 2005 was one of the most significant policy development and success story in mitigation of vulnerability among OVC. This initiative is spearheaded by the Ministry of Public Service, Labour and Social Welfare (MoPSLSW). The NAP aims to reach 25% of orphans and other vulnerable children through various interventions, including educational, medical, legal, and psychosocial assistance. A Working Party of Officials that is comprised of Government, bilateral donor, United Nations, and Non-Governmental representatives is charged with an oversight role, while a secretariats at national, provincial and district levels overseen by the MoPSLSW are responsible for coordinating its the implementation. To date, the program has been successfully implemented in 68 out of the 83 census districts in Zimbabwe and has reached 147 012 beneficiaries through the disbursement of Program of Support (PoS) funding. The strength of this initiative is the multi-sectoral implementation that includes faith based and community based organizations.

3.5 Macroeconomic policies

Zimbabwe has adopted macroeconomic policies to mitigate the effects of HIV and AIDS. These include the National Economic Development priority program (NEDPP) of 2005-2006, whose main objective was to reduce inflation, stabilize the currency, ensure food security, increase output and productivity, generate foreign exchange, and enhance expenditure and revenue management, removal of price distortions and effective policy coordination and implementation. Zimbabwe is also in the process of coming up with an economic strategy, the Zimbabwe Economic Development Strategy (ZEDS) 2009-2013, which aims to achieve sustainable, balanced and robust economic growth and development, oriented towards poverty reduction and the integration of previously

¹⁵ IOM Reassessment for Emergency Assistance in Zimbabwe, September 2007

marginalized groups of people. 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.

In order to circumvent the effects of economic challenges facing the country, the Government declared HIV/AIDS a national emergency in May 2003. This paved a way for pharmaceutical companies to import generic drugs into the country. This declaration was initially for a period of six months but it has since been extended to December 2008.

4.0 Prevention Programs

4.1 Background

In order to consolidate the gains on HIV prevention and accelerate the country's goal to reduce the HIV prevalence to less than 10% by 2010, in line with the MDGs, the National Behavioral Change Strategy (NBCS) 2006-2010 has been developed. The purpose of the NBCS is to guide systematic and strategic programming in the area of promoting behavioral change as a means of preventing HIV transmission. It is envisaged that the ZNASP and the NBCS will guide and bolster the implementation of HIV prevention from a multi-sectoral perspective.

The NBCS covering the period 2006 - 2010 guides implementation of scale up prevention programs based on 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, two large initiatives started in support of the implementation of the strategy at district level namely;

- Behaviour change promotion within 16 ESP funded districts and,
- The program "Engendering HIV prevention" in 10 European Commission funded districts.

District action plans were made for the 26 districts. The main activities included those of creating an enabling environment mainly through community leaders' involvement and gender equality as well as stigma reduction through the Meaningful Involvement of People openly living with HIV and AIDS (MIPA). Professionals meeting these criteria are being assimilated into key positions within the district structures. The strategy also seeks to increase the adoption of safer sexual behaviours, risk reduction and increased utilization of HIV prevention services (Testing and Counselling including post test support, PMTCT and PEP). The semi-annual report, 1 April 2007 to 30 September 2007 produced by UNFPA showed that most key activities in this plan were already taking place.

4.2 Health Sector's Response

NATIONAL Programs

3. Percentage of donated blood units screened for HIV in a quality assured manner
100% (2006) and 100% (2007)
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy. *8.0% (2005), 17.5% (2006) and 38% (2007)*
5. Percentage of HIV positive pregnant women who received antiretroviral to reduce the risk of mother to child transmission. *40% (2005), 60% (2006) and 67.4% (September 2007)*
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV. *Data not available at national level*

The health sector is wide-ranging and encompasses organized public and private health services (including those for health promotion, disease prevention, diagnosis, treatment and care); non-governmental organizations; community groups; and professional associations; as well as institutions which directly input into the health care system (e.g. the pharmaceutical industry, and teaching institutions). In Zimbabwe, the health sector is composed of diverse players including but not limited to;

- 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 2006 indicate that there are approximately 2 777 registered health institutions comprising 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.

4.2.1 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 organisation. 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 at the Harare laboratory. Screening for HIV started in 1985. The NBSZ has been designated a WHO collaborating centre for Southern Africa. It also attained ISO certification in 2006. 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 EDLIZ. 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. Quality assurance is at three levels, at recruitment, general internal quality assurance and proficiency testing systems affiliated to Australian laboratories. The company screened 35 000 blood units in 2005, 69 510 in 2006 and 52 062 in 2007 for HIV. The decrease in the number of units screened reflects a decrease in the number of units collected due to fewer clients coming up to donate as a result of community awareness of HIV and AIDS.

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

The Ministry of Health and Child Welfare through the AIDS and TB Unit coordinates programs aimed at HIV prevention, care and mitigation. Implementation of PMTCT was guided by the National HIV and AIDS Policy of 1999, which was followed by the 1999- 2004 HIV and AIDS framework. In line with global changes a National PMTCT and Paediatric HIV Prevention Treatment and Care National Plan 2006-2010 was developed in 2005. Other supporting policy documents and guidelines that guide the PMTCT program include the National Feeding Policy of 1999, Reproductive Health Policy, 2005, Psychosocial Support Guideline 2006, and the PMTCT training manual 2007. The PMTCT program is based on the 4 pronged UN promoted components which are:

- Primary prevention of HIV infection in women
- Prevention of unintended pregnancies in women living with HIV
- Prevention of transmission from women living with HIV to their infants
- Provision of care, treatment and support for women living with HIV and their families

The Goal of comprehensive PMTCT and Paediatric HIV prevention, care, treatment and support programme in Zimbabwe is:

“To reduce HIV infection among children, to reduce HIV related morbidity and mortality and improve the quality of life among children living with HIV and AIDS.”

The two broad objectives in order to reach this goal are:

- To provide comprehensive PMTCT services to at least 80% of pregnant women, their babies and families, including care and treatment of pregnant women, in the context of universal access, with the aim of reducing MTCT rates to less than 10% by the end of 2010.
- To provide paediatric HIV prevention, care, treatment, and support services to at least 80% of all children less than 15 years of age by the end of 2010, in the context of universal access, with the aim of improving child survival among HIV infected and affected children by at least 50%.

