



**FOLLOW-UP TO THE DECLARATION
OF COMMITMENT ON HIV/AIDS
(UNGASS)**

Zimbabwe Country Report
Reporting period: January 2003-December 2005

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Acronyms

Antenatal Care	ANC
Antiretroviral drugs	ARVs
Antiretroviral therapy	ART
Basic Education Assistance Module	BEAM
Biomedical Research and Training Institute	BRTI
Central Statistics Office	CSO
Demographic and Health Survey	DHS
Direct Observed Treatment Strategy	DOTS
District AIDS Coordinators	DAC
District AIDS Action Committees	DAAC
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	UNADIS
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 Association of Non Governmental Organisations	NANGO
National Plan of Action for Orphans and Vulnerable Children	NPA-OVC
Opportunistic Infections	OI
Population Service International	PSI
Prevention of Mother to Child Transmission	PMTCT
Primary care counsellors	PCCs
Rapid Assessment, Analysis and Action Planning process	RAAAP
Sexually Transmitted Infections	STIs
Tuberculosis	TB
United Kingdom Department for International Development	DFID
United Nations Children Fund	UNICEF
United Nations Population Fund	UNFPA
United States Agency for International Development	USAID
United States President's Initiative on HIV and AIDS	PEPFAR
Voluntary Counselling and Testing	VCT
World Bank Multi-Country AIDS	MAP

Programme	
Zimbabwe Business Council on HIV/AIDS	ZBCA
Zimbabwe National Family Planning Council	ZNFPC
Zimbabwe AIDS Network	ZAN

I. Status at a glance

EXPENDITURES

1. Amount of national funds disbursed on HIV/AIDS → **US\$6.3 million (2003) and US\$9.9 million (2004) (NAC)**

POLICY DEVELOPMENT AND IMPLEMENTATION STATUS

2. National Composite Policy Index → **Refer to NCPI-A&B**

NATIONAL PROGRAMMES

3. Percentage of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year → **Not available**¹
4. % large enterprises/companies that have HIV/AIDS workplace policies and programmes → **7.7% (ZBCA 2004-5)**²
5. Percentage of women and men with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled → **Not Available; due to be collected in 2006**
6. Percentage of HIV positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT → **6.6% (MoHCW, 2004)**
7. Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy → **8.3% (MoHCW, 2004)**
8. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child → **43% (MoPSSLW/UNICEF, 2004)**³
9. Percentage of transfused blood units screened for HIV → **100% (NBTS, 2004)**

KNOWLEDGE AND BEHAVIOUR

10. Percentage of young women and men 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention
(Target: 90% by 2005; 95% by 2010) → 55% (PSI, 2003)
11. Percentage of young women and men who have had sex before the age of 15 → **8.3% (MoPSSLW/UNICEF, 2004)**
12. Percentage of young women and men 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months → **51% (MoPSSLW/UNICEF, 2004)**
13. Percentage of young women and men 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner → **50% (MoPSSLW/UNICEF, 2004)**
14. Ratio of orphaned to non-orphaned children 10-14 years of age who are currently attending school → **0.89 (MoPSSLW/UNICEF, 2004)**

IMPACT

15. 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) → 17% (MoHCW & CDC, 2004)
16. Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy → **Not available; due to be collected in 2006**
17. Percentage of infants born to HIV infected mothers who are infected
(Target: 20% reduction by 2005; 50% reduction by 2010) → 24% (MoHCW, 2004)

¹ As per Ministry records 100% of trained teachers have been trained in life-skills based HIV/AIDS education and are teaching the material within the normal curriculum in all public schools at primary and

II. Overview of the AIDS epidemic

HIV prevalence at a glance

15. Percentage of young women and men aged 15-24 years of age who are HIV infected → **17% (MoHCW & CDC, 2004)**
17. Percentage of infants born to HIV infected mothers who are infected → **(24% (MoHCW, 2004)**

It is now nearly two decades since the first AIDS case was confirmed in Zimbabwe. Since then, HIV and AIDS has become the major public health problem facing the country and was declared an emergency by the president of Zimbabwe in 2002. Zimbabwe continues to have one of the highest HIV infection rates in the world. By the end of 2005, it was estimated that 20.1% of the adult population (15-49) was infected with the virus. The main mode of transmission is heterosexual (92%) and vertical transmission (7%). The latest estimates based on the ANC surveillance data of 2004, however, indicates that the epidemic has been on a steady decline since the late 1990s--the first such decline to be documented in southern Africa. However, the same estimates, indicate a slight rise in new infections among the adult population since 2002. Additional years of data are required before it can be established whether the decline in HIV prevalence is temporary or long-term.

