Zimbabwe HIV and AIDS Toolkit

Welcome to the Zimbabwe HIV and AIDS e-toolkit. This toolkit consists of different forms of materials on HIV and AIDS in Zimbabwe. The materials are in the form of: research papers, periodicals, books, training materials (toolkits and manuals), behaviour change communication (BCC) and awareness raising products (posters, booklets, leaflets, presentations), that creatively and factually share current and dynamic knowledge and skills relating to HIV and AIDS, TB, and other related prevention and impact mitigation responses.

The Zimbabwe HIV and AIDS e-toolkit is a collection of various publications from different organizations and individuals. The materials are based on the national strategy to the HIV response they are divided into six main sections;

- Coordination, Management and System Strengthening
- Key Populations
- Monitoring and Evaluation
- Prevention
- Treatment, Care and Support
- Youth and Adolescents

The toolkit was developed to be a one-stop shop for all resources on HIV and AIDS in Zimbabwe. The materials were selected basing on their contribution to the HIV response in Zimbabwe.

The intended audience for this toolkit includes researchers, health and development practitioners, health management teams and health professionals interested in the concerted effort to prioritize HIV prevention and integrate HIV prevention with other healthcare services.

Welcome to the Zimbabwe Prevention e-toolkit. This toolkit consist of different forms of materials on HIV prevention in Zimbabwe developed by the Zimbabwe e-toolkit taskforce. The materials are in the form of : Research papers, Periodicals, Books, Training Materials (toolkits and manuals), Behaviour Change Communication (BCC) and Awareness Raising products (posters, booklets, leaflets, presentations), that creatively and factually share current and dynamic knowledge and skills relating to HIV and AIDS, TB, and other related prevention and impact mitigation responses.
The Zimbabwe Prevention e-toolkit is a collection of various publications from different organizations and individuals. The materials are BCC, Family Planning and HIV Service Integration, Male Circumcision (MC), Multiple and Concurrent Partnerships (MCPs), Prevention of Mother to Child Transmission (PMTCT) and Voluntary Counselling and Testing (VCT). The toolkit was developed to be a one-stop shop for all resources on HIV prevention in Zimbabwe. The materials were selected basing on their contribution to HIV prevention in Zimbabwe.

The intended audience for this toolkit includes researchers, health and development practitioners, health management teams and health professionals interested in the concerted effort to prioritize HIV prevention and integrate HIV prevention with other healthcare services.

The Zimbabwe e-toolkit taskforce consists of the following organisations: SAfAIDS, Women's Action Group (WAG), Zimbabwe National Network for People Living with HIV/AIDS (ZNNP+), Zimbabwe National Family Planning Council (ZNFPC), Patsime, National AIDS Council (NAC), Zimbabwe AIDS Network (ZAN), Ministry of Health and Child Welfare, SAYWHAT and The Centre. The taskforce came together as they have a mandate of enabling the entire Zimbabwean community to have access to correct and reliable information on HIV Prevention.

Coordinated, Management and Systems Strengthening

This toolkit page contains information on Gender, Mainstreaming of HIV and AIDS, Meaningful Involvement of People Living with HIV and AIDS, Sexual Reproductive Health Integration, Social and Cultural Issues, Stigma and Discrimination, Strategies and Policies and Systems Strengthening.
Gender

Mainstreaming of HIV & AIDS

Meaningful Involvement of People Living with HIV and AIDS

Sexual and Reproductive Health Integration

Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman’s ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy.

Integrating HIV and other sexual and reproductive health services, such as family planning and maternal health. Integrating services is a good strategy that leverages existing and scarce resources, without placing an undue burden on health care systems. Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility.

Integrating HIV services and other sexual and reproductive health helps service providers and individuals or couples make informed decisions, helping in HIV prevention. This section contains publications on various HIV integrating services especially family planning services.

Resources:

- Potential of Dual-Use Policies to Meet Family Planning and HIV Prevention Needs: A case study of Zimbabwe and Mozambique
Background and methodology: The fight against the HIV epidemic in many high-prevalence countries is a struggle to motivate culturally relevant risk reduction in general populations that have been educated to associate HIV risk with commercial sex, injection drug use and other stigmatised behaviours. Common concurrent partnerships, which facilitate transmission of HIV in many high-prevalence countries, are only beginning to receive the attention they deserve. This has made the promotion of dual-use methods, such as condoms, for individuals who require both HIV protection and contraception very difficult. Recent research on concurrent partnerships and the implications for high HIV risk in sexually networked but sexually modest general populations is forcing another assessment of the response to HIV. In the light of the epidemic, it is important to better understand which policies will better meet HIV prevention and family planning (FP) needs. This article explores the potential of dual-use policies by examining Zimbabwe and Mozambique.

Results: Zimbabwe, with a vertically driven, stronger FP programme predating the HIV epidemic, has not yet seen an increase in condom use to the level desired by their moderately strong HIV prevention programme — one that has adopted a primarily single-use condom policy.

• A Tool for Maternal Health Advocates ? Maternal and Neonatal Program Effort Index

Worldwide, over 500,000 women and girls die of complications related to pregnancy and childbirth each year. Over 99 percent of those deaths occur in developing countries such as Zimbabwe. But maternal deaths only tell part of the story. For every woman or girl who dies as a result of pregnancy-related causes, between 20 and 30 more will develop short- and long-term disabilities, such as obstetric fistula, a ruptured uterus, or pelvic inflammatory disease. Zimbabwe’s maternal mortality rate continues at an unacceptably high level. While maternal mortality figures vary widely by source and are highly controversial, the best estimates for Zimbabwe suggest that roughly between 1,300 and 2,800 women and girls die each year due to pregnancy-related complications. Additionally, another 26,000 to 84,000 women and girls will suffer from disabilities caused by complications during pregnancy and childbirth each year.

• An Assessment of the Zimbabwe National Family Planning Council’s Community Based Distribution
Programme

Since its inception, the Zimbabwe National Family Planning Council’s (ZNFPC) Community Based Distribution (CBD) programme has made significant and well-documented contributions to the demand for and use of family planning in Zimbabwe. Data from several studies have shown, however, a steady decline in this contribution and that the CBD agents spend more time re-supplying existing clients than recruiting new acceptors. Moreover, the CBD programme needs urgently to be able to address the AIDS crisis in the country. ZNFPC has undertaken this review to guide it in making appropriate decisions about the future direction for the programme. Data were collected through a review of documents, in-depth interviews with key staff at headquarters and provincial levels, interviews with 128 CBDs, 37 Group Leaders, 33 Community Leaders, 23 Environmental Health Technicians, 40 Clinic Nurses, 19 District Nursing Officers and 22 Community Health Nurses, and through sixty-one focus group discussions with different groups of community members. The review confirmed that the number of pill clients served and Couple Years of Protection (CYPs) provided has been steadily declining since 1987. However, these performance measures do not take into account the client contacts undertaken or the non-family planning information and services offered by CBD agents. Several potential reasons for the declining performance were identified. There are now many alternative sources for family planning that compete with the CBD agents for clients. Moreover, the proportion of women wanting to use the injectable has increased, putting the agents at a disadvantage compared with clinics. The average age of the CBDs is over 40 years and many are finding it difficult to cover their catchment areas effectively and to reach younger clients.

An Assessment of the Zimbabwe Family Planning Programme: Results from the 1996 Situation Analysis Study

Within the past 10 years, the Zimbabwe National Family Planning Council (ZNFPC) has conducted two major studies for assessing the availability and quality of reproductive health services. The two studies, generally referred to as Situation Analysis Studies, were conducted in 1991 and 1996.

The 1996 survey collected data from 192 health facilities spread throughout Zimbabwe. During this exercise, an inventory of physical facilities, equipment and educational materials was taken. In addition, 758 provider-client interactions of new and revisit clients were observed. Exit interviews were conducted with service providers, family planning and Maternal and Child Health clients. Wherever possible, findings from the 1996 study are compared to those of 1991 in which 181 health facilities were visited. However, the evolution of the Situation Analysis methodology since 1991 limits the degree to which comparisons can be made between the two studies.
Impact of Family Planning on Women's Participation in the Development Process

The development process in Zimbabwe has proceeded unevenly since the country achieved independence in 1980. Although the new government took steps to create a climate of equal opportunity for men and women, men have tended to play the more prominent roles in development. This study examines the question of how family planning use may affect the ability of women to participate in the development process. It investigates the extent to which women who control their fertility also control other important aspects of their lives.

The roles of women in Zimbabwe's development tend to have been more circumscribed than the roles of men attributable in part to the country's colonial history. The colonial administration imposed a "hut tax" on every male head of household, which had to be paid in cash. The tax forced men to migrate to sell their labor in the rapidly growing areas of mining and commercial agriculture. Thus, migration for work and the dual economy were established. The influence of this pattern persists today. When men were absent from rural areas, women became the de facto heads of households. Men acquired skills and technical knowledge through training and experience, but women who remained behind achieved little or no improvement in status.

Development of the Zimbabwe Family Planning Program

Family planning was introduced in Zimbabwe as a voluntary movement in the 1950s. Volunteers formed a Family Planning Association in the mid-60s. The government became interested in family planning in the late 1960s after analysis of the 1961 population census. It gave the Family Planning Association an annual grant, allowed contraceptives to be available through Ministry of Health facilities, and allowed nonmedical personnel to initiate and resupply family planning clients with condoms and pills. But before Zimbabwe achieved independence in 1980, family planning was viewed with great suspicion by the black majority, so the program's effectiveness was limited to the urban few. A new era began after independence. The new government took over the Family Planning Association and changed its outlook completely. Through government and international donor support, the family planning program was restructured and expanded. The number of family planning personnel more than doubled in some units. More service delivery points were set up, particularly in rural areas. And the information, education, and communication and evaluation and research units were established. Through a World Bank-assisted project (with grant funding from
Norway and Denmark), the Ministry of Health began strengthening its family planning capabilities. These efforts helped increase the contraceptive prevalence rate from about 14 percent in 1982 to 43 percent in 1988. But the program’s growth is beginning to stall. More effort and resources are needed if the program is to grow or even maintain its present status. Particularly important are the following:

- Designing innovative strategies to reach hard-to-reach populations. Giving more emphasis to information, education, and communication, especially for men and youths, using multimedia.
- Involving other sectors in the delivery of family planning services.
- Broadening the mix of contraceptive methods (especially promoting long-term and permanent methods).
- Making use of alternative family planning delivery systems, such as the use of depot holders, volunteers, and government extension workers.
- Establishing a national population policy.
- Considering cost recovery and other measures for self-sustainment and program growth.

Fertility Levels and Trends in Zimbabwe

In this article I attempt to establish the fertility level in Zimbabwe for the years 1982-4. In view of the inaccuracy of recorded data from censuses and surveys several methods of estimation are used. This period was chosen because a census was taken in 1982 (Central Statistical Office, 1985) and a reproductive health survey was conducted in 1984 (Zimbabwe National Family Planning Council, 1985). The data from this period can be compared with those from 1969, when a population census was taken (Central Statistical Office, 1969), with those from 1987 when an intercensal demographic survey was conducted (Central Statistical Office, 1991), and with those from 1988 when a demographic health survey was undertaken (Central Statistical Office, 1989). I then consider fertility trends over a 20-year period (1969-88).

Empirical analysis is based on the 1982 ten per cent sample (Central Statistical Office, 1985) and data from the Zimbabwe Reproductive Health Survey, 1984 (Zimbabwe National Family Planning Council, 1985). There is evidence that fertility declined between the 1969 population census and 1984. If the data recorded in the 1987 intercensal demographic survey (Central Statistical Office, 1991) and the 1988 demographic health survey are correct, this decline seems to have continued up to 1988. Such a decline may be the result of an increased use of modern methods of contraception. However, little can be said about the magnitude and the timing of the decline until further research is undertaken.
Zimbabwe - Prevention of Mother to Child Transmission of HIV Intervention

Prevention of mother-to-child transmission (PMTCT) of HIV is one of the key HIV prevention strategies in Zimbabwe’s national response to the HIV/AIDS epidemic. Mother-to-child transmission (PMTCT) of HIV is the most significant source of HIV infection in children below the age of 15 years. Over 90% of HIV infection in infants and children is due to PMTCT.

About 30 to 35% of pregnant women are HIV positive. Without any PMTCT intervention, about a third of the HIV infected women will pass the virus to their babies. It is estimated that about 20% of the infected babies become infected during pregnancy, 60% during labour and delivery, and 20% after birth through breast-feeding. Most infections therefore occur during labour and delivery.