The MOHCW and its partners have demonstrated high level commitment in supporting introduction and rapid expansion of PMTCT. A multi-sectoral national PMTCT partnership forum has been established and it meets regularly to improve coordination of the programme. At the end of 2006, a total of 1 422 health institutions were offering PMTCT services. Of these 547 offered “comprehensive PMTCT services” i.e. the women can access on site HIV testing and counselling as well as ARV prophylaxis. A total of 875 sites were offering a minimum/supportive package of PMTCT services that includes on-site supportive counselling as well as ARV prophylaxis but the testing is done at another site. Thus, PMTCT services are offered in 98% of all health institutions in

Zimbabwe. A total of 68 ART sites have been created at the same institutions where comprehensive PMTCT is being offered, enabling HIV positive women, their partners and family to access ART when indicated.

A total of 163,868 pregnant women attended PMTCT supported antenatal care (ANC) clinics for the first time out of 166 794 institutional deliveries in 2006. This signifies 98% of pregnant women receiving PMTCT services. By the end of September 2007, there were 135 997 institutional deliveries and 99% (135,323) deliveries accessed PMTCT services. The percentage of HIV positive women receiving antiretroviral therapy to reduce the risk of mother to child transmission of HIV increased from 40% in 2005, 60% in 2006 and 67.4% at the end 2007¹⁶. PMTCT has been successfully integrated into antenatal care services at all service delivery levels. Despite these achievements Nevirapine (NVP) uptake has remained low due to several factors which include poor male participation in ANC and critical human resources shortage in the public health sector particularly at the primary health care level.

Collaborative work between the Reproductive Health Department, the PMTCT Unit, and the Prevention Partnership Forum (PPF) partners also resulted in the revision of the mothers' ANC/postnatal hand held card. The revised card bears indicators that make it easy for health workers to identify HIV positive mothers to facilitate more rigorous follow up and to ensure additional services are offered. In line with the Abuja 'Call to Action' towards an HIV-free and AIDS-free generation, the MOH&CW developed a national PMTCT and pediatric HIV prevention, care, support and treatment strategy covering 2006-2010. The strategy gives structure and direction for the implementation of an integrated PMTCT and pediatric treatment program in Zimbabwe. The broad objectives of the plan are to: guide planning; set time-bound targets; determine the resources required to achieve the overall goals; and to facilitate partner collaboration and coordination. The strategic plan takes cognizance and provides guidance, on how to address the challenges within the program such as: limited human resource capacity; low male participation in PMTCT and HIV testing; poor disclosure of HIV status as well as other technical areas. The National PMTCT and Pediatric HIV and AIDS treatment care and support Strategic plan 2006-2010 has not only laid out targets but also provides a detailed costing for the different components of the program. Roles and responsibilities of all stakeholders are well elaborated including that of MOHCW who have overall responsibility for leadership, programme implementation and coordination.

However, it acknowledged that the PMTCT program still needs to put in place strategies to comprehensively address the primary prevention of HIV infection in women as well as and prevention of unintended pregnancies in women living with HIV.

4.2.3 TB and HIV Collaborative Activities

HIV is the single most important factor for the resurgence of TB in Africa. WHO estimates that the prevalence of TB/HIV co-infection is around 80%. It is therefore important to address both TB and HIV in an integrated and holistic manner. Zimbabwe is currently in the process of ensuring the integration of TB and HIV activities in health care settings. In 2006 a committee on TB and HIV Collaborative activities was formed to report to the National HIV and AIDS

¹⁶ PMTCT Program Annual Report 2007

partnership forum. The National TB manual was finalized in 2006 to incorporate TB and HIV collaborative activities. The implementation of provider initiated testing and counseling in health care settings started in July of 2007 in 10 learning sites. It is envisaged that all TB patients will be 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. Data on TB/HIV co-infection will be available in future reports.

4.2.4 HIV Testing and Counseling Services

NATIONAL Programs

7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months who know their results. *6.6% women and 6.6% men (ZDHS 2005/06)*
8. Percentage of most at risk populations that have received an HIV result in the last 12 months and who know their results. *Not available*
9. Percentage of most –at-risk populations reached with HIV prevention Programs *(Not available)*

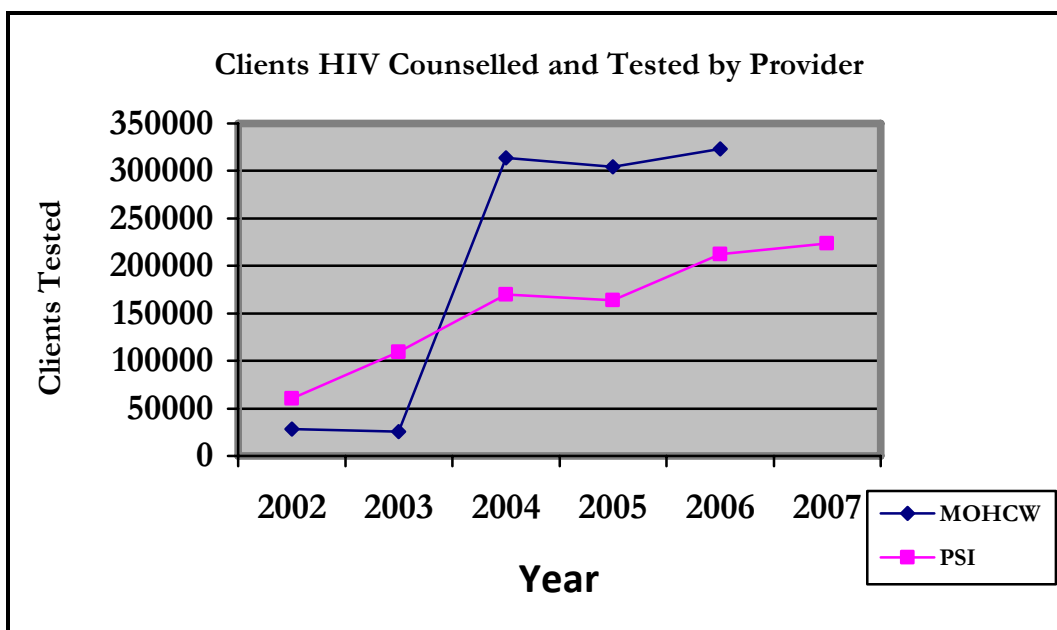
The benefits of HIV Testing and Counseling (HTC) are that it promotes behavior change, facilitates early referral for care, treatment and support, including access to ARV therapy and it is believed to reduce stigma in the community. Implementation of testing and counseling was initially guided by National Aids Policy Document of 1999. This was followed by the development of HIV Testing and Counselling Guidelines of 2005. The MOHCW and its partners is in the process of finalising the HTC Strategic plan 2007- 2010 which includes implementation of Provider Initiated Testing and Counselling (PITC). This plan also contains guidelines on HIV testing and counseling in children 0-16 years. Manuals to train health workers on child counseling and testing are being finalized.