With a population of 11.6 million (CSO 2002), it was estimated that by the end of 2005 the country had 1.61 million people living with the HIV virus, 115,000 of them were children under 15. Globally it is estimated that 90% of infections among under 15s occur through vertical transmission from HIV+ mothers to infants and that one fifth of HIV+ mothers transmit the virus to their infants. According to the Ministry of Health and Child Welfare (MoHCW), in 2004, the transmission rate was 24.2%.

The epidemic in Zimbabwe is driven by socio-cultural and economic determinants. Factors such as lower social status of women, increasing levels of poverty leading to sex work, lack of open discussion on sex, STI, HIV and AIDS leading to ignorance and stigmatization all fuel the spread of the epidemic. The HIV incidence is highest among youth (15-24). The Young Adult Survey 2001-2002 found that 18% of youth (15-24) were HIV positive, and HIV prevalence among women were more than three times as high as that of men. Of the estimated 135,000 new adult (15-49 years) HIV infections during 2005, over half, 58% (78,000) were in women (MoHCW 2005). The majority of new AIDS cases (57%) and deaths (58%) were also women (MoHCW 2005).

secondary levels. A nationally representative school-based survey is required to find out what transpires at school level. Some small-scale studies have found that many teachers do not in fact teach the HIV/AIDS modules in the curriculum.

² *The sample was only drawn from the private sector and included 13 companies as opposed to the 25 stipulated in the guidelines.*

³ *The survey took the household as a unit of analysis rather than the child. We were therefore unable to fill in GE-Indicator 8 form.*

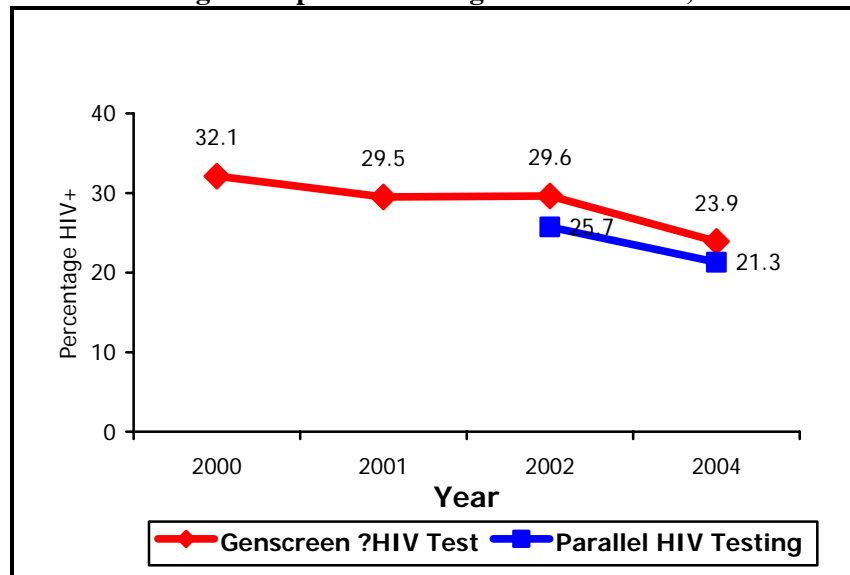
Table 1: National HIV and AIDS Estimates For Zimbabwe in 2005

	New HIV infection	New AIDS cases	Number living with HIV/AIDS	Number of AIDS deaths
Adults (15-49)	134,993	142,330	1,391,397	139,950
Women (15-49)	78,120	81,570	780,000	81,100
Children (0-14)	26,611	29,460	115,182	29,154

*Source: Zimbabwe National HIV Estimates, 2005.

The recent epidemiological review by UNAIDS concluded that the decline was partly due to mortality in older age groups in absence of a large scale treatment programme and partly due to lower infection rates. The latter was a result of increased condom use among non-regular partners and increased faithfulness to partners. Additional new data are likely to become available over the next 12 months. In particular, data on HIV prevalence and sexual behaviour are being collected in the nationally representative Zimbabwe Demographic and Health Survey 2005. Comparisons with similar data collected in the Young Adult Survey in 2001-2002 will provide important new evidence on contemporary trends in HIV prevalence and behaviour in the 15–29 year age-group. Comparison of estimates based on data collected in the 2005 and 1999 Demographic and Health surveys will also provide information on recent trends in adult as well as early childhood mortality.

Figure 1: Overall Percentage HIV-positive among ANC Attendees, Zimbabwe 2000-2004



* Source of data: Antenatal clinic surveys (Ministry of Health and Child Welfare Zimbabwe)

Note that the graph above describes the prevalence rates of pregnant women from the Sentinel Antenatal Clinic Sites and not the prevalence of the general population which is estimated at 20.1% in 2005.