The goal of Zimbabwe PMTCT is to reduce PMTCT of HIV infection, thereby leading to reduction of infant morbidity and mortality.

Social and Cultural Issues

Stigma and Discrimination

Strategies and Policies

Resources:

• Zimbabwe National HIV and AIDS Strategic Plan [ZNASP II] 2011-2015

The Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) is a five-year 2011 to 2015,
multi-sectoral framework developed to inform and guide the national response towards achieving zero new infections, zero discrimination and zero AIDS related deaths by 2015. The development of the plan is premised on human rights based planning approach that is complemented by evidence and results based management approaches. The strategic plan has mainstreamed gender dimensions in the response strategies, anticipated results and indicators that will be used to measure performance. The plan provides meaningful opportunities for man and diverse stakeholders' participation in the implementation of the national response. The strategic plan succeeds the outgoing ZNASP (I) - 2006-2010.

An Assessment of the Zimbabwe National Family Planning Council?s Community Based Distribution Programme

Since its inception, the Zimbabwe National Family Planning Council?s (ZNFPC) Community Based Distribution (CBD) programme has made significant and well-documented contributions to the demand for and use of family planning in Zimbabwe. Data from several studies have shown, however, a steady decline in this contribution and that the CBD agents spend more time re-supplying existing clients than recruiting new acceptors. Moreover, the CBD programme needs urgently to be able to address the AIDS crisis in the country. ZNFPC has undertaken this review to guide it in making appropriate decisions about the future direction for the programme. Data were collected through a review of documents, in-depth interviews with key staff at headquarters and provincial levels, interviews with 128 CBDs, 37 Group Leaders, 33 Community Leaders, 23 Environmental Health Technicians, 40 Clinic Nurses, 19 District Nursing Officers and 22 Community Health Nurses, and through sixty-one focus group discussions with different groups of community members. The review confirmed that the number of pill clients served and Couple Years of Protection (CYPs) provided has been steadily declining since 1987. However, these performance measures do not take into account the client contacts undertaken or the non-family planning information and services offered by CBD agents. Several potential reasons for the declining performance were identified. There are now many alternative sources for family planning that compete with the CBD agents for clients. Moreover, the proportion of women wanting to use the injectable has increased, putting the agents at a disadvantage compared with clinics. The average age of the CBDs is over 40 years and many are finding it difficult to cover their catchment areas effectively and to reach younger clients.

Systems Strengthening
Community

Health Systems Strengthening

Key Populations

Zimbabwe is committed to addressing the needs of specific populations within the context of prevention, treatment, care and support, three of the four components of the current National HIV and AIDS Strategic Plan (ZNASP II) 2011-2015 [1]. These specific populations, also termed as key populations, consist of people who are considered to be at a significantly higher risk of HIV infection than the general population due to their behaviours, the nature of their duty, lifestyle practices[1] and/or circumstances. The illegality of some of these behaviours, duties and practices in Zimbabwe and indeed in many settings has grave implications for understanding and addressing the health needs of these populations and tackling stigma and discrimination.

This section draws on local, regional and international resources regarding known key populations namely:

- People who use drugs (termed "drug users")
- The lesbian, gay, bisexual, transgender and intersex (LGBTI) community
- Mobile populations
- Orphans and vulnerable children (OVC)
- People living with disabilities
- Prisoners and
- Sex workers

It should be noted that though these populations are described separately, there is overlap across them e.g. injecting drug use among prisoners and interaction both within them e.g. truck drivers (mobile population) as clients of sex workers and between them and the general population e.g. spouses or partners of the incarcerated.


Drug Users
Sub-Saharan Africa remains the region most heavily affected by HIV. The majority of new HIV infections occur through heterosexual sex, but recent epidemiological evidence attributes an increasingly significant role to injecting and non-injecting (illicit) drug use in driving many national epidemics [1]. People who inject drugs are at increased risk because of the high transmissibility of HIV (and Hepatitis B and C) when injecting equipment is shared [2]. When a needle, syringe or other injecting equipment (e.g. tourniquets) is shared, the blood from the first injector is often still in the equipment and is injected into the next user’s body [2]. All drug users, regardless of their preferred method of administration are at risk of HIV through sex; there is a body of research linking drug (and alcohol) use with the occurrence of unsafe sexual behaviour [3].

Harm reduction relates to interventions that aim to reduce the harms associated with drug use, without necessarily reducing the extent to which this behaviour occurs. Currently, key harm reduction interventions (including needle and syringe exchange and opioid substitution therapy) are not available in the majority of countries in Sub-Saharan Africa [2], including Zimbabwe.

This section draws on local and international resources describing the relationship between and prevalence of illicit drug use and HIV, as well as guidelines for health workers, researchers and rights advocates.

1 Sub-Saharan Africa - Regional Overview. Harm Reduction International. Available at: http://www.ihra.net/sub-saharan-africa


Resources:


Intravenous drug use and tattooing remain one of the major routes of HIV/AIDS transmission among prisoners. We formulate and analyze a deterministic model for the role of intravenous drug use in HIV/AIDS transmission among women prisoners. With the aid of the Centre Manifold theory, the endemic equilibrium is shown to be locally asymptotically stable when the corresponding reproduction number is greater than unity. Analysis of the reproduction number and numerical simulations suggest that an increase in intravenous drug use among women prisoners as they fail to cope with prison settings fuels the HIV/AIDS epidemic in women prisoners. Failure to control HIV/AIDS among female prisoners may be a time bomb to their communities upon their release. Thus, it may be best to consider free needle/syringe
exchange and drug substitution treatment programmes in women prisons as well as considering open prison systems for less serious crimes.

- **Drug News Africa: Let the continent speak out! 2(1)**

Drug News Africa: Let the continent speak out! is a quarterly newsletter aimed at stimulating discussion and debate on drug control and related crime challenges on the African continent and the efforts underway to address them.

- **Drug trafficking, use, and HIV risk: The need for comprehensive interventions**

The rapid increase in communication and transportation between Africa and other continents as well as the erosion of social fabric attended by poverty, ethnic conflicts, and civil wars has led to increased trafficking and consumption of illicit drugs. Cannabis dominates illicit trade and accounts for as much as 40% of global interdiction. Due to escalating seizures in recent years, the illicit trade in heroin and cocaine has become a concern that has quickly spread from West Africa to include Eastern and Southern Africa in the past 10 years. All regions of Africa are characterized by the use of cannabis, reflecting its entrenched status all over Africa. Most alarming though is the use of heroin, which is now being injected frequently and threatens to reverse the gain made in the prevention of HIV/AIDS. The prevalence of HIV infection and other blood-borne diseases among injection drug users is five to six times that among the general population, calling for urgent intervention among this group. Programs that aim to reduce the drug trafficking in Africa and needle syringe programs as well as medication-assisted treatment (MAT) of heroin dependence while still in their infancy in Africa show promise and need to be scaled up.

- **Guidelines on surveillance among populations most at risk for HIV**

The overall goal of this document is to provide guidance on how to develop and maintain HIV surveillance among populations most at risk for HIV. Ultimately, these surveillance activities should improve the overall understanding of HIV in countries and improve the response to HIV.

This guide complements the second generation surveillance guidelines on how to conduct HIV surveillance activities in low- and middle-income countries. Those guidelines recommend that all countries conduct HIV surveillance among populations with behaviours that increase
their risk for HIV, or populations most at risk for HIV infection

- **Drug News Africa: Let the continent speak out! 1(2)**

Drug News Africa: Let the continent speak out! is a quarterly newsletter aimed at stimulating discussion and debate on drug control and related crime challenges on the African continent and the efforts underway to address them.

- **Good Practice Guide: HIV and Drug Use**

This guide aims to support the scale up of community-based HIV and harm reduction programmes in developing and transitional countries. It looks at practice and research in developing and transitional countries and the principles underlying practice and research in resource-rich countries. It also sets out an approach to programming at the community level, where communities are fighting poverty, rapid social change, in settings where there are low levels of capacity or political support for harm reduction programmes.

- **Prevalence and predictors of illicit drug use among school-going adolescents in Harare, Zimbabwe**

Objective: To estimate the prevalence and predictors of illicit drug use among school-going adolescents in Harare, Zimbabwe.

Methods: We used data from the Global School-based Health Survey (GSHS) conducted in 2003 in Harare to obtain frequencies of a selected list of characteristics. We also carried out logistic regression to assess the association between illicit drug use and explanatory variables. For the purpose of this study, illicit drug use was defined as marijuana or glue use.

Results: A total of 1984 adolescents participated in the study. Most of the sample were females (50.7%), 15-year-olds (30.3%), nonsmokers and non-alcohol drinkers. Nine percent of the subjects (13.4% males and 4.9% females) reported having ever used marijuana or glue. Males were more likely to have used marijuana or glue than females (OR 2.70; 95% CI [1.47, 4.96]). Marijuana or glue use was positively associated with cigarette smoking (OR 11.17; 95% CI [4.29, 29.08]), alcohol drinking (OR 7.00; 95% CI [3.39, 14.47]) and sexual intercourse (OR 5.17; 95% CI [2.59, 10.29]). Parental supervision was a protective factor for marijuana or glue use (OR 0.31; 95% CI [0.16, 0.61]).

Conclusions: Public health intervention aimed to prevent marijuana or glue use among adolescents should be designed with the understanding that illicit drug use may be
associated with other behaviors such as teenage sexual activity, cigarette smoking and alcohol use.

**Injection drug use, unsafe medical injections, and HIV in Africa: a systematic review**

The reuse of injecting equipment in clinical settings is well documented in Africa and appears to play a substantial role in generalized HIV epidemics. The U.S. and the WHO have begun to support large scale injection safety interventions, increased professional education and training programs, and the development and wider dissemination of infection control guidelines. Several African governments have also taken steps to control injecting equipment, including banning syringes that can be reused. However injection drug use (IDU), of heroin and stimulants, is a growing risk factor for acquiring HIV in the region. IDU is increasingly common among young adults in sub-Saharan Africa and is associated with high risk sex, thus linking IDU to the already well established and concentrated generalized HIV epidemics in the region. Demand reduction programs based on effective substance use education and drug treatment services are very limited, and imprisonment is more common than access to drug treatment services. Drug policies are still very punitive and there is widespread misunderstanding of and hostility to harm reduction programs e.g. needle exchange programs are almost non-existent in the region. Among injection drug users and among drug treatment patients in Africa, knowledge that needle sharing and syringe reuse transmit HIV is still very limited, in contrast with the more successfully instilled knowledge that HIV is transmitted sexually. These new injection risks will take on increased epidemiological significance over the coming decade and will require much more attention by African nations to the range of effective harm reduction tools now available in Europe, Asia, and North America.

**Harm Reduction in Southern Africa: Strategies used to Address Drug-Related HIV**


**Advocacy guide: HIV/AIDS prevention among injecting drug users**

Te World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS
(UNAIDS) and the United Nations Office on Drugs and Crime (UNODC) developed this guide jointly based on a wealth of experiences by individuals, institutions and nongovernmental and international organizations on the role of advocacy in establishing HIV/AIDS prevention and care programmes for injecting drug users (IDUs).

The purpose of this guide is to provide a wide audience with a systematic approach to such advocacy, which could be replicated and adapted to various cultural, economic and political circumstances.

**LGBTI**

People who identity as lesbian, gay, bisexual, transgender or intersex (LGBTI) have specific health needs (1). These needs however are seldom met due to the legal ramifications of being a part of this community, and discrimination and prejudice in healthcare settings and society at large.

While confirmed cases of female-to-female transmission of HIV via sexual contact are extremely rare, possible modes of female-to-female transmission during sex include exposure to vaginal or other bodily fluids, blood from menstruation, or blood from damage sustained during rougher sex (2). Men who have sex with men (MSM) are often identified as another population at increased risk for HIV because unprotected anal sex has much higher transmissibility than vaginal sex (3) and this risk is applicable to bisexual and heterosexual women who have unprotected anal sex.

Transgender populations can vary from an individual who dresses as the other sex (transvestite) to persons who have had surgery to modify body parts (trans-sexual). Transgender persons often have unique networks of sexual partners or clients (3). The risk behaviours are often the same as described above but they take place in select venues or with select populations (3).