The ZDHS of 2005/06 reported that 6.6% women and 6.6% men (15-49 years) 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). In an effort to increase testing and counseling coverage, the MOHCW has adopted a four delivery models, namely;

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

During the period 2006-2007, the Ministry of Health and Child Welfare with assistance from partners continued geographic expansion of testing and counseling services to reach all populations. The number of stand-alone and integrated testing and counseling sites increased from 395 sites in 2005, 547 in 2006 to 649 at the end of 2007.

The number of people accessing testing and counselling services has continued to increase steadily in the public sector as well as in sites run in collaboration with partners. Population Services International (PSI), one of the MOHCW major partners in testing and counselling celebrated the passage of one million clients through its sites branded “New Start Centres” in November 2007.



To boost political commitment and support for HTC, a workshop to sensitize parliamentarians was conducted in March 2006. This resulted in 10 parliamentarians taking public HIV test. This was followed by celebrities from a home grown HIV and AIDS prevention soap opera also taking a public HIV test.

The main challenge slowing progress in achieving universal access to HTC is a critical human resource. To circumvent this challenge, a new cadre, the Primary Counselor was created in 2004 to enhance the counselling capacity in health institutions.

There is no law in Zimbabwe that denies any group or person access to medical or social services as a result of their political, sexual or any other affiliation. Commercial sex workers, homosexuals, 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/mobile populations accessed testing and counseling services from designated public health facilities supported by IOM. In the period July to November 2007, a total of 1 505 clients accessed counseling and testing services in locations considered to serve commercial sex workers and other high risk groups. Because data is based on clients coming voluntarily to these sites, the denominator is not known and hence the program coverage cannot be calculated. Data from other groups, MSM and IDU groups is not easily accessible due to the individuals' inability to publicly acknowledge orientation as a result of these activities being considered as illegal or being socially unacceptable.

Data from prison services is channeled through NAC district offices where it is aggregated into a district report with data from other sources.

Mobile populations, such as truck drivers, other migrant workers and OVC's have been acknowledged as vulnerable groups in Zimbabwe. Various targeted prevention programs have been

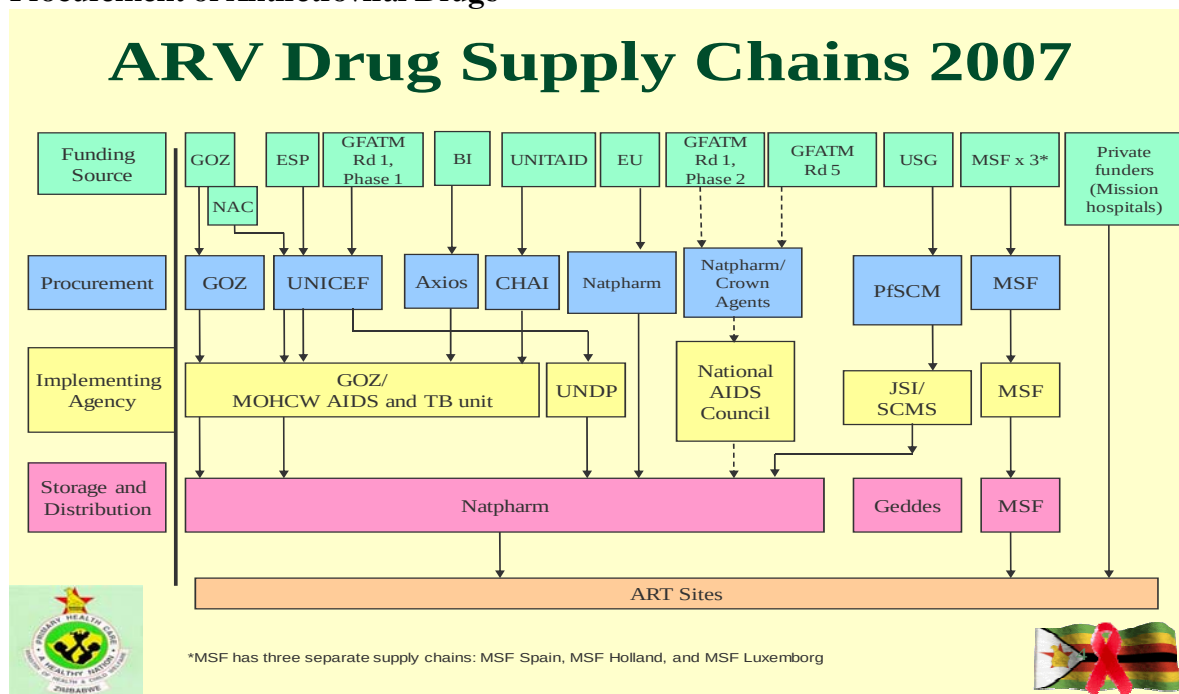
put in place by Government and collaborating partners. National Employment Council for the Transport Industries (NECTOI), works very closely with truck drivers. In 2006, through a SADC initiative, a one border post clearing system was established between Zambia and Zimbabwe. This reduces the time spent at border posts clearing trucks hence reducing vulnerability. UNICEF in collaboration with MoPSLSW works closely with Ministry of education to implement prevention strategies among OVC's.

4.2.5 Antiretroviral Therapy

The estimated number of HIV positive clients that were likely to die in the absence of treatment was 322 000 in 2005, 342 000 in 2006 and 102 566 in 2007¹⁷. Realizing the need to strengthen delivery of comprehensive HIV and AIDS services, the MOHCW developed the Plan for the Nationwide Provision of ART (2005-2007). The goal of the plan was to reduce related morbidity and mortality due HIV and AIDS and to improve the quality of life of PLWHA in Zimbabwe. The target of the plan was to provide ART services to 60,000 PLWHA by December 2005; 150,000 by December 2006; and 250,000 by December 2007. These targets were however revised downwards as a result of the numerous challenges such as demand far outweighing supply, limited human resources and acute foreign currency shortage for purchase of either ARV's or raw materials for their local manufacture. Despite these challenges in scaling up ART services, the MOHCW made significant progress in improving adult ART coverage from less than 1% in 2002 to 8.3% in 2005, 17.5% in 2006 and 38% as of December 2007.