The HIV and AIDS epidemic has resulted in a sharp increase in the burden of disease. Currently over 70% of admissions to medical wards in our major hospitals are due to patients with HIV/AIDS related opportunistic infections such as TB and other pneumonias (MoHCW). The capacity of health delivery system to cope with demands of this epidemic, in the face of limited

financial and human resources has been severely undermined. Infant mortality rate doubled from 60 /1000 to 130 000/ 1000 while the projected life expectancy dropped from 61 years in only three years? that is not possible the early 1990s to 43 years in the 2000-2005 period (MDG Progress Report 2005).

In 2003, UNICEF estimated that the number of orphans had risen to 1.3 million, about 19% of the child population. Recent national and sub-national surveys have found, however, that the number maybe closer to 1.6 million accounting for 25-30% of the child population⁴.

III. National response to the AIDS epidemic

1. Policy development and implementation status

Expenditure and policy development and implementation status at a glance

1. National Composite Policy Index → **Refer to NCPI-A&B**
2. Amount of national funds disbursed on HIV/AIDS → **US\$6.3 million (2003) and US\$6.5 million (2004) (NAC)**

Zimbabwe has made much progress in establishing a good policy framework. However, there are still gaps that exist, especially in sectoral policies. While Mines, Transport and the Public Service have HIV policies already in place, Education and Agriculture are still in the process of developing theirs.

The 2000-2004 National HIV/AIDS Strategic Framework has been extended to the end of 2005, due to late implementation. At present, the first draft of the next Framework 2006-2010 has been prepared and is undergoing extensive reviews by stakeholders.

During the reporting period, significant efforts were made to strengthen the coordination capacity of NAC. It recruited and trained 95 District AIDS Coordinators (DACs) to strengthen district and sub –district responses through the improved coordination, planning, implementation and monitoring of District AIDS Action Committees (DAACs) activities. Moreover, to improve financial management, NAC has recruited District Accounts and Administration Officers in each district to handle NAC and project funds. Furthermore, significant strengthening has occurred at national level, with five substantive national officers recruited. The establishing of a new fund management unit is planned.

The launch of the National Plan of Action for Orphans and Other Vulnerable Children (NPA-OVC) by the Vice President in 2005 was the most significant policy development during the reporting period. Spearheaded by the Ministry of Public Service, Labour and Social Welfare (MPSLSW), 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 MPSLSW are responsible for coordinating its the implementation.

⁴ MoPSSLW/UNICEF OVC Survey of 2004 found that 30% of the child population in rural and urban high density Zimbabwe were orphans. The 2003 Poverty Assessment Study Survey which had a national coverage found 25% of the child population was orphaned.

The MoHCW launched the National Home-based Care standards in April 2004. A draft training manual has been developed and is expected to be finalized in 2005. Moreover, to enhance coordination at national level, a Home-based Care focal point has been newly appointed in NAC.

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. The national ART roll out plan was initiated in 2004, and national guidelines were developed the same year

The National AIDS Trust Fund established in 2000 and funded through the HIV/AIDS levy of 3% from all taxable income remains an innovative programme to mobilize funds to fight against the epidemic in southern Africa.

The Government of Zimbabwe allocated a total of US\$ 6.3 and US\$ 9.9 million in 2003 and 2004 respectively for HIV/AIDS. The National HIV/AIDS Trust Fund managed by the NAC contributes the lion share of the amount.

Table 2: Government expenditures on HIV/AIDS, 2003-2005

	2003	2004	2005	Total
1. MoFED ⁵	4.6	2.7	-	-
2. NAC ⁶	1.7	7.2	-	-
Total	6.3	9.9	-	-

Figures are in millions of USD. 1USD=6,000 ZWD exchange rate is used for calculation.

2. National programmes

⁵ *The figures represent the total amount spent on HIV/AIDs by Government ministries.*

⁶ *The amount includes funds disbursed to civil society partners as well as national institutions. Approximately half of the funds are allocated to civil society partners in 2003 and 2004.*

National programmes at a glance

3. Percentage of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year → **Not available**⁷
4. % large enterprises/companies that have HIV/AIDS workplace policies and programmes → **7.7% (ZBCA 2004-5)**⁸
5. Percentage of women and men with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled → **Not Available; due to be collected in 2006**
6. Percentage of HIV positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT → **6.6% (MoHCW, 2004)**
7. Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy → **8.3% (MoHCW, 2004)**
8. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child → **43% (MoPSLSW/UNICEF, 2004)**
9. Percentage of transfused blood units screened for HIV → **100% (NBTS, 2004)**

Zimbabwe has made efforts in scaling up its approach in the three main thematic areas, namely prevention, care and mitigation. Zimbabwe has sought to improve coordination in HIV and AIDS responses at all levels by strengthening the three ones, viz, one strategic plan, one monitoring and evaluation system and one coordinating authority. The National AIDS Council coordinates HIV related activities with close collaboration with Ministry of Health and Child Welfare (MoHCW).