This section draws on local and international resources regarding the LGBTI community and their sexual and reproductive health. For more information, please refer to the LGBTI Populations and HIV Prevention Toolkit on this site: [toolkits/lgbti-hivprevention](http://toolkits/lgbti-hivprevention)


**Resources:**
Sexual practices, identities and health among women who have sex with women in Lesotho - a mixed methods study

Despite the high prevalence of HIV and STIs among women in Africa and the growing literature on HIV and STIs among women who have sex with women, research on the sexual health of women who have sex with women in Africa is scant. This study used mixed methods to describe sexual identity, practices and health among women who have sex with women in Lesotho. Most respondents (48%) described themselves as lesbian, 29% as bisexual and 23% as heterosexual. Almost half (45%) had disclosed their same-sex attraction to family, but only 25% had done so with health care workers. A total of 8% reported having HIV. Self-reported HIV was associated with having three or more male partners, having male and female partners at the same time and having a history of STIs. Gender norms, the criminalisation of homosexuality, varied knowledge of, and access to, safer-sex strategies, and mixed experiences of HIV/STI testing and sexual healthcare provided social and structural contexts for HIV- and STI-related vulnerability.

Teaching lesbian, gay, bisexual and transgender health in a South African health sciences faculty: addressing the gap

Background

People who identity as lesbian, gay, bisexual and transgender (LGBT) have specific health needs. Sexual orientation and gender identity are social determinants of health, as homophobia and heteronormativity persist as prejudices in society. LGBT patients often experience discrimination and prejudice in health care settings. While recent South African policies recognise the need for providing LGBT specific health care, no curricula for teaching about LGBT health related issues exist in South African health sciences faculties. This study aimed to determine the extent to which LGBT health related content is taught in the University of Cape Town's medical curriculum.

Methods
A curriculum mapping exercise was conducted through an online survey of all academic staff at the UCT health sciences faculty, determining LGBT health related content, pedagogical methodology and assessment.

**Results**

127 academics, across 31 divisions and research units in the Faculty of Health Sciences, responded to the survey, of which 93 completed the questionnaire. Ten taught some content related to LGBT health in the MBChB curriculum. No LGBT health related content was taught in the allied health sciences curricula. The MBChB curriculum provided no opportunity for students to challenge their own attitudes towards LGBT patients, and key LGBT health topics such as safer sex, mental health, substance abuse and adolescent health were not addressed.

**Conclusion**

At present, UCTs health sciences curricula do not adequately address LGBT specific health issues. Where LGBT health related content is taught in the MBChB curriculum, it is largely discretionary, unsystematic and not incorporated into the overarching structure. Coordinated initiatives to integrate LGBT health related content into all health sciences curricula should be supported, and follow an approach that challenges students to develop professional attitudes and behaviour concerning care for patients from LGBT backgrounds, as well as providing them with specific LGBT health knowledge. Educating health professions students on the health needs of LGBT people is essential to improving this population’s health by providing competent and non-judgmental care.

• **Integration of gender and human rights in HIV and sexual and reproductive health services**

The aim of this resource is to improve availability, acceptability, accessibility and quality of HIV and sexual and reproductive health (SRH) services for women, men, girls, and boys, regardless of gender identity or sexual orientation, with the ultimate goal to improve HIV and SRH related health outcomes, including prevention of HIV infection and mortality, and reduction of other sexually transmitted infections, unwanted and unplanned pregnancy, and intimate partner violence.
Internalized homonegativity/homophobia is associated with HIV-risk behaviour among Ugandan gay and bisexual men

We investigated the relationship of internalized homonegativity/homophobia (IH) to sexual risk behaviours among 216 Ugandan gay and bisexual men, using the 7-item IH scale previously developed on this population. IH was significantly associated with unprotected anal intercourse, and more so with unprotected receptive anal intercourse. Higher IH was also associated with more sex while intoxicated. There was a strong association between anal intercourse of any type and IH, suggesting a complex relationship between anal sex and identification with, or internalization of, homonegativity/homophobia. Specifically, it may be the anal component of sex rather than the sex with another man that is seen as labeling one as homosexual or stigmatizing. Those men who stated that they engaged in sex with other men for love, rather than for the physical feeling or for money, had higher IH scores. These data suggest that there may be an interactive relationship between IH and sexual behaviour, with greater internalization being associated with more stereotypically gay activities, which in turn may lead to more self-identification as gay and thus greater susceptibility to internalization.

Safety and adherence to intermittent pre-exposure prophylaxis (PrEP) for HIV-1 in African men who have sex with men and female sex workers

Methods/Principal Findings:
MSM and FSW were randomized to daily oral FTC/TDF or placebo, or intermittent (Monday, Friday and within 2 hours after sex, not to exceed one dose per day) oral FTC/TDF or placebo in a 2:1:2:1 ratio; volunteers were followed monthly for 4 months. Adherence was assessed with the medication event monitoring system (MEMS). Sexual activity data were collected via daily text message (SMS) queries and timeline followback interviews with a one-month recall period. Sixty-seven men and 5 women were randomized into the study. Safety was similar among all groups. Median MEMS adherence rates were 83% [IQR: 63–92] for daily dosing and 55% [IQR:28–78] for fixed intermittent dosing (p=0.003), while adherence to any post-coital doses was 26% [IQR:14–50]. SMS response rates were low, which may have impaired measurement of post-coital dosing adherence. Acceptability of PrEP was high, regardless of dosing regimen.

Conclusions/Significance:
Adherence to intermittent dosing regimens, fixed doses, and in particular coitally-dependent doses, may be more difficult than adherence to daily dosing. However, intermittent dosing may still be appropriate for PrEP if intracellular drug levels, which correlate with prevention of HIV acquisition, can be attained with less than daily dosing and if barriers to adherence can be addressed. Additional drug level data, qualitative data on adherence barriers, and better methods to measure sexual activity are necessary to determine whether adherence to post-coital PrEP could be comparable to more standard regimens.

You become afraid to tell them that you are gay: Health service utilization by men who have sex with men in South African cities

We describe the utilization of health services by men who have sex with men (MSM) in South African cities, their perceptions of available health services, and their service preferences. We triangulated data from 32 key informant interviews (KIIs), 18 focus group discussions
(FGDs) with MSM in four cities, and a survey of 285 MSM in two cities, recruited through respondent-driven sampling in 2008. FGDs and KIs revealed that targeted public health sector programs for MSM were limited, and that MSM experienced stigma, discrimination, and negative health worker attitudes. Fifty-seven per cent of the survey participants had used public health services in the previous 12 months, and 69 per cent had no private health insurance, with no difference by HIV status. Despite these findings, South Africa is well placed to take the lead in sub-Saharan Africa in providing responsive and appropriate HIV services for MSM.

• **Guidelines on surveillance among populations most at risk for HIV**

The overall goal of this document is to provide guidance on how to develop and maintain HIV surveillance among populations most at risk for HIV. Ultimately, these surveillance activities should improve the overall understanding of HIV in countries and improve the response to HIV.

This guide complements the second generation surveillance guidelines on how to conduct HIV surveillance activities in low- and middle-income countries. Those guidelines recommend that all countries conduct HIV surveillance among populations with behaviours that increase their risk for HIV, or populations most at risk for HIV infection.

• **HIV & GBV Prevention for Intersex People**

Within the grouping of sexual minorities, specifically LGBTI people, the ?I? is given the least attention by LGBTI advocacy organisations. It is also very misunderstood, often seen as a sexual orientation or gender identity issue, even by those advocating for the rights of sexual minorities.

This booklet is aimed at service providers, NGOs and CBOs, and those working on HIV and gender-based violence prevention and mitigation, to provide knowledge and skills for programming and services that will meet the needs of Intersex people.

• **HIV & GBV Prevention for Lesbian & Bisexual Women**

This booklet is useful for service providers, NGOs and CBOs, and those working on HIV and
gender-based violence prevention and mitigation, to provide knowledge and skills for programming and services that will meet the needs of lesbian and bisexual women.

- **Handbook for training service providers on integrating LGBTI issues into HIV and GBV prevention**

  This handbook has been designed to assist individuals in understanding human sexuality through a rights based approach. This approach includes human rights, as well as sexual and reproductive health and rights. This handbook provides a means by which to disseminate information pertaining to African sexualities, human sexuality and sexual minorities, specifically on how sexual orientation relates to and interconnects with HIV and gender based violence. The activities outlined in this manual explore the different concepts and constructs of sexuality through an active and experiential learning approach.

- **HIV & Transgender Identity ? Towards Inclusion and Autonomy**

  A position paper developed by 19 Transgender activists from an African Exchange Program, advocating for HIV and sexual and reproductive health services.

- **Sexing women: Young black lesbians’ reflections on sex and responses to safe(r) sex.**

  Review of young lesbians of colour and the impact of stigma and discrimination on their sexual risks and practices.

- **Understanding the challenges facing gay and lesbian South Africans: Some guidelines for service providers**

  This resource booklet aims to provide guidelines for service providers dealing with clients who are lesbian, gay, bisexual, transgender and intersex to ensure that they receive appropriate and non-discriminatory services according to the rights afforded to them by the constitutional and legal framework of South Africa.
Mobile Populations

Resources:

- **Short-term mobility and the risk of HIV infection among married couples in the fishing communities along Lake Victoria, Kenya**

  **Objective:**
  Mobility has long been associated with high HIV prevalence. We sought to assess sex differences in the relationship between mobility and risk for HIV infection among married couples in the fishing communities.

  **Methods:**
  We conducted 1090 gender-matched interviews and rapid HIV testing with 545 couples proportionally representing all the different sizes of the fish-landing beaches in Kisumu County. We contacted a random sample of fishermen as our index participants and asked them to enrol in the study together with their spouses. The consenting couples were separated into different private rooms for concurrent interviews and thereafter reunited for couple rapid HIV counselling and testing. In addition to socio-economic and behavioural data, we collected information on overnight travels and divided couples in 4 groups as follows both partners not mobile, both partners mobile, only woman mobile, and only man mobile. Other than descriptive statistics, we used X and U tests to compare groups of variables and multivariate logistic regression to measure association between mobility and HIV infection.

  **Results:**
  We found significant differences in the number of trips women travelled in the preceding month (mean 4.6, SD 7.1) compared to men (mean 3.3, SD 4.9; p < 0.01) and when the women did travel, they were more likely to spend more days away from home than their male partners (mean 5.2 [SD 7.2] versus 3.4 [SD 5.6]; p = 0.01). With an HIV prevalence of 22.7% in women compared to 20.9% among men, mobile women who had non-mobile spouses had 2.1 times the likelihood of HIV infection compared to individuals in couples where both partners were non-mobile.

  **Conclusion:**
  The mobility of fishermen’s spouses is associated with HIV infection that is not evident among fishermen themselves. Therefore, interventions in this community could be a combination of sex-specific programming that targets women and combined programming for couples.

- **Short-term mobility and increased partnership concurrency among men in Zimbabwe**

  **Background:**
  Migration has long been understood as an underlying factor for HIV transmission, and sexual partner concurrency has been increasingly studied as an important component of HIV transmission dynamics. However, less work has examined the role of short-term mobility in sexual partner concurrency using a network approach. Short-term mobility may be a risk for HIV for the migrant’s partner as well either through the partner’s risk behaviors while the migrant is away, such as the partner having additional partners, or via exposure to the return migrant.

  **Methods:**
  Using data from the 2010?11 Zimbabwe Demographic and Health Survey, weighted generalized linear regression models were used to investigate the associations between short-term mobility and partnership concurrency at the individual and partnership levels.

  **Results:**
  At the individual level, we find strong evidence of an association between short-term mobility and concurrency. Men who traveled were more likely to have concurrent partnerships compared to men who did not travel and the relationship was non-linear: each trip was associated with a 2% higher probability of concurrency, with a diminishing risk at 60 trips (p < 0.001). At the partnership level, short-term mobility by the male only or both partners was associated with male concurrency. Couples in which the female only traveled exhibited less male concurrency.

  **Conclusions:**
  Short-term mobility has the ability to impact population-level transmission dynamics by facilitating partnership concurrency and thus onward HIV transmission. Short-term migrants may be an important population to target for HIV testing, treatment, or social and behavioral interventions to prevent the spread of HIV.

- **Zimbabwe research report on HIV prevention among the mobile population**

  Action Institute for Environmental, Health and Development Communication (IEHDC) is a locally based Social and Behaviour Change Communications Non-Governmental Organization, which uses the power of the mass media (radio, TV and print), advocacy and community and social mobilization to reach out to the local masses to effect social and behaviour change. The organization uses a rigorous formative research process to generate appropriate content on relevant health and development priority issues in the country. Action IEHDC will embark on a programme that is aimed at reducing HIV incidences among mobile populations, primarily long distance truck drivers, commercial sex workers and young women by promoting reduction of multiple and concurrent sexual partnerships and
encouraging the correct and consistent condom use.