The Government of Zimbabwe with assistance from developmental partners has been able to scale up both the provision of cotrimoxazole and antiretroviral therapy to children. In 2006 of the 60 920 patients accessing ART, only 4 364 were children (0-14 years). The number of children accessing ART increased to slightly over 10 000 by the end of 2007. The detailed scale up plan for Pediatric HIV and AIDS care was finalized in the last quarter of 2006 and was in use during 2007.

Procurement of Antiretroviral Drugs



Procurement of ARV's is well coordinated by the National Pharmaceutical Company of Zimbabwe

¹⁷ According to WHO, this is 20% of population living with HIV and AIDS for each year

Bilateral partners have separate procurement systems but all drugs are accounted for and distributed either through Natpharm or directly to users. Partners distributing directly to users have their drugs warehoused at Geddes or MSF warehouse. The system tries to avoid duplication and overlap of drug provision.

Funding for the ART program continued to be a challenge in the period 2005 through 2007. The NAC provided Z\$67 billion (US \$ 83 750) for the purchase of ARVs in 2005, Z\$2.2billion (revalued)(US \$ 1 375 000) in 2006 and Z\$303,4 billion(US \$ 75 850) in 2007 respectively. The shortage of foreign currency severely limited the use of the available local currency to finance the ART program. In order to circumvent the looming supply crisis of ARVs, the MOHCW and NAC entered into a 'currency swap' arrangement whereby WHO and UNICEF were supposed to procure ARVs on behalf of the government and reimbursed in local currency at the prevailing foreign exchange rate.

The MOHCW also endeavored to subsidize local manufacture of ARVs through provision of foreign currency by the Central bank for purchase of raw materials and waiver of duty on raw materials for local production of ARVs and imported ARVs. This has been maintained despite the unfavourable economic environment and has resulted in an improvement in the supply of ARVs in the public and private sector. Shortage of foreign currency has however had a negative impact on progress.

4.3.1 Orphans and Vulnerable Children

NATIONAL Programs

10. Percentage of orphaned and vulnerable children aged 0-17 years whose households received free basic external support in caring for the child
31.2% received at least one type of external assistance (ZDHS 2005/06)
11. Percentage of schools that provided life skills-based HIV education in the last academic year
100 % Schools provided life skills-based HIV education (2006)
100 % Schools provided life skills-based HIV education (2007)
12. Current school attendance among orphans among non-orphans aged 10-14 years*
School attendance among orphans both parents dead 87.9% (ZDHS 2005/06)
School attendance among non-orphans 92.4 % (ZDHS 2005/06)

Zimbabwe has been experiencing an increase in the number of orphans and vulnerable children as a result of the impact of HIV and AIDS epidemic and worsening macro-economic conditions. In 2003, there were 5 943 845 orphans and vulnerable children below the age of 18 years¹⁸. Out of this group, 1 307 645(22%) were orphans. The Zimbabwe national estimates process estimated that there would be 1,008, 542 and 975,956 HIV and AIDS orphans in Zimbabwe in 2006 and 2007 respectively. The ZDHS 2005/06 reported that 23.9% of the children (0-17years) in the survey had one or both parent's dead. The survey assessed the extent to which free and basic external care and support were received by households that had an OVC in the 12 months prior to the survey. The survey revealed that 6.5% of cases received medical support, 6.0% emotional support and 13.3 % received social or material support. None (0.0%) of the OVC received all types of support.

The National Plan of Action for Orphans and Other Vulnerable Children (NAP FOR OVC) to guide the care and support of orphans and vulnerable children in Zimbabwe has been in place since 2005. This is spearheaded by the Ministry of Public Service, Labour and Social Welfare (MoPSLSW), the NPA aims to reach 25% of orphans and other vulnerable children through various interventions, including educational, medical, legal, and psychosocial assistance. A working party of officials that is comprised of Government, bilateral donor, United Nations, and Non-Governmental representatives is charged with an oversight role, while a secretariats at national, provincial and district levels overseen by the MoPSLSW are responsible for coordinating its the implementation. The thrust of the National Orphan Care Policy is to strengthen the community care method through extended families. Out of an estimated total of 1.3 million OVCs in Zimbabwe, 1% are believed to be on the streets, 1% within institutions and the remainder are within the community⁸.

According to MoPSLSW, there are 48 local and international NGOs working in the area of care and support for OVC. UNICEF, the major contributor has partnered with several NGOs to provide care and support to almost 100,000 OVC and provided intensive training on psycho-social support for 31 District Psychosocial Support Facilitators drawn from 10 project districts. In addition, UNICEF supported the training of more than, 4000 community based counselors through districts, colleges, universities and NGOs. The plan supported nearly 70,000 orphans and other vulnerable

¹⁸ UNICEF and Ministry of Health and Child Welfare. Zimbabwe. World Fit for Children. Mid-Decade Progress Report 2002-2006

children as well as 646 PLWHA groups in the reporting period 2006 to 2007 through the multisectoral Program of Support. This program has been one of the main successes stories in mitigating the impact of HIV and AIDS.

4.3.2 Life skills based HIV and AIDS education in schools

The Ministry of Education, Sport and Culture's response to HIV and AIDS started in 1992 with the introduction of the HIV and AIDS life skills program in schools. Life skills teaching on HIV and AIDS became a compulsory for Grade 4 to Form 6 and tertiary education. UNICEF in partnership with MoESC is supporting the in-service training of primary and secondary school teachers in HIV and AIDS life-skills and counseling. The training is aimed at improving the teaching methodology and breaking inter-generational communication barriers between teachers and their students. Since the training was initiated in 2006, 2753, primary and secondary have been trained in participatory HIV and AIDS life skills methodologies. The training offers new and practical ways to teach life-skills for HIV prevention, understand and address the gender dimensions of HIV, prevent and combat gender based violence and develop and provide psychosocial counseling. While the Ministry of education hopes that all (100%) give lectures on life skills, initial surveys by UNICEF show that while trainers are trained, life skills education does not consistently take place in all schools¹⁹.