Prevention

Voluntary Counseling and Testing (VCT)

⁷ As per Ministry records 100% of trained teachers have been trained in life-skills based HIV/AIDS education and are teaching the material within the normal curriculum in all public schools at primary and secondary levels. A nationally representative school-based survey is required to find out what transpires at school level. Some small-scale studies have found that many teachers do not in fact teach the HIV/AIDS modules in the curriculum.

⁸ The sample was only drawn from the private sector and included 13 companies as opposed to the 25 stipulated in the guidelines.

The country has standalone VCT centers and those integrated within public health institutes. VCT centers are supported by government, and local and international partners. At the end of 2004, there were forty standalone sites and 270 integrated within health institutions. Mobile outreach activities are conducted to cater for hard to reach communities. VCT uptake is increasing, reaching nearly 288,000 among the adult population (15 -49 years in 2004). While the introduction of the cadre of primary care counsellors (PCCs) has been a notable further achievement, there are difficulties in rolling out the service. The main challenges hampering expansion of the program are critical manpower shortage at both the national and health facility level. Resources to train the PCCs are limited and efforts to strengthen existing and new partnerships are being made.

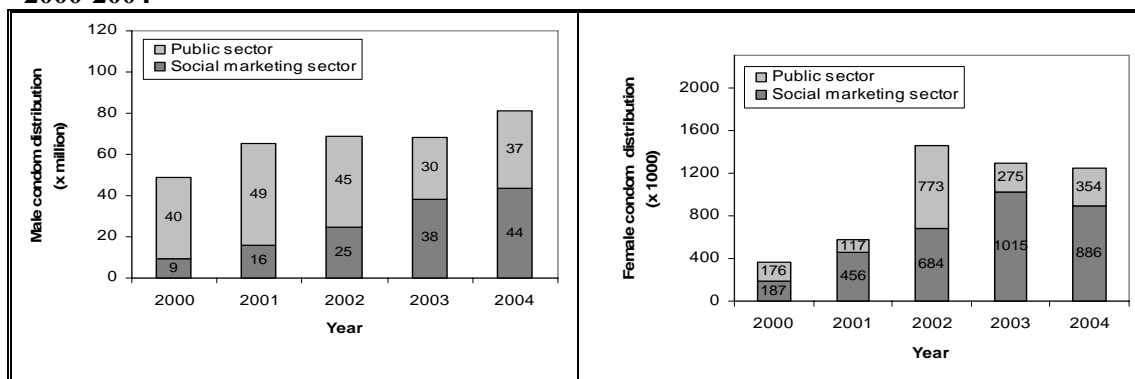
Lifeskills based HIV/AIDS education in schools

Since 1994, all teachers undergo pre-service training on lifeskills based HIV/AIDS education. Most colleges allocate 1 to 2 hours weekly and ensure that every student teacher goes through the programme. Each of the 13 Teachers' and 11 Technical Colleges have either a full time coordinator or a team of trained lecturers to teach the subject. The biggest challenge is that the training is usually delivered through mass lectures, potentially reducing its effectiveness of the training. There is a need to introduce in-service refresher courses. In 2005 an integrated training package focusing on gender issues, learner-centred HIV/AIDS participatory methodologies and counselling skills will be developed, so that every teacher who is trained is able to support both the cognitive and psychosocial needs of children. Initial surveys that while trainers are trained, life skills education does not consistently take place in all schools.

Condom Distribution and Social Marketing

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 2000. According to ZNFPC, 37.3 million male and 353,600 female condoms were distributed in 2004. In the social marketing sector, PSI sold 48 million male and 750,000 female condoms in 2004 in various outlets, including liquor stores, hair salons, supermarkets, and service stations. The total number of male condoms distributed and sold per year has therefore reached more than 80 million. The numbers of female condoms sold by PSI in Zimbabwe are the highest in southern Africa.

Figure 2: Male and Female Condom Sales in Public and Social Marketing Sales, Zimbabwe 2000-2004



Source: Overview of Condom Programming in Zimbabwe: Working Draft (UNFPA, PSI, ZNFPC, 2005)

Interventions for Out-of-School Youth

A number of organizations have been involved in programmes 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 programmes, youth-friendly reproductive health services, media programmes 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 programmes. A recent behavioural change review has indicated that in addition to activities targeting youth directly, programs addressing adult sexual norms are needed.

Prevention of Mother to Child Transmission (PMTCT)

Out of a total of 1 600 public health institutions, a total of 800 were registered as PMTCT sites at the end of 2004 compared to 205 in 2003 and 69 in 2002. This included all 58-district hospitals, the 4 provincial hospitals and mission hospitals that are registered with the MoHCW and excludes private hospitals that do not access their nevirapine from AIDS and TB Unit, MOHCW.