The research on sexual and reproductive health and rights among the mobile population was conducted within two border areas namely Chirundu and Beitbridge. A total of 4 focus group discussions were held with the target audience namely, truck drivers, female sex workers and the community of the mobile at the two borders. In-depth interviews were carried out with 2 female and 3 male key informants.

- **Guidelines on surveillance among populations most at risk for HIV**

The overall goal of this document is to provide guidance on how to develop and maintain HIV surveillance among populations most at risk for HIV. Ultimately, these surveillance activities should improve the overall understanding of HIV in countries and improve the response to HIV.

This guide complements the second generation surveillance guidelines on how to conduct HIV surveillance activities in low- and middle-income countries. Those guidelines recommend that all countries conduct HIV surveillance among populations with behaviours that increase their risk for HIV, or populations most at risk for HIV infection.

**Orphans and Vulnerable Children**

**Resources:**

- Zimbabwean Good Practices Responding to the Needs of Orphans and Vulnerable Children: "Our Children, Our Future"
This document represents part of a SAfAIDS project implemented in collaboration with the Ministry of Labour and Social Services (MoLSS), which documents Good Practices in OVC programming in Zimbabwe. The goal of the project is to scale-up information generation and dissemination and thereby encourage the replication of Good Practices in the care and support of orphans and vulnerable children (OVC) in Zimbabwe. The two programmes, coined as Good Practices, and documented here are:

- Africaid’s Zvandiri Programme – Providing psychosocial support to children and adolescents living with HIV; and
- Kapnek Trust’s Early Childhood Development (ECDs) Centres.

The Zvandiri Programme focuses on providing psychosocial support to young people living with HIV through their support groups, which are present in most districts of Harare. Kapnek ECD Centres focus on pre-school children in the Zvimba area of Zimbabwe and provide them with food, health care and educational interventions.

The framework for the documentation was adapted from the SADC Framework for HIV and AIDS Best Practice documentation which was elaborated on by SAfAIDS. This is a practical guide to facilitate the sharing of Good Practices in programming among Member States in order to scale up interventions based on what is known to work.

The documentation and sharing of Good Practices encourages the replication of small, successful interventions on a larger scale and involves the rigorous interrogation of a project in seven key areas: effectiveness, ethical soundness, cost effectiveness, relevance, replicability, innovativeness and sustainability. How well a project scores in each of these critical areas determines whether or not it can be classified as a Good Practice. The programmes documented here therefore represent some of the very best work being done on the ground in Zimbabwe in the care and support of OVC.

Both programmes obtained excellent scores as Good Practices using the Best Practice criteria (Africaid’s Zvandiri Programme, 92% and Kapnek Trust’s ECD programme, 97%). They are characterised by commendable management systems, skilled and conscientious staff, a close working relationship with Zimbabwe Government Ministries and partners, detailed attention to ethical issues and a commitment to the use of participatory programme implementation strategies.

- Child sexual abuse and links to HIV and orphanhood in urban Zimbabwe

**Background** Evidence of a link between sexual violence and HIV is growing; however, studies among children are scarce. The authors sought to characterise child sexual abuse in Harare, Zimbabwe, and explore its links with HIV and orphanhood.
Methods Records for new clients attending a child sexual abuse clinic from July 2004 to June 2005 were computerised and reviewed. Information on characteristics, medical examinations, laboratory tests and perpetrators were summarised. Orphan prevalence was compared with Demographic and Health Survey (DHS) 2005/2006 data for Harare, and a household- based survey in a neighbouring community.

Results Over 1 year, 1194 new clients (90% female) aged 7 weeks to 16 years were assessed, with 93% of boys and 59% of girls classi?ed clinically as prepubertal. 94% of clients reported penetrative sexual abuse, occurring most often in the child?s home. Most perpetrators were identi?ed as relatives or neighbours by children under 12 years, and ?boyfriends? by adolescent girls. At presentation, 31/520 (6%) clients tested were HIV-positive. Where recorded, 39 (6%) clients presented within 3 days of abuse, and 36 were given postexposure prophylaxis for HIV (PEP). Among female clients, orphan prevalence was higher than in the DHS (OR=1.7; 1.4 to 2.2) and neighbouring community (OR=1.7; 0.7 to 4.3).

Conclusions High numbers of children in Harare experience penetrative sexual abuse, and most present too late for PEP. More immediate presentation of sexual abuse can help to prevent HIV and recurrent abuse, and assist in examination and prosecution. Orphanhood emerged as a possible risk factor for sexual abuse and an important area for further research.


The National Action Plan for Orphans and Vulnerable Children, Phase II (NAP II - 2011-2015) provides a framework for coordinated action to ensure that orphans, vulnerable children and their families, in Zimbabwe, have incomes and access to basic services, and that all children are protected from abuse and exploitation.

NAP II will address the needs of about one million children and their families throughout Zimbabwe and it will build on the experience gained in implementing NAP I (2004-2010).

The formation, constitution and social dynamics of orphaned child headed households in rural Zimbabwe in the era of HIV/AIDS pandemic

Abstract
This thesis focuses on children who have lost both parents and are currently living on their own as child headed households (CHHs) in a rural community in Zimbabwe. Children heading households and taking care of siblings is a very "un-childlike" behavior yet these are growing phenomena. Through an exploration of how CHHs are constituted and evolve the thesis aims to examine whether local constructions of childhood are being (re) conceptualised as a result of Zimbabwe's escalating HIV/AIDS crisis. In particular it examines whether the socialisation of children within ?child only? units is leading to social transformation and/or whether children are in some way attempting to mimic "normal" family/gender relations. It also looks at CHH?s interactions with adults and explores how these affect survival strategies, socialisation and conceptualisations of childhood.

This thesis draws on an intensive ethnographic research project with five CHHs and their siblings in a rural community in Zimbabwe. Participant observation, narratives, drama, essays, focus groups, conversations and participatory techniques were employed to gain an in-depth insight into household evolution, the socialisation of family members, gender roles and survival strategies.

The thesis shows that while children living in CHHs are vulnerable, they exhibited considerable competence and capabilities to sustain themselves. However, state and non-governmental organisations' definition of childhood and orphanhood on the other hand, and cultural and local understanding of childhood and orphanhood produce new conceptual struggles of childhood that impacts negatively on the CHHs? integration into society and their capacity to function fully.

The ambivalent position of orphaned children in CHHs needs to be addressed if CHHs are to be recognised as an alternative orphan care arrangement.

- National Action Plan for Orphans and Vulnerable Children

This national plan of action (NPA) for orphans and vulnerable children (OVC) covers an initial time frame of three to five years, incorporating the United Nations General Assembly Special Session's (UNGASS) goals for 2005, and therefore attempts to address the basic and urgent needs of vulnerable children. Although the NPA for OVC proposes to identify and maximise the use of local resources through coordinated, multi-sectoral efforts, additional resources will be mobilised to support the Secretariat and meet unmet needs identified by Child Protection Committees in their local workplans.

- People Living With Disabilities

Resources:
Perceptions of deaf youth about their vulnerability to sexual and reproductive health problems in Masvingo District, Zimbabwe

Abstract

This article examined the perceptions of deaf youth about their vulnerability to sexual and reproductive health problems in Masvingo District of Zimbabwe. A quasi-survey was employed to carry out the field study. Therefore, a snowball sampling procedure was used to identify the respondents mainly because the target population constitutes one of the hard-to-reach groups. A sample of 50 deaf youth aged between 15 ? 24 years was conveniently determined due to lack of comprehensive data of deaf population in the study area. Therefore, conclusions made in data analysis only referenced to the sampled population. Fifty questionnaires were administered among the deaf youth to collect quantitative data. Ten in-depth face-to-face interviews were carried out with deaf youth in order to qualify the magnitude of perceptions of deaf youth about their vulnerability to sexual and reproductive health problems. Sexual activity is taking place among the sampled deaf. The perceptions they had about vulnerability to sexual and reproductive health problems are mainly shaped by sexual socialization than their sensory conditions. Understanding the factors which influence the perceptions of deaf youth about sexual and reproductive health problems is significant mainly because the sexuality of people living with disabilities is poorly understood and neglected thereby putting them at risk of sexual and reproductive health problems as well as exposed to sexual violence. The study recommends that the government may adopt a human-rights approach to the provision of sexual and reproductive health services to ensure universal access information and inclusivity.

Prisoners

Resources:

- The high burden of TB and HIV in a large Zambian prison: A public health alert

Background:

Tuberculosis (TB) and human immunodeficiency virus (HIV) represent two of the greatest health threats in African prisons. In 2010, collaboration between the Centre for Infectious Disease Research in Zambia, the Zambia Prisons Service, and the National TB Program established a TB and HIV screening program in six Zambian prisons. We report data on the prevalence of TB and HIV in one of the largest facilities: Lusaka Central Prison.

Methods:

Between November 2010 and April 2011, we assessed the prevalence of TB and HIV amongst inmates entering, residing, and exiting the prison, as well as in the surrounding community. The screening protocol included complete history and physical exam, digital radiography, opt-out HIV counseling and testing, sputum smear and culture. A TB case was defined as either bacteriologically confirmed or clinically diagnosed.

Results:
A total of 2323 participants completed screening. A majority (88%) were male, median age 31 years and body mass index 21.9. TB symptoms were found in 1430 (62%). TB was diagnosed in 176 (7.6%) individuals and 52 people were already on TB treatment at time of screening. TB was bacteriologically confirmed in 88 (3.8%) and clinically diagnosed in 88 cases (3.8%). Smear was positive in only 25% (n=20) of bacteriologically confirmed cases. HIV prevalence among inmates currently residing in prison was 27.4%. Conclusion: Ineffective TB and HIV screening programs deter successful disease control strategies in prison facilities and their surrounding communities. We found rates of TB and HIV in Lusaka Central Prison that are substantially higher than the Zambian average, with a trend towards concentration and potential transmission of both diseases within the facility and to the general population. Investment in institutional and criminal justice reform as well as prison-specific health systems is urgently required.

• Impact of Intravenous Drug Use on HIV/AIDS among Women Prisoners: A Mathematical Modelling Approach

Intravenous drug use and tattooing remain one of the major routes of HIV/AIDS transmission among prisoners. We formulate and analyze a deterministic model for the role of intravenous drug use in HIV/AIDS transmission among women prisoners. With the aid of the Centre Manifold theory, the endemic equilibrium is shown to be locally asymptotically stable when the corresponding reproduction number is greater than unity. Analysis of the reproduction number and numerical simulations suggest that an increase in intravenous drug use among women prisoners as they fail to cope with prison settings fuels the HIV/AIDS epidemic in women prisoners. Failure to control HIV/AIDS among female prisoners may be a time bomb to their communities upon their release. Thus, it may be best to consider free needle/syringe exchange and drug substitution treatment programmes in women prisons as well as considering open prison systems for less serious crimes.

• Criminal justice reform as HIV and TB prevention in African prisons

This policy proposal discusses how criminal justice system failures and limited financial resources present barriers to reducing HIV and TB transmission in prisons and how structural rights interventions focused upon criminal justice system reform are needed to guarantee detainees' human rights and health. To better understand structural barriers to HIV and TB prevention in African prisons, the authors conducted a survey of prison commissioners and medical directors in East and Southern African countries with high HIV and TB rates.

• Antiretroviral outcomes in South African prisoners: A retrospective cohort analysis

Background and Methods:
Little is known about antiretroviral therapy (ART) outcomes in prisoners in Africa. We conducted a retrospective review of outcomes of a large cohort of prisoners referred to a public sector, urban HIV clinic. The review included baseline characteristics, sequential CD4 cell counts and viral load results, complications and co-morbidities, mortality and loss to follow-up up to 96 weeks on ART.

Findings:
148 inmates (133 male) initiated on ART were included in the study. By week 96 on ART, 73% of all inmates assessed in the study and 92% of those still accessing care had an undetectable viral load (400 copies/ml). The median CD4 cell count increased from 122 cells/cubic mm at baseline to 356 cells/cubic mm by 96 weeks. By study end, 96 (65%) inmates had ever received tuberculosis (TB) therapy with 63 (41%) receiving therapy during the study. 28% had a history of TB prior to ART initiation, 33% were on TB therapy at ART initiation and 22% developed TB whilst on ART. Nine (6%) inmates died, 7 in the second year on ART. Loss to follow-up (LTF) was common: 14 (9%) patients were LTF whilst still incarcerated, 11 (7%) were LTF post-release and 9 (6%) whose movements could not be traced. 16 (11%) inmates had inter-correctional facility transfers and 34 (23%) were released of whom only 23 (68%) returned to the ART clinic for ongoing follow-up.