4.3.3 Male Circumcision

According to the ZDHS 2005/06, 10.5% (700) of men 15-54 years reported that they were circumcised. Of the circumcised men, 16.6 5 were HIV positive. Zimbabwe has accepted in principle that male circumcision is beneficial in the prevention and control of HIV infection. During a stakeholder's meeting early 2007, a plan of action was developed to develop policy and implement MC in the public health system²⁰. Currently, further consultations on the formulation of a national policy are still going on with a view to implement MC as a public health program in Zimbabwe.

¹⁹ Unicef Report

²⁰ Male circumcision Kadoma Report 2007

4.4 Knowledge and Behaviour

KNOWLEDGE and BEHAVIOUR

13. Percentage of young women and men aged 15-24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.* *43.7% women and 45.6% men (ZDHS 2005/06)*
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
Not available
15. Percentage of young women and men aged 15-24 years who had sexual intercourse before the age of 15. *5.3% women and 4.5% men (ZDHS 2005/06)*
16. Percentage of women and men aged 15-49 years who had sexual intercourse with more than one partner in the last 12 months. *1.3% women and 14.1% men (ZDHS 2005/06)*
17. Percentage of women and men aged 15-49 years who had more than one sexual partner in the last 12 months who reported using a condom during their last sexual act.
45.6% women 71.0% men (ZDHS 2005/06)
18. Percentage of female and male sex workers reporting the use of condom on their most recent client. *80% women and 73.1% men (ZDHS 2005/06)*
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner *(Not available)*
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse. *(Not available)*
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected *(Not available)*

4.4.1 Background

The future course of the Zimbabwe's HIV and AIDS epidemic depends on a number of variables including knowledge levels on HIV and AIDS among the general population, reduction in stigma, risk behaviour modification and adoption of positive behaviours leading to increase in uptake of prevention services.

Knowledge of how HIV is transmitted is crucial to enabling people to avoid HIV, especially for young people who are often at a greater risk because they may have shorter and risky relationships. While a high proportion of adult (15-49 years) women (97.9%) and men (99.2%) had ever heard about HIV and AIDS, comprehensive knowledge levels were very low (ZDHS 2005/06). Comprehensive knowledge among adult women (15-49 years) was 44.2% and in men (15-49 years) was 46.9%. Among young people, 43.7 % women (15-24 years) and 45.6% men (15-24 years) had comprehensive knowledge levels. The young people are considered a window of hope for the

prevention of new infections. Adoption of safe sexual behaviours is desirable among youth, as a way reducing HIV incidence. A small proportion of young people engaged in sexual activity before the age of 15 years, 5.3% women and 4.5% men. Delay in sexual debut, is a desirable outcome measure for behavior change. The national programs will have to target a change in behavior among youth in order to have a reduction in HIV incidence that will result in a significant decrease in HIV prevalence.

4.4.2 Interventions for Out-of-School Youth

A number of organizations have been involved in programs specifically targeting young people out-of-school including government, national and international NGOs, faith-based organizations, UN agencies and bi-lateral donors. Major activities include peer education programs, youth-friendly reproductive health services, and media programs including a very popular prime-time TV show as well as strengthening integration of young people in their communities. Increased attention was paid to improving co-ordination among the major stakeholders to ensure consistency of approaches and to streamline the fragmented geographical coverage of programs. During the period under review, NAC with assistance from partners was able to provide an ATLAS mapping partners and their geographic location. This tool which will be updated annually seeks to improve coordination and avoid duplication of activities.

The recent behavioral change review that preceded the NBCS of 2006-2010 indicated that in addition to activities targeting youth directly, programs addressing adult sexual norms are needed. The NBCS of 2006-2010 will seeks to address the widespread change in behavior and adoption of safer sexual behaviours. The overall goal is to reduce the number of new infections by providing an enabling environment for behavior change created by increased leadership and gender equality. The implementation of the BCS started in 2006 in 26 pilot districts. Dissemination of the strategy was carried out in all 26 districts. The roll out of the BCS has been delayed by limited resources. The monitoring and evaluation (M & E) framework of the BCS feeds into the National Action Framework (NAF) of the M & E plan. The ESP is supporting the implementation of the BCS in the 26 districts.

4.4.3 Condom Distribution and Social Marketing

The high levels of sexual transmission of HIV make negotiating for safer sex indispensable, especially in marital unions where the women's status is compromised by societal expectations, thereby increasing their vulnerability to HIV transmission. Results of the ZDHS 2005/06 showed that a majority of women (79%) and men (77%) acknowledge that if a man has a sexually transmitted infection, a wife can refuse to have sex with him. A larger percentage women (83%) and men (86%) consider it appropriate that a wife can ask the husband to use a condom in cases of STI. For those women and men who reported having engaged in high risk sex, the use of condom was relatively lower, 45.6% women and 71.0% for men (age 15-49 years). Due to a reported increase in sexual networks in the Sub-Saharan region, it is imperative that correct and consistent condom use be advocated for in all social spheres.

Public sector condom distribution through MoHCW, other health facilities and NGOs is managed by the Zimbabwe National Family Planning Council (ZNFPC) with support of John Snow International (JSI), DFID, USAID, and UNFPA. Condom consumption appears to be on the rise