In 2004, out of a total of 351 624 women giving births recorded in public health facilities, 23.9% were estimated to be HIV positive based on the recent ANC estimates. In 2004, 5,534 pregnant women received a full course of antiretroviral prophylaxis, which represents 6.6% of the estimated 84,038 HIV positive pregnant women who delivered in the public health facilities.⁹

Of all ANC attendees in PMTCT sites, 76% were pretest counseled for an HIV test in 2003 and 65% in 2004, recording a notable decline. Of those women who were pretest counselled, 65% were tested for HIV in 2003 and 73% were tested in 2004, representing a notable increase. Of those who were tested, 25.5% tested positive in 2003 and 22% tested positive in 2004, suggesting a stabilization of the epidemic as in the results of the recent ANC surveillance surveys. Out of the identified HIV exposed babies, 53% received nevirapine in 2003 while 47% received nevirapine in 2004. The main challenges to the program were high staff turnover leading to increased costs in training new staff as well as limited follow up and care of mothers and babies.

Table 3: PMTCT programme statistics, Zimbabwe 2002-2004

⁹ The 6.6% is an estimate figure. The private sector also offers PMTCT services, but is not included in the calculation here. Furthermore, according to the Census, 412,000 live births were recorded in 2002.

Indicator	2004		2003		2002	
	No.	%	No.	%	No.	%
ANC	116279	100%	98505	100%	45690	100%
Pre-test Counselling	75226	65%	74704	76%	33724	74%
HIV Tested	54742	73%	48662	65%	22257	66%
HIV positive	12046	22%	11941	25%	4861	22%
ARV_M (ANC)	5534	46%	6695	56%	1696	35%
ARV_M (swallowed)	5027	42%				
ARV_B (swallowed)	5698	47%	6208	52%	1407	29%

Source: MoHCW PMTCT programme records

Control of Sexually Transmitted Infections (STIs)

Presence of STIs increases the risk of being infected by HIV. Therefore prevention and control of sexually transmitted infections (STI) is a major strategy for the overall prevention and control of HIV and AIDS. Zimbabwe has adopted the syndromic management approach for STI. Due to high staff attrition rates, the MoHCW continues to train medical personnel in syndromic management of STI. In the year 2004, 99 nurses were trained at national level, while some districts conducted their own local STI workshops.

Care and Treatment

Antiretroviral Treatment

The MoHCW coordinates all efforts to provide ART. The ART program was implemented in public health institutions using the phased out approach and a multidisciplinary team in the learning sites. Four sites representing the different health institutes (Central Hospital-Harare and Mpilo, rural-Howard, urban local authority- Bulawayo City and private – Triangle) were selected as learning sites in 2003. Preparation for implementation of ART included training health personnel, equipping of laboratories and training of laboratory personnel in using CD machines. Counseling capacity was also increased in the sites.

A National ART roll-out plan was launched in March 2004 and by the end of 2004 a total of 18 health facilities including research projects were offering ART. In addition, 9 sites were assessed and were deemed ready to offer ART at the beginning of 2005. Private practitioners also offer a significant but poorly documented proportion of ART. Altogether, there are now more than 40 ART sites in Zimbabwe at the end of 2005.

Training of health care staff on comprehensive management of HIV and AIDS including ART has started. Government has also set aside over Z\$10 billion for ARVs and Z\$ 5 billion from NAC in the year 2004. Unfortunately the unavailability of foreign currency has delayed the rapid expansion program of ARVs in the public sector health institutions. In 2005, only 20,000 patients have received ART in private and public health facilities. This represents a mere 8.3% of the estimated total number of people with advanced HIV infection.

Treatment of Opportunistic Infections

The Government has made strides in introducing treatment of opportunistic infections and in planning for provision of ARVs. Policies and Protocols for the management of HIV/AIDS opportunistic infections were developed in 2003 and continue to be updated. Opportunistic infection (OI) clinic services have been established for both adults and children at 18 public

health facilities (provincial and district hospitals) during the period 2003 to 2004. These OI clinics offer ARV drugs.

Prevention and Control of Tuberculosis

Zimbabwe is one of the 22 tuberculosis high burden countries worldwide. TB notification rates have steadily risen since 1982 from 68 to 462/100 000 population in 2003. This unprecedented increase in the TB burden can be attributed to increase in poverty and the HIV epidemic. Amongst TB patients, the estimated sero-prevalence is between 50 to 80%. Zimbabwe is currently working at integrating TB and HIV care activities. Currently, Zimbabwe has 100% coverage of the Direct Observed Treatment Strategy (DOTS) on TB. Strategies to improve TB/HIV collaborative activities include the screening of VCT clients for TB. By the end of 2004, the National TB control program had trained approximately 50% of all private medical practitioners on TB/HIV management. In addition, there has been increased awareness and involvement among the community on TB diagnosis and care in HIV and AIDS patients.