Conclusions:
Inmates responded well to ART, despite a high frequency of TB/HIV co-infection. Attention should be directed towards ensuring eligible prisoners access ART programs promptly and that inter-facility transfers and release procedures facilitate continuity of care. Institutional TB control measures should remain a priority.

Guidelines on surveillance among populations most at risk for HIV

The overall goal of this document is to provide guidance on how to develop and maintain HIV surveillance among populations most at risk for HIV. Ultimately, these surveillance activities should improve the overall understanding of HIV in countries and improve the response to HIV.

This guide complements the second generation surveillance guidelines on how to conduct HIV surveillance activities in low- and middle-income countries. Those guidelines recommend that all countries conduct HIV surveillance among populations with behaviours that increase their risk for HIV, or populations most at risk for HIV infection.

Sex Workers

Resources:

"You are wasting our drugs": health service barriers to HIV treatment for sex workers in Zimbabwe.

Background

Although disproportionately affected by HIV, sex workers (SWs) remain neglected by efforts to expand access to antiretroviral treatment (ART). In Zimbabwe, despite the existence of well-attended services targeted to female SWs, fewer than half of women diagnosed with HIV took up referrals for assessment and ART initiation; just 14% attended more than one appointment. We conducted a qualitative study to explore the reasons for non-attendance and the high rate of attrition.

Methods

Three focus group discussions (FGD) were conducted in Harare with HIV-positive SWs.
referred from the "Sisters with a Voice" programme to a public HIV clinic for ART eligibility screening and enrolment. Focus groups explored SWs' experiences and perceptions of seeking care, with a focus on how managing HIV interacted with challenges specific to being a sex worker. FGD transcripts were analyzed by identifying emerging and recurring themes that were specifically related to interactions with health services and how these affected decision-making around HIV treatment uptake and retention in care.

Results

SWs emphasised supply-side barriers, such as being demeaned and humiliated by health workers, reflecting broader social stigma surrounding their work. Sex workers were particularly sensitive to being identified and belittled within the health care environment. Demand-side barriers also featured, including competing time commitments and costs of transport and some treatment, reflecting SWs' marginalised socio-economic position.

Conclusion

Improving treatment access for SWs is critical for their own health, programme equity, and public health benefit. Programmes working to reduce SW attrition from HIV care need to proactively address the quality and environment of public services. Sensitising health workers through specialised training, refining referral systems from sex-worker friendly clinics into the national system, and providing opportunities for SW to collectively organise for improved treatment and rights might help alleviate the barriers to treatment initiation and attention currently faced by SW.

Engagement with HIV prevention treatment and care among female sex workers in Zimbabwe: a respondent driven sampling survey

Objective(S):
To determine the HIV prevalence and extent of engagement with HIV prevention and care among a representative sample of Zimbabwean sex workers working in Victoria Falls, Hwange and Mutare.

Design:
Respondent driven sampling (RDS) surveys conducted at each site.

Methods:
Sex workers were recruited using respondent driven sampling with each respondent limited to recruiting 2 peers. Participants completed an interviewer-administered questionnaire and provided a finger prick blood sample for HIV antibody testing. Statistical analysis took account of sampling method.

Results:
870 women were recruited from the three sites. HIV prevalence was between 50 and 70%. Around half of those confirmed HIV positive were aware of their HIV status and of those 50-70% reported being enrolled in HIV care programmes. Overall only 25-35% of those confirmed HIV positive were accessing antiretroviral therapy. Among those reporting they were HIV negative, 21-28% reported having an HIV test in the last 6 months. Of those tested HIV negative, most (66-82%) were unaware of their status. Around two thirds of sex workers reported consistent condom use with their clients. As in other settings, sex workers reported high rates of gender based violence and police harassment.

Conclusions: This survey suggests that prevalence of HIV is high among sex workers in Zimbabwe and that their engagement with prevention, treatment and care is sub-optimal. Intensifying prevention and care interventions for sex workers has the potential to markedly reduce HIV and social risks for sex workers, their clients and the general population in Zimbabwe and elsewhere in the region.

Zimbabwe research report on HIV prevention among the mobile population

Action Institute for Environmental, Health and Development Communication (IEHDC) is a locally based Social and Behaviour Change Communications Non-Governmental Organization, which uses the power of the mass media (radio, TV and print), advocacy and community and social mobilization to reach out to the local masses to effect social and behaviour change. The organization uses a rigorous formative research process to generate appropriate content on relevant health and development priority issues in the country. Action IEHDC will embark on a programme that is aimed at reducing HIV incidences among mobile populations, primarily long distance truck drivers, commercial sex workers and young women by promoting reduction of multiple and concurrent sexual partnerships and encouraging the correct and consistent condom use.

The research on sexual and reproductive health and rights among the mobile population was conducted within two border areas namely Chirundu and Beitbridge. A total of 4 focus group discussions were held with the target audience namely, truck drivers, female sex workers and the community of the mobile at the two borders. In depth interviews were carried out with 2 female and 3 male key informants.

Safety and adherence to intermittent pre-exposure prophylaxis (PrEP) for HIV-1 in African men who have sex with men and female sex workers

Background: Little is known about safety of and adherence to intermittent HIV PrEP regimens, which may be more feasible than daily dosing in some settings. We present safety and adherence data from the first trial of an intermittent PrEP regimen among Kenyan men who have sex with men (MSM) and female sex workers (FSW).

Methods/Principal Findings: MSM and FSW were randomized to daily oral FTC/TDF or placebo, or intermittent (Monday, Friday and within 2 hours after sex, not to exceed one dose per day) oral FTC/TDF or placebo in a 2:1:2:1 ratio; volunteers were followed monthly for 4 months. Adherence was assessed with the medication event monitoring system (MEMS). Sexual activity data were collected via daily text message (SMS) queries and timeline followback interviews with a one-month recall period. Sixty-seven men and 5 women were randomized into the study. Safety was similar among all groups. Median MEMS adherence rates were 83% [IQR: 63?92] for daily dosing and 55% [IQR:28?78] for fixed intermittent dosing (p=0.003), while adherence to any post-coital doses was 26% [IQR:14?50]. SMS response rates were low, which may have impaired measurement of post-coital dosing adherence. Acceptability of PrEP was high, regardless of dosing regimen.

Conclusions/Significance: Adherence to intermittent dosing regimens, fixed doses, and in particular coital/dose-dependent doses, may be more difficult than adherence to daily dosing. However, intermittent dosing may still be appropriate for PrEP if intracellular drug levels, which correlate with prevention of HIV acquisition, can be attained with less than daily dosing and if barriers to adherence can be addressed. Additional drug level data, qualitative data on adherence barriers, and better methods to measure sexual activity are necessary to determine whether adherence to post-coital PrEP could be comparable to more standard regimens.

Guidelines on surveillance among populations most at risk for HIV
The overall goal of this document is to provide guidance on how to develop and maintain HIV surveillance among populations most at risk for HIV. Ultimately, these surveillance activities should improve the overall understanding of HIV in countries and improve the response to HIV.

This guide complements the second generation surveillance guidelines on how to conduct HIV surveillance activities in low- and middle-income countries. Those guidelines recommend that all countries conduct HIV surveillance among populations with behaviours that increase their risk for HIV, or populations most at risk for HIV infection.

Monitoring and Evaluation

Monitoring and evaluation is an important part of the response to HIV and AIDS in Zimbabwe. In this section, there is a comprehensive, but not exhaustive list of resources on monitoring and evaluation of the HIV and AIDS response in Zimbabwe.

Prevention

Condom Promotion and Distribution

Dual protection and condom use and several strategies promoted and used in Zimbabwe in HIV and AIDS prevention. Not only do these two strategies prevent the spread of HIV and AIDS but also help in reducing the risk of pregnancy and getting sexually transmitted infections. These strategies involve:

- Using condoms correctly with every act of sex.
- Using condoms consistently and correctly plus another birth control method.
- Using birth control method in mutually faithful relationship.
- Practice non-penetrative sex.
- Delay or avoid sexual activity.

The publications in the sections show the researches and ways in which various stakeholder in Zimbabwe have promoted the use these strategies to mitigate the spread of HIV and AIDS.

Resources:
Brand Equity and Willingness to Pay for Condoms in Zimbabwe

Background: Zimbabwe suffers from one of the greatest burdens of HIV/AIDS in the world that has been compounded by social and economic instability in the past decade. However, from 2001 to 2009 HIV prevalence among 15-49 year olds declined from 26% to approximately 14%. Behavior change and condom use may in part explain this decline. PSI-Zimbabwe socially markets the Protector Plus (P+) branded line of condoms. When Zimbabwe converted to a dollar-based economy in 2009, the price of condoms was greatly increased and new marketing efforts were undertaken. This paper evaluates the role of condom marketing, a multi-dimensional scale of brand perceptions (brand equity), and price in condom use behavior.

Methods: We randomly sampled sexually active men age 15-49 from 3 groups - current P+ users, former users, and free condom users. We compared their brand equity and willingness to pay based on survey results. We estimated multivariable logistic regression models to compare the 3 groups.

Results: We found that the brand equity scale was positive correlated with willingness to pay and with condom use. Former users also indicated a high willingness to pay for condoms. We found differences in brand equity between the 3 groups, with current P+ users having the highest P+ brand equity. As observed in previous studies, higher brand equity was associated with more of the targeted health behavior, in this case and more consistent condom use.

Conclusions: Zimbabwe men have highly positive brand perceptions of P+. There is an opportunity to grow the total condom market in Zimbabwe by increasing brand equity across user groups. Some former users may resume using condoms through more effective marketing. Some free users may be willing to pay for condoms. Achieving these objectives will expand the total condom market and reduce HIV risk behaviors.

Female Condoms: Lessons from Zimbabwe

Zimbabwe is regularly cited as a female condom success story and has among the highest distribution and sales of female condoms in the world.

Several crucial and complementary factors have fostered Zimbabwe’s female condom success: strong civil society participation, innovative social marketing, well-functioning...
condom distribution mechanisms, capacity building of service providers across sectors, and sustained financial and technical support from the Government of Zimbabwe and funding partners. Zimbabwe provides important considerations for female condom introduction, effective distribution and programming, and high rates of acceptability among users.

- **Female Condom Uptake and Acceptability in Zimbabwe**

As the first phase of a two-phase prospective cohort study to assess the acceptability of the diaphragm as a potential HIV/STI prevention method, we conducted a 2-month prospective study and examined the effect of a male and female condom intervention on female condom (FC) use among 379 sexually active women in Harare, Zimbabwe. Reported use of FC increased from 1.1% at baseline to 70.6% at 2-month follow-up. Predictors of FC uptake immediately following the intervention included interest in using FC, liking FC better than male condoms, and believing one could use them more consistently than male condoms. Women reported 28.8% of sex acts protected by FC in the 2 weeks prior to last study visit. Though FC may not be the preferred method for the majority of women, with access, proper education, and promotion they may be a valuable option for some Zimbabwean women.

- **Consistent Condom Use in Married Zimbabwean Women after a Condom Intervention**

Objectives: Condom use to prevent HIV in Africa has increased in non-marital sexual encounters but remains low within marriage. Married women of reproductive age, however, are at high risk of HIV.

Goal: This study investigated factors associated with consistent condom use after a brief intervention.

Study Design: We conducted an HIV prevention condom intervention with a cohort of 394 married women, aged 17 to 47, recruited from clinics in Zimbabwe. Consistent condom users were ineligible. At enrollment, participants received education and were offered free male and female condoms and HIV testing. Women completed a follow-up questionnaire at 2-months. We used logistic regression analysis to measure the association of protected sex (i.e., 100% use of male or female condoms) at follow-up with condom attitudes, negotiation skills, HIV risk perception and testing.

Results: At follow-up, 179 (48.5%) women reported consistent condom use throughout the study, and 318 (87%) reported condom use at last sexual episode; 72 women tested HIV-positive, only 4 of whom reported at enrollment that it was likely that they were infected. Results showed that women who tested positive were more likely to report consistent condom use (OR 2.9, 95% CI 1.7–5.2). HIV risk perceptions and condom negotiation self-
ef?cacy increased post-intervention, and were signi?cantly associated with consistent condom use. Hormonal contraception was negatively associated with consistent condom use (OR 0.3, 95% CI 0.19?0.65).
Conclusions: Married women reported signi?cant increases in consistent condom use in response to a brief intervention, especially if HIV-positive.