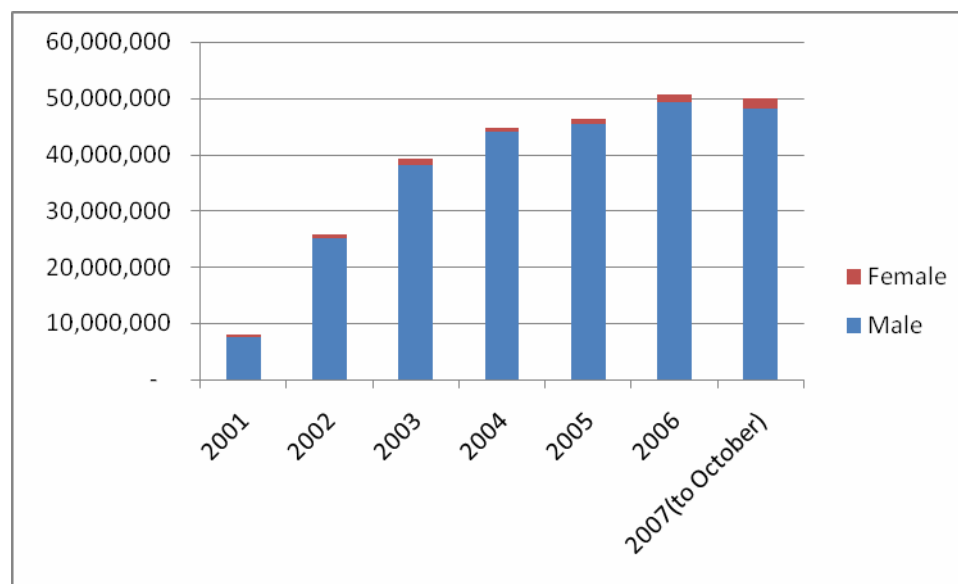
since 2001. According to ZNFPC, 980 560 female condoms and 55 567 000 male condoms were distributed in 2006. To increase the MOHCW' capacity to deliver condoms, a total of 769 personnel out of a target of 800 was trained in condom programming. Condom programming has been main streamed into all HIV prevention strategies.

In the social marketing sector, PSI in collaboration with MOHCW, sold 50 million male and female condoms in through various outlets, including liquor stores, hair salons, supermarkets, and service stations in 2006 and 2007.

Table : Condoms sold through PSI

Year	2001	2002	2003	2004	2005	2006	2007
Female condoms	455,566	683,700	1,015,380	887,440	900,620	1,368 760	1,806,760
Male(Protector	7,593 930	25,063,560	38,128,680	43,928,280	45,427,810	49,178,700	48,134,700

Figure 2: Male and Female Condom Sales in Public and Social Marketing Sales, 2000-2007



Source: PSI Data 2007

4.5 Impact

KNOWLEDGE and BEHAVIOUR

22. Percentage of young women and men aged 15-24 years who are HIV infected*
11% young women and 4% young men (ZDHS 2005/06)
Target: 25% reduction in most affected
23. Percentage of most at risk populations who are HIV infected
Not available see narrative
24. Percentage of adults and children with HIV know to be on treatment 12 months after initiation of antiretroviral therapy.
91.1 % survival on ART (2006) & 93.5 % (2007) (MOHCW Program Report)
25. Percentage of infants born to HIV infected mothers who are infected
Not available. Zimbabwe has not been doing PCR routinely.

It is desirable that the implementation of HIV and AIDS prevention, care and treatment programs will result in the reduction of HIV prevalence among high risk groups and in the general population especially among the young age group(15-24 years). Millennium Development Goal number 6 states that Zimbabwe aims to reduce the HIV prevalence in the 15-24 year age group by half from a baseline prevalence of 24% in 2004 by the year 2010. Using antenatal clinic surveillance, HIV prevalence was 19.9% in 2002, 17.0% in 2004 and 12.5 % in 2006. This signifies 37.2% decline over a period of 4years. The ZDHS 2005/06 showed that HIV prevalence was 11% among young women and 4% among young men, it is likely that the target of halving prevalence in this age group by 2010 has been reached and superseded.

As ART becomes more widely available, the more useful measure of the impact of programs will be a reduction in incidence and a stabilization of the HIV prevalence. In 2006, the death rate among patients started on ART in the public sector was 8.9% hence a survival rate of 91.1%. Similarly in 2007, the rate of patient survival was high at 93.1%.

5.0 Monitoring and Evaluation Environment

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

Monitoring and Evaluation is a crucial and integral part of the national response on HIV and AIDS. To comply with the “Three Ones” principles, Zimbabwe has come up with one M&E system to which national programs and partner projects are linked. The NAC has the overall responsibility for the national monitoring and evaluation system. A multi-sectoral and multi-disciplinary National M&E Task Force provides technical advice in the development and operationalization of the national M&E system

The overall goal of the national M&E system is to provide a comprehensive tracking system to collect and share information on HIV and Aids that will enhance decision-making at all levels in the implementation of interventions under the multi-sectoral response to HIV and Aids in Zimbabwe.

Specific objectives include the following:

- To measure the progress in implementing the Zimbabwe National AIDS Strategic Plan (ZNASP).
- To track inputs and results of the national response to HIV and AIDS epidemic in Zimbabwe.
- To compare and improve the cost-effectiveness of different types of HIV and AIDS interventions.
- To provide programme data to meet global and donor reporting requirements e.g UNGASS, GFATM, etc.
- To continuously identify and resolve any problems arising in the course of implementing the national response.
- To ensure transparency, effective coordination and communication among different groups involved in the national response to HIV and AIDS.
- To strengthen M&E capacity of NAC, MOHCW and other stakeholders in the public, private and civil society sectors i.e NGOs, FBOs and CBOs to collect, analyze and utilize data.
- To make available user-friendly data summaries and key trends to all stakeholders throughout the country.

Major data sources

National program monitoring and population-based surveys are the major sources of data for the Zimbabwe National M&E system.

National programme monitoring system (NPMS)

A national program monitoring system (NPMS) branded as the NAC Activity Reporting System (NARS) was developed through a consultative and participatory process led by the National M&E Task Force during period 2006-2007. NARS collect data on National Core Output Indicators (NCOI). The national M&E system is decentralized at all levels. All implementing organizations from the civil society, public and private sectors should register and report through an Organization Details Form (ODF). It is a simple system that is not expensive yet provides information important for program monitoring and improvement.

It is has the following key component:

- A national strategic/program area framework
- A set of national core output indicators (COI) for each program area that is supported by an Indicator Guide
- A National Activity Report Form (NARF)-a standardized core data collection and reporting tool supported by a Reporting Guide.
- A list of implementing organizations (from civil society, public and private sectors)registered through an Organization Details Form (ODF) implementing HIV and AIDS program at District level and reporting monthly to the District AIDS Action Committee (DAAC) through the NARF.
- A National Database System to capture COI data, analyze and produce a report at district level electronically linked to Province and National levels The Country Response Information System (CRIS) has been adopted as the National Database System and serves for both internal(district level) and external reporting(UNGASS DOC)
- An M&E data dissemination program.