Home-Based Care

As mentioned earlier, the MoHCW launched the National Home-based Care standards in April 2004. This is seen as a critical development in order to harmonize various training initiatives ongoing in the country by a number of NGOs. In 2004, tens of thousands of volunteer caregivers were trained countrywide. The challenge to scale up is remuneration, as most caregivers are currently employed in other jobs and cannot be full time carers on a voluntary basis.

Care and Support for OVC

In relation to care and support for orphans and other children made vulnerable by HIV/AIDS, the Rapid Assessment, Analysis and Action Planning process (RAAAP) of 2004 led by the MoPSLSW found that there are 48 local and international NGOs working in the area of care and support for OVC. UNICEF, for example, 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 4,000 community based counsellors through districts, colleges, universities and NGOs. PLAN supported nearly 70,000 orphans and other vulnerable children as well as 646 PLWHA groups.

The MoPSLSW/UNICEF OVC Baseline survey of 2004 found that 43% of the households who care for at least one orphan or vulnerable child had received some form of free external support to care for these children. By contrast, only a third of households that do not care for OVC received such support, implying that targeting in the various programmes is functioning to a certain extent.

Blood Screening and Transfusion

Blood screening is centralized at the National Blood Transfusion Services (NBTS), a parastatal institution. The private sector purchases the screened blood for transfusion. In 2004, all the blood that was transfused were screened for HIV.

3. Knowledge and Behaviour

Knowledge and Behaviour at a glance

10. Percentage of young women and men 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention
(Target: 90% by 2005; 95% by 2010) → 55% (PSI, 2003)
11. Percentage of young women and men who have had sex before the age of 15 → **8.3%**

(MoPSSLW/UNICEF, 2004)

12. Percentage of young women and men 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months → **51% (MoPSSLW/ UNICEF, 2004)**
13. Percentage of young women and men 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner → **50% (MoPSSLW/ UNICEF, 2004)**
14. Ratio of orphaned to non-orphaned children 10-14 years of age who are currently attending school → **0.89 (MPSLSW/UNICEF, 2004)**

While AIDS awareness in Zimbabwe is generally considered to be very high, knowledge is not complete and correct knowledge not universal. The National KAP study organized by PSI in 2003 found that among young people 15-24, 55.2% of them had completely correct knowledge on HIV transmission and prevention. The proportion was higher in urban areas than rural areas at 57.8% and 53.4% respectively. There was only slight difference between the sexes; 56.3% of males and 54.1% of females were found to have correct knowledge. This may reflect the fact that in Zimbabwe, there is near gender parity of school enrolment both at primary and secondary levels (MoESC 2004).

However, two recent studies conducted in 2004 found that knowledge levels may be even lower in rural areas. The MPSLSW/UNICEF OVC Baseline Survey found that only 34% of young people 15-24 were able to correctly answer all the 5 questions on HIV transmission and prevention correctly. The BRTI Manicaland Demographic Surveillance Site also recorded that only 36% of young people had correct knowledge. There is no comparable data available for earlier years to establish a trend. The latter two surveys had a rural bias in their samples.

While knowledge levels therefore remain unsatisfactory, protective behavior appears to be relatively high among young people. Sexual debut is still relatively late in Zimbabwe at 17-18 year old. The MPSLSW/UNICEF OVC Baseline survey found that 49.6% of young people (56.5% males, 42.6% females) had used a condom in the last sex with a non-regular partner. The DHS of 1999 had also found high levels of condom use with non-regular partners, among all age groups. The DHS found that 68.9% and 41.3% of young men and women respectively reported use of condom in the last sexual encounter with a non-regular partner. As described above, condom consumption rates are steadily increasing since the 1990s, and the HIV prevalence rates among younger age groups appears to be dropping. There may be significant under-reporting of condom use.¹⁰

Finally, according to the MPSLSW/UNICEF OVC Baseline survey, orphans (double orphans) in Zimbabwe are slightly less likely to attend school than their non-orphan counterparts. The same survey also found that over 20% of double orphans had received some form of education support. The gap between orphans and non-orphans in school attendance could be large if the level of assistance is lower.

Impact at a glance

15. 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) → 17% (MoHCW & CDC, 2004)

¹⁰ Indeed the PSI KAP Survey found very high rates of condom. The survey found that 85.7% of males and 84.9% of females in the 15-24 age group reported use of condom during their last sexual encounter with a non-regular partner.