- **Situational Analysis of the Female Condom in Zimbabwe**

This document attempts to take a snapshot of the current situation around the Female Condom in Zimbabwe. Social marketing activities have shifted but are still successfully distributing Female Condoms in significant numbers to targeted populations. Though no clear national policy exists for how the Female Condom should be distributed, programmes have developed in the public sector that attempt to reach the population at large. Because condom stocks have been inadequate, local decision makers often target FC stocks to those perceived to need female condom stocks the most in order to protect them from a perceived increased risk of HIV infection.

- **Factors Associated with Use of the Female Condom in Zimbabwe**

CONTEXT: Because women can initiate use of the female condom, the method is believed to make it easier for women to protect themselves against sexually transmitted infections (STIs), including HIV infection. Evidence is lacking about factors associated with trying the female condom and using it consistently. METHODS: A sample of 1,740 sexually active consumers visiting retail outlets in urban Zimbabwe that sell male or female condoms were surveyed in 1998, one year after a social marketing campaign had begun. Logistic regression analyses were conducted to assess factors associated with ever-use of the female condom and consistent use (always or often) with marital and regular non marital partners. RESULTS: Perceived ease of use and affordability of the product and prior use of the male condom were associated with men?s and women?s ever-use. Consistent use with marital partners was negatively associated with reporting multiple partners in the past year (odds ratio, 0.3) and positively associated with using the device for pregnancy prevention (5.4) and previously using the male condom (8.0). Consistent use with regular non marital partners was associated with numerous variables, including perceived ease of use (1.9) and effectiveness for STI prevention (3.8), low HIV risk perception (2.4), and use for pregnancy (2.9) and STI (2.3) prevention. CONCLUSIONS: Perceived affordability and ease of use may encourage couples to try the female condom but may not lead to consistent use. Because the reasons for use can vary between marital and non marital relationships, the female condom may need to be positioned differently for different target populations.
Condom Use in Uganda and Zimbabwe: Exploring the Influence of Gendered Access to Resources and Couple-Level Dynamics

An estimated 5 million new HIV/AIDS infections occurred in sub-Saharan Africa in 2003, most the result of heterosexual transmission. Strategies to prevent the spread of HIV have focused on raising awareness of risk factors, promotion of condom use, reduction of numbers of sexual partners, treatment of sexually transmitted diseases (STDs) and postponement of first sex. There is, however, an increasing appreciation that behavior and choices are shaped by not only what individuals know, but also by larger contextual factors that may limit or promote levels of personal control. It is therefore important to understand the wider socio-cultural and economic forces, as well as the patterns of interpersonal power relations, that drive women’s and men’s susceptibility to HIV infection. The socio-cultural construction of gender emerges as a key factor in these processes.


This paper compares the views about abstinence and condom use expressed by young people in Zimbabwe in focus-group discussions with the views underlying national policies and religious and traditional beliefs. Young people’s decisions to adopt one or the other of these risk-reduction strategies may not necessarily indicate genuine individual choices, but rather their deference to adults’ interests as they understand those interests. Policymakers and traditional and Christian leaders promote abstinence as the exclusive strategy for all young people, whereas non-governmental organizations and the private sector promote condom use. Evidence from the focus group discussions indicates that adolescents are aware of this conflict between choice of strategy and sometimes conceal their condom use in order not to disappoint adults. In some cases, their moral conflict gives young people limited choices about reproductive behaviour. Clear and open policies regarding condom use and abstinence should be promoted as complementary alternatives. Moreover, adults should reconsider their moralizing concerning young people’s sexual activity and support real rather than limited choices with regard to adolescents’ reproductive health. In a country where the level of HIV prevalence among sexually active adults is one of highest in the world, and where a large proportion of HIV infections is believed to occur during adolescence, this message carries an urgency that can no longer be ignored.
Patterns of condom use in urban males in Zimbabwe: evidence from 4,600 sexual contacts

The objective of this paper is to get detailed information on the dynamics of condom use with various partner types, including consistency of use, and to estimate the frequency of unprotected intercourse. The study is based on a prospective cohort study of 222 urban workers in urban Zimbabwe. Respondents' sexual behaviour and condom use were tracked for a period of six weeks using daily interviewer administered questionnaires. In total, the observation period covers 9,324 person-days, during which 4,601 sexual contacts were reported. The results indicate that most sexual encounters with casual partners are protected, and condom use with these partners is very consistent.

However, although the majority of sex acts with regular non-marital partners are protected, only four out of ten men with regular partners used condoms consistently. Because many men have both regular and casual partners, fewer than one in seven males used condoms in all their sex acts. We estimate that nearly half of all males have more than 85 unprotected sex acts per year. Although many of these acts are with spouses, who have comparatively low risk, we estimate that about one in five men have 25 or more unprotected acts with regular non-marital partners annually. We conclude that regular partners are likely to be a major source of HIV transmission in Zimbabwe, partly because condom use is inconsistent and partly because they account for a large share of all sex acts. Given that over one in four adults in the general population are HIV-positive, and that some studies show that married persons have the highest HIV prevalence, it is important for future HIV programmes to focus on increasing levels of protection with regular partners.

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Male and Female Condom Use by Sex Workers in Zimbabwe: Acceptability and Obstacles

Methods that are thought of as being women-controlled, such as female condoms, still need the willingness of men to be used in many situations. Women who are socio-economically disadvantaged have fewer skills and opportunities to negotiate for safer sex, to prevent sexually transmitted infections or unwanted pregnancies. This paper draws on issues arising from two studies conducted in Zimbabwe on the acceptability of female condoms to different groups of women sex workers and the responses they report from their partners, which found high levels of satisfaction with this method. However, technological solutions to the HIV epidemic should not distract from the reasons why many women cannot negotiate for protection from infection. The nature of relationships plays a crucial role in determining whether negotiation for male or female condom use is successful or not. Many of the mechanical obstacles to use of female condoms can be overcome by sympathetic and
knowledgeable support from health workers. The role of women’s support groups in orienting the
to the attitudes of health workers and encouraging social approval for behaviour change is also
essential. Significant shifts in values and ideology are needed to support women and men in
changing the power balance in their relationships if good sexual health is to be achieved.

Condom Use in Marital and Non-Marital Relationships in
Zimbabwe

Context: Zimbabwe is one of the few Sub-Saharan African countries that have made
substantial efforts to involve men in contraceptive use, and also has one of the highest HIV
prevalence rates. Therefore, it is worthwhile to examine men’s patterns of condom use in
marital and non-marital relationships.

Data: Differences in the pattern of condom use by sexually active single and married men
were investigated using data from the 1994 Zimbabwe Demographic and Health Survey.
Multivariate logistic regression models were used to isolate the effects of various
determinants of male condom use.

Results: Condoms were used primarily for non-marital sexual relations. Sexually active single
men were more than seven times as likely to use condoms (50%) as to have relied on the pill
(7%). Likewise, 50% of sexually active single men were currently using condoms, more than
eight times the level among married men (6%). In contrast, while 47% of married men said
their spouse relied on the pill, only 7% of unmarried men reported pill use by their partner. In
a multivariate logistic regression analysis, marital status had the largest and most statistically
significant effect on condom use. Region of residence also had a significant impact on men’s
condom use: Sexually active men in the more ethnically diverse Midlands province tended to
use condoms more than men in other regions.

Conclusions: The condom is the method of choice among single, sexually active men in
Zimbabwe, while the pill seems to be the preferred method for use within marital unions. In
Zimbabwe, men appear to be heeding advice to use condoms in non-marital relationships.

The Female Condom: Dynamics of Use in Urban
Zimbabwe

In July 1997, Population Services International (PSI), at the request of the Zimbabwe
National AIDS Coordination Programme (NACP), launched a social marketing program for
the female condom in Zimbabwe. To avoid stigma associated with condoms and STI prevention, the female condom was marketed as a family planning product or “contraceptive sheath?” under the brand name careTM. The female condom was initially sold through selected pharmacies and clinics at a heavily subsidized retail price of US $0.24 for a box of two; distribution has since expanded to other urban outlets, including large supermarkets and convenience stores. Approximately one year after the start of the female condom social marketing program, the Horizons Project and PSI conducted a descriptive, cross-sectional study of female condom users, male condom users, and non-users of either barrier method. The goal of this research is to increase understanding of the patterns and dynamics of female condom use in order to inform policy makers and program planners involved in decisions about promotion and distribution of the female condom in Zimbabwe.

The study used a combination of quantitative and qualitative methods. An intercept survey was conducted with women and men exiting urban sales outlets that carry both Protector PlusTM male condoms and careTM female condoms. In total, 493 female condom users, 633 male condom users, and 624 non-users are included in the analyses upon which this report is based. Male and female users of the female condom also participated in in-depth interviews and focus groups.

*Zimbabwe Further Analysis: Knowledge of STIs and AIDS, Risks Awareness and Condom Use? Demographic and Health Surveys*

This report summarises the findings of one of five further analysis projects for the 1994 Zimbabwe Demographic and Health Survey (ZDHS). These analyses were funded by USAID/Zimbabwe and are envisaged to inform health and family planning policy development. A significant objective of the further analysis effort was to facilitate a collaborative link between individuals and institutions in Zimbabwe and researchers working in the international arena. The present paper represents one of the important "fruits" of that investment. It presents the findings of an analysis entitled "Knowledge of STIs and AIDS, Risks Awareness and Condom Use?". Given the serious challenge in the health sector presented by the HIV/AIDS pandemic, the paper comes at a timely juncture.

**Multiple and Concurrent Partners (MCP)**

Multiple Concurrent Partnerships (MCPs) are defined as overlapping partnerships where sexual intercourse with one partner occurs between two acts of intercourse with another partner. MCPs
have been identified as a key driver of HIV transmission in countries with generalised epidemics, low condom use and low prevalence of male circumcision.

The publications in this section highlight and address strategies on how to prevent the spread of HIV and AIDS through MCPs.

Resources:

- **The Prevalence of Concurrent Sexual Partnerships among Students in Institutions of Higher Education in Zimbabwe**

This study set out to establish the level of sexual activity and prevalence of concurrent sexual partnerships among students in two Faculties at a University in Zimbabwe. The study also investigated the extent and motivation for age-discrepent sexual partnerships and the possible link between multiple concurrent sexual partnerships and the spread of HIV/AIDS. Four research questions were posed to establish the level of sexual activity among university students, prevalence of concurrent relationships, motivation for and involvement in intergenerational sexual partnerships, and students? knowledge of the possible link between concurrent sexual behaviour and the spread of HIV/AIDS. A convenience sample of 145 student respondents (85 females and 60 males) was used in this study. A ten-item self-administered questionnaire and focus group discussion were used to collect the necessary data. The study found high levels of sexual activity (more for male than for female students) and high prevalence of concurrent sexual behaviour. The study also found that female students participated in concurrent sexual partnerships to benefit from the resources of their male partners while males were largely motivated around the sex motive. In spite of the high levels of knowledge about HIV/AIDS, high levels of concurrent sexual relationships were prevalent among students who participated in this study. This study confirmed results reported in the literature and has implications for the spread of HIV/AIDS.

- **Multiple and Concurrent Partnerships: Driving Southern Africa’s HIV Epidemic - How to Card**

A useful resource on How to Card for Parliamentarians on the impact of Multiple and Concurrent Partnerships (MCPs) on HIV and AIDS

- **Multiple and Concurrent Sexual Partnerships in**
Zimbabwe: A Target Audience Research Report

The organisation, ACTION, conducted formative target audience research on the topic HIV prevention through reduction in Multiple and Concurrent Partnerships in Zimbabwe. The aim of the research was to find out the extent of people’s knowledge, awareness, understanding and beliefs as well as to uncover myths and misconceptions around Multiple Concurrent Partnerships (MCP).

The research that this report is based on was done in nine provinces in Zimbabwe: Manicaland, Midlands, Mashonaland Central, Mashonaland East, Mashonaland West, Harare, Bulawayo, Matabeleland North and Matabeleland South. The research used focus group discussions and key informant interviews to source data.

Multiple Concurrent Partnerships: The story of Zimbabwe? Are small houses a key driver?

Twenty-five years on, Zimbabwe’s HIV and AIDS epidemic is characterised by a prevalence rate of 18.1%, 3,000 deaths per week, and more than 800,000 orphans. A combination of high levels of poverty in the country and the negative impact of HIV and AIDS are driving people, especially women, to concentrate on the day-to-day survival of themselves and their children, even if it means exposing themselves to high risk situations. While so far, government has responded to the epidemic primarily by utilising its own resources mobilised through the popular AIDS Levy, without external support and resources the AIDS Levy is grossly inadequate in fighting the devastations of the epidemic.