All NAC staff and implementing partners received training in the NARS and CRIS database system in 2006-2007 before roll out. Implementation Organizations use their own primary data collection tools to record program output data from which they will extract, summarize and report NCOI through the NARF. Regular joint review and planning sessions are conducted at district level where all implementing organizations and stakeholders participate and share experience and at the same time contribute in shaping HIV and AIDS program direction in the district based on reports from the CRIS database.

Population-based surveys

Data on outcome and impact indicators is periodically collected through population-based surveys which include;

- Antenatal clinic sentinel surveillance
- Behavioral Surveillance
- Demographic Health Surveys DHS
- Young Adult Survey (YAS)
- Census
- Special Surveys-health facility, school-based, community-based and high –risk surveys, academic research, program and project reports.

Summary M&E data collection plan and activities

NAC and MOHCW in collaboration with development partners coordinate the following data collection plans and activities summarized below.

Data Collection/ Plan Activities	2006	2007	2008	2009	2010
Household Surveys	Zimbabwe Demographic Health Survey ZDHS				
Health Facility surveys	STI survey AIDS Case Reporting HIV Sentinel Survey	STI survey AIDS Case Reporting HIV Sentinel Survey	STI survey AIDS Case Reporting HIV Sentinel Survey	STI survey AIDS Case Reporting HIV Sentinel Survey	STI survey AIDS Case Reporting HIV Sentinel Survey
Program Monitoring System	Roll out of the National M&E System	Program Monitoring (on-going)	Program Monitoring (on-going)	Program Monitoring (on-going)	Program Monitoring (on-going)

Workplace Surveys	Private Sector Response Survey	Workplace Baseline Survey	Workplace Economic Impact Survey		
Reviews of National Response	Monthly, Quarterly and Annual Review of National Response	Monthly, Quarterly and Annual Review of National Response	Mid –Term review of ZNASP Monthly, Quarterly and Annual Review of National Response	Monthly, Quarterly and Annual Review of National Response	End of ZNASP Evaluation. Review of National Response

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

Linkages between MOHCW and NAC

The AIDS and TB Unit within Ministry has a well functioning data collection system that is not yet feeding into the NARS. Plans are underway to synchronise the MOHCW and NAC data collection systems.

Harmonization Project/Program M&E Systems into the NARS

In line with “Three Ones” principles, the program output data generated by Programs/Projects such Global Fund For Aids TB and Malaria (GFATM), National Action Plan OVC (NAPOVC), Expanded Support Program (ESP), Behavior Change (BC), and National Plan of Action WG& HIV and AIDS (NPA, WG & HIV and AIDS) should be harmonized with and operational into the National M&E system through a link system that makes possible for the NCOI data to feed into the National M&E system.

Reporting by implementing partners

The total number of Implementing Organizations in Zimbabwe at the end of 2006 was 8 926. Of these, only 4 842 (54%) were registered and 2 432(50%) were submitting NARS reports on monthly basis to NAC Districts Offices. The challenge is to achieve a 100% registration and reporting by all implementing organizations in each district.

One of the success stories is the harmonization of the NAP for OVC that is fully harmonized with the national M&E system. This system for routine program monitoring against 18 core national OVC output indicators and additional NAP indicators targets has been developed and piloted, with all organizations funded under the Program of Support for the NAP for OVC reporting monthly against implementation targets. This is probably one of Zimbabwe’s best examples of how a program monitoring system has been successfully harmonized with the National M&E system

NAC is in the process of mobilizing these partners through Faith based Organization (FBO), community based organization (CBO) and the Zimbabwe Business Coalition on HIV and Aids (ZBCA). Some districts have achieved a 100% registration and reporting during 2006-2007.

6.0 Major challenges facing Zimbabwe's HIV and AIDS Response

Economic environment

While rest of Southern Africa is experiencing economic growth, Zimbabwe is the only country experiencing negative economic growth rate. During the period 2000 -2006, real GDP declined by 33.5% in cumulative terms²¹. Zimbabwe's economic growth rate fell from -2% in 2000 to -4.6% in 2006 as result of unstable macro-economic environment. The consecutive drought seasons has also compounded the economic challenges for Zimbabwe. While national budget allocation increased in nominal and real terms in the period 2002 to 2007, the increase was not sufficient to match the demands on the health sector as a result of the impact of HIV and AIDS pandemic. Zimbabwe relied mainly on fiscal funding and support from mainly the UN family. This has adversely affected the provision of antiretroviral drugs to those in need. The low donor funding has affected the coverage of most HIV and AIDS preventive services. The inflationary pressures arising from the drought, low economic growth, high fuel prices on the international market and high HIV and AIDS disease burden has negatively affected the effective response to HIV and AIDS in Zimbabwe. These economic challenges have resulted in rising poverty levels, high unemployment and high international migration. High cross border trading, by mostly women have exposed these traders to sexual and other forms of abuse during the course of their work.

Human resources challenges

Zimbabwe has suffered the worst human resource attrition in all sectors as a result of low remuneration not commensurate with the prevailing economic conditions. The Health and education sectors have been hardest hit. The challenges associated with staff attrition in the health sector have affected the quality and coverage of health programs including HIV and AIDS related preventive programs. The shortage of most commodities has made work in the health sector non-conducive leading to low motivation. Although a Health Services Board was created in 2005 to address working conditions of health staff not much has been accomplished and the gap between vacancies and posts that are filled continues to increase. The high attrition of skilled health personnel has negatively affected the Primary Health Care implementation and the effective implementation of HIV and AIDS program. The antiretroviral program implementation relies on availability of skilled manpower.

Other challenges

Unemployment challenges

There has been a decline in the formal sector employment from 2.7% in 1980 to minus 0.17 between 1999 to 2002. The high unemployment had an effect of reducing the Government revenue from taxes and therefore reduction in the AIDS levy²¹.

Orphan pandemic

The effects of HIV and AIDS have created a new pandemic, the orphan pandemic. The increased morbidity and mortality associated with the HIV and AIDS epidemic has had an effect on number of orphans who were just over a million in 2005 to more than 1.3 million in 2007.

²¹ Zimbabwe Economic Development Strategy Document, 2007

Medicines and other supplies

The availability of medicines and supplies has been severely compromised by the shortage of foreign currency and the inability of the MOHCW to keep up with the hyperinflationary environment.