- | |
|---|
| <ol style="list-style-type: none">16. Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy → Not available; due to be collected in 200617. Percentage of infants born to HIV infected mothers who are infected (Target: 20% reduction by 2005; 50% reduction by 2010) → 24% (MoHCW, 2004) |
|---|

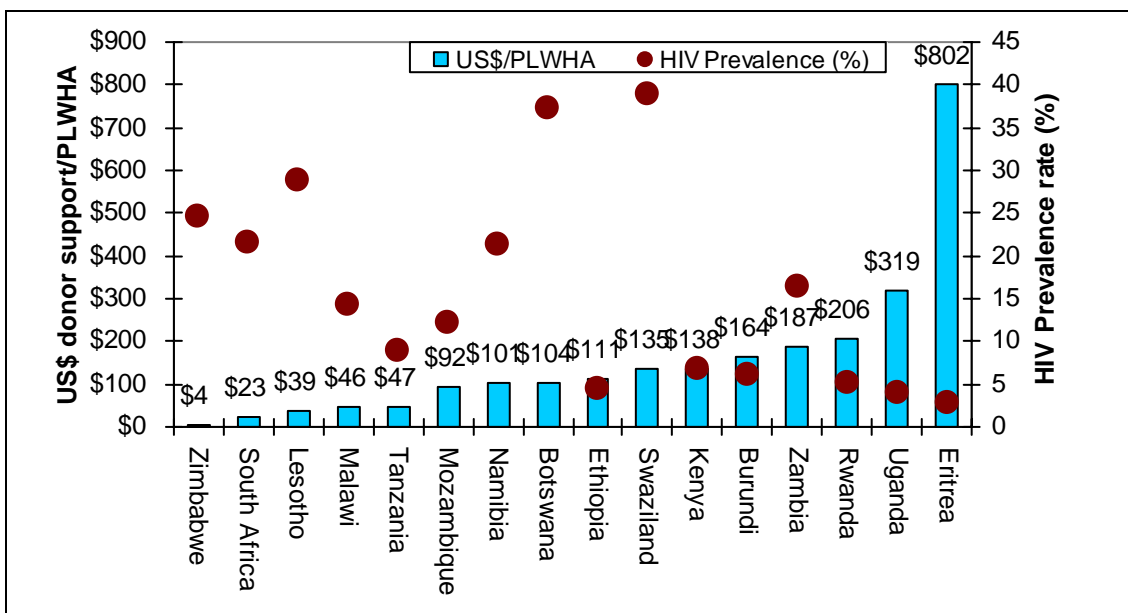
IV. Major challenges faced and actions needed to achieve the goals/targets

Although efforts by the Government and civil society are underway to address the impact of the epidemic, the magnitude of the problem and the difficult socio-economic situation pose a severe constraint to scaling up interventions. The already constrained human resources situation is aggravated by illness and death of government and NGO staff and by retrenchment and resignation from employment in search of greener pastures. Linked to this are commonly experienced logistical constraints, including shortages of vehicles, spare parts and fuel, which, together with the constraints mentioned above affects implementation and monitoring of interventions. The single most important challenge facing the national response is the severe shortage of foreign currency.

The situation has been exacerbated by policy differences, mostly regarding non HIV related matters, between Zimbabwe and key international partners, which have led to a significant reduction in bilateral and multilateral funding for key national priorities, including HIV. In contrast to its Southern-African neighbours, Zimbabwe has received no funding from the US President's Initiative on HIV and AIDS (PEPFAR) or the World Bank MAP Initiative, and has received very limited funds from the Global Fund to Fight AIDS, TB and Malaria (GFATM)^{11, 12}. The result is that whereas the average annual donor spending per HIV-infected person by these three initiatives is US\$74 in Eastern and Southern Africa, Zimbabwe receives on average US\$4 per HIV-infected person annually. By contrast Zambia, a country with slightly lower HIV rates than Zimbabwe, annually receives US\$187 per HIV-positive person, Namibia \$101, Uganda \$319, and Eritrea \$802.

¹¹ The grant from the first round of GFTAM proposals was signed in April 2005. The grant totalled 10.3 million USD.

¹² In 2005, a 60 million US\$ 5th round GFATM proposal was approved, but is still awaiting operationalization.



Source: http://www.worldbank.org/afr/aids/map_docs.htm; <http://www.state.gov/s/gac/>; <http://www.theglobalfund.org/en/>. (Accessed 1 nov. 2004)

Achieving greater integration between HIV prevention, care and mitigation initiatives remains a challenge that must be overcome in order to take interventions to scale while at the same time ensuring that they reach the most vulnerable young people. The slow progress made in revising the expiring National HIV/AIDS strategic Framework, has exacerbated this challenge. In 2005, stakeholders in Government, bilateral donor community, UN and civil society are actively collaborating to develop a new National Strategic Framework which should ensure a comprehensive, coherent HIV/AIDS response in years to come.