Close to 600,000 people infected with HIV and AIDS are in need of treatment right now and yet less than 10% are accessing the life prolonging drugs. Therefore, prevention and programmes to reduce new infections must remain the backbone of Zimbabwe’s HIV and AIDS response. Awareness of HIV and AIDS is very high among Zimbabweans, but behaviour change remains a clear challenge, as observed in the continuing high levels of new infections.

A study by Gregson, in Manicaland in 2005, which helps to explain the decline in prevalence rate (from 25.5% in 1998 -2000 to 18.1 % in 2004) attributed this to a general decline in casual sex among young Zimbabweans and delayed sexual debut. While this has been applauded as an indication of positive behaviour change, the emergence of another phenomenon that seems to have replaced casual sex, commonly called the small house, is an area of concern. It seems that men are viewing small houses as a new and safer way of dealing with HIV and AIDS. Although this paper is not
based on any scientific study or evidence, it is based on findings from focus group discussions held with men and women in Harare who are all very familiar with the small house practice.

Post Exposure Prophylaxis (PEP)

Prevention and Control of STIs

Prevention of Mother To Child Transmission

Prevention Mother-to-child transmission (PMTCT) is when an HIV-infected woman passes the virus to her baby. This can occur during pregnancy, labour and delivery, or breastfeeding. Pregnant women must be tested for HIV. Where prevention of mother-to-child HIV transmission is accessible, it must be delivered consistently and with the most effective drugs available. Preventing mother-to-child transmission as much as it involves taking tablets, effective PMTCT programmes must provide counselling and testing services to determine which women need assistance.

This section of the toolkit provides publications of the PMTCT programmes in Zimbabwe. Its impact and implications in HIV prevention.

Resources:


Zimbabwe remains a high priority country for the UK. This plan reflects close consultation with other UK Government Departments on both programme development and implementation, notably the Foreign and Commonwealth Office (FCO) and the Ministry of Defence.

The political situation and therefore the development prospects for Zimbabwe have been in the balance for several years; and for the next 12-18 months the political space will be heavily contested with the outcome very uncertain. The Global Political Agreement which led to the establishment of the Inclusive Government in February 2009 has run into a political
impasse which the Southern Africa Development Community (as guarantor of the Agreement) has not so far been able to help resolve. The focus has now turned to the next national Parliamentary and Presidential elections.

Zimbabwe made exemplary progress towards the Millennium Development Goal indicators throughout the 1980s and into the 1990s, but the economic and humanitarian crisis of the last decade has stalled or in some cases starkly reversed many of those gains. There is good data up until the last few years on most indicators of need. The DFID programme has gradually progressed from humanitarian relief to more conventional development support since the establishment of the Inclusive Government. This has played an important part in helping the Inclusive Government stabilise the economy and humanitarian situation after the political and economic crisis of 2008. Working through the multilateral institutions, in particular the UN, the African Development Bank and the World Bank, as well as international non-governmental organisations (NGOs) and the private sector, DFID has been able to deliver excellent results for the people of Zimbabwe.

- **Contraceptive uptake, reproductive choices and sexual behavior of HIV positive compared to HIV negative women participating in the prevention of mother to child transmission of HIV program in Zimbabwe**

Contraceptive uptake and pregnancy desires have not been adequately reported within prevention of mother to child transmission (PMTCT) initiatives in developing countries. Women were enrolled from a PMTCT program at 36 gestational weeks. A questionnaire on contraception and conception desires was interview administered to the women between 3 and 24 months after birth. A total of 273 women responded to the questionnaire, 189 HIV infected and 84 HIV negative. Significant differences were observed by HIV status for all types of contraception with 22% of the HIV infected women reporting none usage compared to 14% for HIV negatives ($p < 0.001$). Over 50% of the HIV infected women reported using condoms compared to 13% among the negatives ($p < 0.001$), whereas 13% of HIV infected women expressed desire for subsequent children. More than 60% of the women did not know their sexual partner’s HIV status regardless of their own, whilst 25% of the HIV infected had not disclosed their status to their sexual partners. Contraceptive use was high regardless of women’s HIV status, whereas a high proportion of HIV negative women were not using condoms. Some of the HIV infected women expressed future pregnancy desires whilst others had not disclosed their HIV status.
Advocacy and Communication Strategy to Support the Implementation of Revised ART, PMTCT and Infant Feeding Guidelines in Zimbabwe

Zimbabwe has achieved significant milestones in the multi-sectoral response to the HIV epidemic, as evidenced by the progressive sliding trend in the incidence and prevalence rates, as well as the increase in access to and availability of HIV prevention, care and treatment services. The Government of Zimbabwe remains committed to ensuring high quality care for all People Living with HIV, including vulnerable and at risk populations. The adoption of the revised WHO 2010 guidelines for antiretroviral therapy for adults, adolescents and children, Prevention of Mother-To-Child Transmission (PMTCT) and infant feeding, is an indication of the commitment to the scaling up of evidence-informed quality services for People Living with HIV (PLHIV) in Zimbabwe.

The guidelines advocate for earlier initiation of PLHIV on more patient friendly regimens and earlier initiation of prophylaxis for PMTCT. Whilst we endeavour to mobilise resources to facilitate the complete roll out of the new guidelines, a phased approach to implementation is being adopted. The advocacy and communication strategy aims to support the coordinated and standardised implementation of the revised HIV treatment and prevention guidelines, through the dissemination of accurate and target specific information, as well as minimising confusion and negative feedback around the adoption and implementation of the guidelines.

The Government of Zimbabwe aims to fully implement the new guidelines within the following three years, and revisions and changes to the phasing strategy will be communicated as and when necessary. In the meantime, I urge you to make use of this Advocacy and Communication Strategy to guide Antiretroviral therapy (ART), PMTCT and infant feeding service provision and to enable roll out...
of the revisions to be conducted in a standardised and coordinated manner, as we work together to address the HIV situation in Zimbabwe.

- **The feasibility of preventing mother-to-child transmission of HIV using peer counselors in Zimbabwe**

  Background: Prevention of mother-to-child transmission of HIV (PMTCT) is a major public health challenge in Zimbabwe.

  Methods: Using trained peer counselors, a nevirapine (NVP)-based PMTCT program was implemented as part of routine care in urban antenatal clinics.

  Results: Between October 2002 and December 2004, a total of 19,279 women presented for antenatal care. Of these, 18,817 (98%) underwent pre-test counseling; 10,513 (56%) accepted HIV testing, of whom 1986 (19%) were HIV-infected. Overall, 9696 (92%) of women collected results and received individual post-test counseling. Only 288 men opted for HIV testing. Of the 1807 HIV-infected women who received posttest counseling, 1387 (77%) collected NVP tablet and 727 (40%) delivered at the clinics. Of the 1986 HIV-infected women, 691 (35%) received NVPsd at onset of labor, and 615 (31%) infants received NVPsd. Of the 727 HIV-infected women who delivered in the clinics, only 396 women returned to the clinic with their infants for the 6-week follow-up visit; of these mothers, 258 (59%) joined support groups and 234 (53%) opted for contraception. By the end of the study period, 209 (53%) of mother-infant pairs (n = 396) came to the clinic for at least 3 follow-up visits.

  Conclusion: Despite considerable challenges and limited resources, it was feasible to implement a PMTCT program using peer counselors in urban clinics in Zimbabwe.

- **Routine offer of antenatal HIV testing (?opt-out? approach) to prevent mother-to-child transmission of HIV in urban Zimbabwe**

  Objective: To assess the impact of routine antenatal HIV testing for preventing mother-to-child transmission of HIV (PMTCT) in urban Zimbabwe.

  Methods: Community counsellors were trained in routine HIV testing policy using a specific training module from June 2005 through November 2005. Key outcomes during the first 6 months of routine testing were compared with the prior 6-month ?opt-in? period, and clients were interviewed.
Findings: Of the 4551 women presenting for antenatal care during the first 6 months of routine HIV testing, 4547 (99.9%) were tested for HIV compared with 3058 (65%) of 4700 women during the last 6 months of the opt-in testing (P < 0.001), with a corresponding increase in the numbers of HIV-infected women identified antenatally (926 compared with 513, P < 0.001). During routine testing, more HIV-infected women collected results compared to the opt-in testing (908 compared with 487, P < 0.001) resulting in a significant increase in deliveries by HIV-infected women (256 compared with 186, P = 0.001); more mother/infant pairs received antiretroviral prophylaxis (n = 256) compared to the opt-in testing (n = 185); and more mother/infant pairs followed up at clinics (105 compared with 49, P = 0.002). Women were satisfied with counselling services and most (89%) stated that offering routine testing is helpful. HIV-infected women reported low levels of spousal abuse and other adverse social consequences.

Conclusion: Routine antenatal HIV testing should be implemented at all sites in Zimbabwe to maximize the public health impact of PMTCT.

A concrete example: PMTCT and PPTCT PLUS in Zimbabwe

Cesvi has supported the national health service of a region of Zimbabwe since 2001 to provide PMTCT services and since 2004 also PPTCT PLUS, integrated into the existing health services, through the supply of equipment and medicines and the specific training of local health workers capacity building component.

Social Behaviour Change Communication

Behaviour Change Communication is a process of working with individuals, communities and societies to develop communication strategies to promote positive behaviours in HIV and AIDS prevention and to provide a supportive environment which will enable people to initiate and sustain positive behaviours. The resources in this section entail all the above and what some stakeholders have done to promote positive behaviours in HIV and AIDS prevention.

Resources:
Zimbabwe: Analysis of HIV Epidemic, Response and Mode of Transmission

This epidemic and response synthesis work was commissioned in order to update Zimbabwe’s evidence base for the formulation of the Zimbabwe National AIDS Strategic Plan (ZNASP) 2011-2015, and to look back and learn from what has been achieved. The work builds on existing reviews, in particular those by Gregson et al. (2005, 2010) and the mid-term review of the implementation of the ZNASP 2006-2010.

The synthesis has four objectives:
1. Describe and understand the epidemiological situation in Zimbabwe (Know your epidemic?)
2. Describe and understand the HIV prevention response in Zimbabwe (Know your response?)
3. Synthesise and link the epidemic and response data to understand scope, relevance and comprehensiveness of HIV prevention policies and programmes, the alignment of prevention resources to strategic priorities, and gaps in strategic information about HIV prevention
4. Recommend improvements to ensure greater success in prevention programmes, and fewer new HIV infections in Zimbabwe.

The epidemiological and response reviews were carried out through desk study of existing published and unpublished data and documentation about Zimbabwe, and relevant studies from other countries. Some secondary data analysis of the 2005 Zimbabwe Demographic and Health Survey (ZDHS) was carried out.


The Zimbabwe National Behavioural Change (BC) Strategy is a multisectoral framework to reduce sexual transmission of HIV by promoting responsible practices. Comprehensive epidemiological and behavioural reviews form the basis of this strategy. They found that HIV prevalence had declined in Zimbabwe and that behavioural change including partner reduction and increased condom use had already started. At the same time, multiple concurrent partnerships and a number of related practices were still seen as key drivers of the epidemic. Imbalanced gender relations, relatively high levels of stigma and other factors continue to be underlying factors for risk practices that lead to new infections. The Strategy builds on past successes and at the same time closes gaps in addressing key drivers of HIV. Four key outcome areas have
been defined:
Enabling environment behaviour services institutional frameworks for behavioural change
created including through increased leadership and gender-equality aswell as reduced stigma
associated with PLWHA
Increased adoption of safer sexual behaviour and reduction in risk behaviour
Increased utilization of HIV prevention services (T&C including post-test support, PMTCT, PEP)
Improved national and sub-national institutional frameworks to address behavioural change

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The HIV and AIDS Epidemic in Zimbabwe: Where Are We Now? Where Are We Going?

This document provides background to the epidemic, gives consideration to the social and
economic impacts of the epidemic, looks at the national strategic response and makes
projections about the epidemic under certain assumptions.
It will be accompanied by a series of policy briefs that look at different programmatic
interventions.
The goal of the book and policy briefs is to provide an update on the epidemic and the
Zimbabwean response. These documents contain much useful information and are written in
a simple language to make them useful to as many people as possible. The HIV and AIDS
epidemic is an extremely complex phenomenon and no single series can capture all
aspects of the situation. Regardless, I believe these documents are an important contribution
to Zimbabwean efforts to limit the spread of HIV and to provide care and support for those
already infected and otherwise affected by the epidemic.
The HIV and AIDS epidemic is the most serious challenge faced by Zimbabwe since
independence. As the book notes, Zimbabwe is one of the worst affected countries in the
entire world. An estimated 24.6 percent of the population aged 15?49 is currently infected,
and HIV prevalence has been at this level for several years. The consequence has been
widespread death and massive suffering among our people. Life expectancy at birth has
fallen below levels that existed at independence, wiping out the gains of a generation.
This is an opportune time to look anew at the status and course of the epidemic and our national response. We have several new sources of information about HIV and AIDS and sexual behaviour, including new sentinel surveillance data and a young adults sexual behaviour survey. This new information means that we know more about the status and course of the epidemic than before and that we have more knowledge by which to plan interventions. This is going to be a long, difficult struggle, and the consequences of the AIDS epidemic are going to be with us for decades. Nonetheless, I believe that we are at a turning point, and I am convinced that with commitment and energy we can now change the course of this epidemic and move towards a nation free from HIV and AIDS.