The RBZ has only availed US \$ 106 000 in 2006 for 5 months up to May 2006, out of the pledged US\$ 2.5M per month for the purchase of medicines in 2006. Although MOHCW received 30% more in 2005 compared to 2004, this fell short of the year on year inflation for that year of 585.8% in December 2005. This trend continued in 2006 and 2007 where inflation rose to 1 400% by end of 2007. Linked to the shortages of foreign currency, the availability of emergency referrals and support to lower level health facilities as well as outreach mobile services have been compromised by inadequate vehicles, vehicle spare parts and fuel shortages. This has affected the monitoring and evaluation of program implementation at all levels. The shortages of equipment is compromising client care and causing staff frustration and de-motivation.

7.0 Best Practices

Health sector policies

Zimbabwe is one of the countries in Sub-Saharan Africa that has had clear multi-sectoral policies and guidelines for the response to HIV and AIDS since 1999. The implementation of the preventive, control, treatment and care programs is well coordinated at all levels.

Leadership and political commitment

The Government of Zimbabwe has demonstrated some strong political commitment to respond to the HIV and AIDS epidemic. As early as 1997, the Government of Zimbabwe recognized the HIV and AIDS epidemic as a multisectoral problem which required multisectoral response. The stages of identifying an expert committee, formulating policy, strategic document and legislation took less than three years to complete. The epidemic was declared a national disaster in 1998. In 1999-2000, the government gazetted the AIDS Levy on taxable income, to mobilize resources

Parliamentary portfolio committee on health

This committee is a Parliament body whose functions, just like other Portfolio Committees, makes input in the formulation and review of policies and legislation, tracking resources and oversight functions on program implementation. This has allowed participation by non-health sector to HIV and AIDS program planning and implementation. The Parliamentary Committee has also helped in critiquing the budgetary allocations to the health sector and HIV and AIDS thereby improving accountability.

Multisectoral coordination and partnership forums

The Ministry of Health, National AIDS Council and stakeholders working on HIV and AIDS meet every month to improve coordination of programs partners are implementing and discuss challenges facing the implementation of HIV and AIDS activities at all levels. Besides creating a forum to share experiences, this has helped to build trust and confidence among all stakeholders and has avoided duplication of activities.

Zimbabwe Business Coalition on HIV and AIDS

The Business sector in Zimbabwe has organized themselves into a group to look at ways of addressing the country's response in the workplace. This has a potential to mobilize more resources for the response to HIV and AIDS.

Funding

Zimbabwe has been hard hit with the shortage of foreign currency. The foreign currency to purchase antiretroviral (ARVs) and other support drugs has been a challenge. To manage this, the MOHCW went into partnership with UN partners to swap Zimbabwe dollars from the National AIDS Trust Fund (NATF) with foreign currency for the purchase of antiretroviral drugs. The mobilization of resources locally through a three percent levy on taxable income has provided the bulk of income to procure ARVs. Other partners have pooled resources together to support 16 Districts with all the HIV and AIDS prevention activities and antiretroviral drugs working through a UN agency. This ESP program has since mobilized US\$50 million and US\$16 million has been disbursed/committed in 2007.

Coordinated drug procurement and distribution

There is a coordinated system of drug procurement and distribution. Most partners channel their drugs through the national pharmaceutical company. This has avoided duplication of resource allocation and has placed accountability on the national pharmaceutical organization.

Zimbabwe Economic Development Strategy

Zimbabwe continues to put in place strategies that seek to address, social and macro-economic conditions. The Government of Zimbabwe with assistance from UNDP started consultations for the formulation of the ZEDS policy in October 2007. This strategy has a medium term plan that integrates macro-economic, structural, sectoral and social considerations of the nation. It lays out a set of wealth creation and poverty reduction measures and strategies that is pro-growth. The strategy aims' vision is to meet basic socio-economic needs of Zimbabweans as enunciated by MDGS and Vision 2020. In addition, it highlights the need for economically linked reforms in order to revitalize the health delivery system with emphasis on funding HIV and AIDS programs.

Meaningful Involvement of People Living with HIV and AIDS

Zimbabwe has successfully implemented the MIPA in 26 districts that are currently scaling up the behavior change strategy (NBCS). This principle will continue to be scaled up in an effort to reduce stigma and discrimination.

Testing and counseling

Efforts to increase/improve staffing include the recent introduction of the primary counselor and, primary care nurse and also through bonding of the nurse²². The recent moratorium by South Africa on recruitment from SADC countries has slowed brain drain. Village Health Workers (VHW) were reintroduced in 2001, a total of 5 762 VHW have been trained in all rural areas as at February 2006. The target of one VHW per village (100 families) has not been reached due to slow training as a result of funding challenges.

Harmonisation of M/E reporting systems

All implementing partners are required to report through the NARF. This harmonization of M/E systems within Zimbabwe, is one of the main success stories.

²² Primary counselor is a lower level cadre with basic training on counseling and testing. Similarly, the primary care nurse is a lower level clinical officer with basic nursing education. This cadre is bonded for an equivalent 3 years, Ministry of Health Policy Reports

Annex 1

CONSTRUCTION/PREPARATION PROCESS FOR THE NATIONAL REPORT ON MONITORING THE FOLLOW-UP TO THE DECLARATION OF COMMITMENT ON HIV/AIDS

1) Which institutions/entities were responsible for filling out the indicators forms?

- a) NAC or equivalent **Yes**
- b) AIDS and TB Program **Yes**
- c) Others **Yes**

UNGASS report sub-committee of the National M&E Task Force on HIV/AIDS led by NAC.

2) With inputs from

Ministries:

- Education **Yes**
- Health **Yes**
- Labour **Yes**
- Foreign Affairs **Yes**
- Others **Yes**

Ministry of Higher Education, Ministry of Finance and Economic Development, Zimbabwe National Army, Zimbabwe Republic Police, Air Force of Zimbabwe

Civil society organizations **Yes**

People living with HIV/AIDS **Yes**

Private sector **Yes**

United Nations organizations **Yes**

Bilaterals **Yes**

International NGOs **Yes**

Others **Yes**
(please specify)

3) Was the report discussed in a large forum? **Yes**

4) Are the survey results stored centrally? **Yes**

5) Are data available for public consultation? **Yes**

LIST OF PARTICIPANTS TO THE UNGASS STAKEHOLDERS CONSULTATIVE MEETING

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