Data collection plan (2005 reporting)	2003	2004	2005
Household surveys	Knowledge, Attitudes, and Practice Study (PSI)	Labour Force Survey Orphans and Other Vulnerable Children Baseline Survey (MPSLSW and UNICEF)	Demographic and Health Survey, Plus (MoHCW and CSO)
Health facility surveys		ANC Sentinel Surveillance (MoHCW)	Sexually Transmitted Infections Case Management Assessment (MoHCW)
School-based surveys		Impact of HIV/AIDS on the Education Sector (MoESC) Regional Study on Gender, HIV/AIDS and Sexuality---Young Voices (UNICEF)	
Workplace surveys		Impact Assessment of HIV and AIDS in the	

		MoHCW (MoHCW) HIV/AIDS Response in the Workplace (ZBCA)	
Desk review		Rapid Assessment, Analysis, and Action Planning (RAAAP), 2004	Comprehensive review of epidemiological data, 2005

V. Support required from country's development partners

The most important area of support required is resource mobilization. As stated above, Zimbabwe receives very little funding from the donor community to respond to the HIV/AIDS epidemic. Development partners, especially those that are resident in Zimbabwe, could do more to advocate with the donor community the dire need for assistance in the area of HIV/AIDS prevention, care/treatment and mitigation. As demonstrated in the relatively high score in the national policy composite index, Zimbabwe has a relatively favourable policy framework and decentralized implementation structures to swiftly and effectively deliver assistance.

Continued support to NAC to strengthen its coordination capacity is also important, especially to ensure a multi-sectoral response both at the national and sub-national levels.

Finally, technical support in various areas such as prevention, condom promotion, surveillance and treatment should continue.

VI. Monitoring and evaluation environment

While epidemiological surveillance activities fall within the aegis of the Ministry of Health and Child Welfare, the National AIDS Council (NAC) co-ordinates routine program monitoring of the expanded response to the epidemic. An operational plan for M&E has been developed, a draft strategic framework is in place, core National output indicators for program level monitoring system have been identified and described. A simple paper-based data collection tool (NAC Activity Report Form) has been developed and an electronic, web-based decentralised data entry and reporting system has been locally designed and is now under pilot. The Pilot phase for data collection and reporting is now in progress. Working closely to plan, the monitoring system is under trial in 20 sites nationwide. The Pilot is expected to conclude in early 2006, after which the national roll out is slated to take place.

Stakeholder participation is central to NAC monitoring and evaluation activities. National M&E meetings have been held annually since 2002 to review progress and obtain consensus on the M&E strategy. The National M and E Taskforce whose membership is representative of all Stakeholders, has been revived and energized and meets monthly. Technical Working Groups who report to the National Taskforce and are voluntarily led by Taskforce members, also meet monthly and actively work towards defined goals (such as development of Core National M&E curricula).

The National M&E system for HIV/AIDS will enable Zimbabwe to gain better understanding of HIV/AIDS interventions, generate adequate information on the response, and improve the utilisation of generated information for appropriate policy formulation, programme planning,

review and improvement and guide allocation of resources to the most vulnerable groups in the country.

Major programmes such as the National Plan of Action on OVCs and patient monitoring for ART have developed their specific M&E sub-system guided by framework and structures of the National M&E System for HIV/AIDS. Work to integrate the core set of indicators into the National M&E system is underway.

Epidemiological surveillance includes ANC sentinel surveillance as well as repeated DHS. The latest DHS+ 2005 is underway.

There are a few in-depth research initiatives currently on-going in the country. The most prominent is the Manicaland Study coordinated through the Biomedical Research and Training Institute (BRTI). It aims to describe and evaluate the temporal dynamics of HIV transmission, impact and control in small towns, large-scale commercial farming estates, roadside trading centres and subsistence farming areas in eastern Zimbabwe. Between 1998 and 2003, a community-randomised controlled trial was used to evaluate the effectiveness of peer education, community condom distribution and intensified syndromic management of sexually transmitted disease – interventions that are widely applied in Zimbabwe – and, unfortunately, found no effect on HIV incidence at the community level over a 3-year period. Data on the determinants and consequences of orphanhood collected in the study are being used in the development of appropriate orphan support programmes.

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** No
b) NAP Yes **No**
c) Others **Yes** No

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

2) With inputs from

Ministries:

- Education **Yes** No
Health **Yes** No
Labour **Yes** No
Foreign Affairs Yes **No**
Others **Yes** No

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

- Civil society organizations **Yes** No
People living with HIV/AIDS **Yes** No
Private sector **Yes** No
United Nations organizations **Yes** No
Bilaterals **Yes** No
International NGOs **Yes** No
Others Yes **No**
(please specify)

3) Was the report discussed in a large forum? Yes **No**

4) Are the survey results stored centrally? Yes **No**

5) Are data available for public consultation? **Yes** No

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Date: 4 January 2005

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