IEC Reference Manual for Health Programme Managers

In 1980, Zimbabwe adopted the Primary Health Care approach to correct imbalance in healthcare. Health programmes address problems identified as priorities by the Ministry of Health and Child Welfare. These priorities include HIV and AIDS, tuberculosis (TB), malaria, nutrition, diarrhoeal diseases and acute respiratory infections (ARI), reproductive health including family planning, dysentery and measles.

The purpose of IEC is to improve people’s health by increasing awareness and knowledge and changing attitudes and behaviour. The Ministry of Health and Child Welfare views IEC as a crucial component of promoting better health in Zimbabwe and developed a five year national IEC/Health Education strategy in 1994 -1995 which emphasises changing behaviour, the process of behaviour change and learning from programme activities about why people do not change their behaviour.

Fact Sheet - HIV Decline in Zimbabwe: Positive Behaviour Change Makes a Difference

Southern Africa is the region most affected by HIV world-wide with HIV prevalence rates peaking between 10 and 40 % of the adult population. Zimbabwe is the only country in this region, in which HIV prevalence has declined substantially at national level. The story of this HIV decline is summarized in this fact sheet.
Comprehensive Review of Behavioural Change for Prevention of Sexual Transmission of HIV in Zimbabwe

The overall aim of this review is to provide an evidence base for the development of a comprehensive, effective national HIV behavioural prevention strategy focusing on sexual transmission of HIV in Zimbabwe.

The objectives are to: Compile, summarise and review research relevant to prevention of sexual transmission of HIV in Zimbabwe; review programmes designed to prevent transmission; and, make recommendations for the development of a national behavioural prevention strategy.

The scope of the report covers two components:

- A situation analysis reviewing key studies (published and unpublished research studies, programme evaluations, reviews) on the status of the epidemic in Zimbabwe, with a focus on the underlying behavioural factors related to vulnerability to HIV infection through sexual transmission.
- A response analysis reviewing key studies, assessments and evaluations of interventions aimed at reducing HIV infections, with a view to understanding current approaches and activities, gaps and opportunities.

Voluntary Counselling and Testing (VCT)

Voluntary counselling and testing (VCT) is the process by which an individual undergoes counselling, enabling him or her to make an informed choice about being tested for HIV. In recent years, voluntary HIV testing, in combination with pre- and post-test counselling, has become increasingly important in national and international prevention and care efforts.

This section of the toolkit contains publications of Voluntary Counselling and Testing and its impact and effects in Zimbabwean community.

Resources:

- **DHS Working Paper: AIDS stigma and uptake of HIV testing in Zimbabwe**

  The objective of this report is to examine the effects of AIDS stigma on uptake of HIV testing
Voluntary counselling and testing: uptake, impact on sexual behaviour, and HIV incidence in a rural Zimbabwean cohort

Objectives: To examine the determinants of uptake of voluntary counselling and testing (VCT) services, to assess changes in sexual risk behaviour following VCT, and to compare HIV incidence amongst testers and non-testers.

Methods: Prospective population-based cohort study of adult men and women in the Manicaland province of eastern Zimbabwe. Demographic, socioeconomic, sexual behaviour and VCT utilization data were collected at baseline (1998-2000) and follow-up (3 years later). HIV status was determined by HIV-1 antibody detection. In addition to services provided by the government and non-governmental organisations, a mobile VCT clinic was available at study sites.

Results: Lifetime uptake of VCT increased from under 6% to 11% at follow-up. Age, increasing education and knowledge of HIV were associated with VCT uptake. Women who took a test were more likely to be HIV positive and to have greater HIV knowledge and fewer total lifetime partners. After controlling for demographic characteristics, sexual behaviour was not independently associated with VCT uptake. Women who tested positive reported increased consistent condom use in their regular partnerships. However, individuals who
tested negative were more likely to adopt more risky behaviours in terms of numbers of partnerships in the last month, the last year and in concurrent partnerships. HIV incidence during follow-up did not differ between testers and non-testers. 

Conclusion: Motivation for VCT uptake was driven by knowledge and education rather than sexual risk. Increased sexual risk following receipt of a negative result may be a serious unintended consequence of VCT. It should be minimized with appropriate pre- and post-test counselling.

Zimbabwe National Guidelines on HIV Testing and Counselling

Zimbabwe is going through challenging times as the impact of HIV and AIDS takes its toll with a very high HIV prevalence rate of 20.1% in 2005 amongst the adult population. Infection rates are highest in the productive age group 15 – 49. This has a negative impact on the socio-economic development of the country. Since the advent of HIV and AIDS, there has also been an increase in the bed occupancy at health institutions.

The vision of the Ministry of Health and Child welfare is to provide a comprehensive HIV and AIDS package of prevention, treatment, care and support to the infected and affected. One of the critical components in the provision of this package is HIV testing and counselling. HIV testing and counselling is also an entry point to prevention, treatment, care and support services. It is generally assumed that knowledge of one’s HIV status acquired in a supportive environment with appropriate pretest and post test counseling is a significant motivator for positive behaviour change. It is also the right of every Zimbabwean to know their HIV status. However, according to the Young Adult Survey of 2002 approximately 10% of the population is aware of their HIV status. It is against this background that there is need to increase access and scale up the HIV testing and counselling as we scale up comprehensive HIV and AIDS service provision.

It is the Ministry of Health and Child Welfare’s expectations that these guidelines will provide national standards that must be adhered to in the provision of high quality client initiated and provider initiated HIV testing and Counselling services in both the public and private sectors in Zimbabwe.

HIV and AIDS Programmes in Zimbabwe: Implications for the Health System

This paper analyzes the implications of HIV and AIDS prevention, treatment, and care
programmes on the health system in Zimbabwe. The programmes have been spearheaded by various stakeholders that include the public and private sectors, nongovernmental organizations, formal and informal institutions, and intergovernmental organizations. There has been a tremendous increase of the programmes as they adapt to local contexts, accommodate new funders, and changes in population attitudes, and expectations in the country. Through a comprehensive literature review, this paper focuses on Behaviour Change, the Antiretroviral Therapy, Home-Based Care, Prevention to Mother To Child Transmission and Voluntary Counselling and Testing programmes and services in relation to the components of the health system that include health service delivery, human resources, finance, leadership and governance, and the medical products and technologies. Thus far, the implications are uneven throughout the health system and there is need to integrate the HIV and AIDS programmes within the health system in order to achieve positive health outcomes.

Voluntary Medical Male Circumcision (VMMC)

Male circumcision is the surgical removal of some or all of the foreskin from the penis. Male circumcision provides only partial protection, and therefore should be only one element of a comprehensive HIV prevention package. Circumcised men can still become infected with the virus and, if HIV-positive, can infect their sexual partners. Promoting and providing safe male circumcision does not replace other interventions to prevent heterosexual transmission of HIV but provides an additional strategy.

Publications in this section provide an understanding of how Male Circumcision helps prevent HIV infection and its impact and implications in Zimbabwe's HIV prevention programmes.

Resources:

- Prevalence and factors associated with knowledge of and willingness for male circumcision in rural Zimbabwe

Objective To explore male circumcision (MC) prevalence, knowledge, attitudes and intentions among rural Zimbabweans.
Methods Representative survey of 18-44 year olds in two provinces, as part of an evaluation of the Zimbabwe National Behaviour Change Programme. We conducted univariate, bivariate and multivariate analyses. Linear regression was employed to predict knowledge of MC (composite index) and logistic regression to predict knowledge that MC prevents HIV,
willingness (oneself or one’s partner) to undergo MC, and willingness to have son circumcised.

Results Two thousand seven hundred and forty-six individuals participated in the survey (87% of eligibles). About two-thirds were women (64%). Twenty per cent of men reported being circumcised, while 17% of women reported having a circumcised partner. Knowledge of MC and its health benefits was low. Attitudes towards MC were relatively positive. If it could prevent HIV, 52% of men reported that they would undergo MC and 58% of women indicated that they would like their partners to be circumcised. Seventy-five per cent of men who reported being HIV positive were willing to undergo MC, against 52% of those who reported HIV negative status. Reported acceptability of neonatal circumcision was high with 58% of men and 60% of women reporting that they would have their sons circumcised if it protected them against HIV. Fear of adverse effects was highlighted as a barrier to MC acceptability.

Conclusion More knowledge about MC’s health benefits positively affects people’s attitudes towards MC. The relatively high MC acceptability suggests an enabling environment for the scale-up programme.

The Potential Cost and Impact of Expanding Male Circumcision in Zimbabwe

In support of efforts to scale up male circumcision (MC) in PEPFAR programs, readily available data have been applied to estimate the potential cost and impact of scaling up medical MC services in Zimbabwe to reach 80 percent of adult (ages 15-49) and newborn males by 2015. The results presented here illustrate only one possible scenario; the scenarios can be modified to reflect a variety of possible policies at the country level. Key conclusions from this initial scenario are that scaling up the program would result in averting almost 750,000 adult HIV infections over the time period from 2009 to 2025, would result in cumulative net savings of more than US$3.8 billion over the same time period, and would require more than 1.1 million MCs to be performed in the peak year (2012).

Attitudes and intentions around male circumcision in a representative sample of rural Zimbabweans

Mathematical modelling estimates that 750,000 HIV infections could be averted in Zimbabwe if 80% of adult men are circumcised within seven years, and suggests that initially prioritizing males aged 15 to 29, will lead to the greatest reduction in HIV incidence in the short-term. In 2009, a representative population-based survey was conducted as part of the evaluation of
Zimbabwe’s National Behaviour Change Programme (NBCP). The survey included questions on reported prevalence, knowledge, attitudes and intentions related to adult male circumcision (MC) among rural Zimbabweans. We report here on results of that survey.

- Models to increase volumes and efficiency in Zimbabwe’s Male Circumcision program

Issues Male circumcision (MC) has been shown to reduce a man’s risk of HIV acquisition by up to 60%. Mathematical modelling suggests that 750,000 new HIV infections could be averted in Zimbabwe if 80% of men are circumcised over the next seven years. This would require a rapid scale-up to achieve 1.1 million MCs in the peak year of scale-up. To achieve these high outputs and optimize the use of staff time, the national MC program considered several approaches that improve efficiencies and reduce surgical time. Several elements of MC MOVE (Models of Optimizing the Volume and efficiency for Male Circumcision Services) were introduced in the national program.

- What you need to know about Male Circumcision

Essential information on what you need to know about Male Circumcision

- What you need to know after Male Circumcision

Essential information on what circumcised men need after being circumcised

- What women need to know about Male Circumcision

Essential information on what women need to know about Male Circumcision

Workplace
Treatment, Care and Support

This toolkit page looks at treatment including ART, Treatment as prevention, issues related to People Living with HIV, Community home based care, Nutrition and Psychosocial support.

Antiretroviral Therapy (ART)

Community Home Based Care (CHBC)

Community and home-based care (CHBC) is an integral component of the continuum of care and support. Services provided in Zimbabwe include palliative care, nursing care, counselling and psychosocial support, spiritual support, nutrition and referral services. Provision of these services is premised on the partnership between government, civil society organizations, support groups of PLHIV and the communities themselves.

The nature of community CHBC service has evolved over time given the impacts of ART on patients that were previously bed ridden and not longer in such status. As a result new services have emerged based on demand such as promoting treatment adherence, addressing issues of stigma and providing social protection, and strengthening capacity of households to initiate and implement sustainable livelihoods.

Support groups of PLHIV have shown to be effective in providing care and support services and in particular in addressing stigma and discrimination through promotion of positive living and human rights education and awareness. Within the context of positive living support groups have focused on addressing dietary and safe health practices that improve quality of life such as regular exercising, psychological wellbeing, effects of alcohol and smoking and nutrition. Therefore ZNASP seeks to increase the number of PLHIV receiving psychosocial support from 112,244 in 2010 to 269,958 by 2015.

*Summary adapted from the Zimbabwe National HIV and AIDS Strategic Plan [ZNASP II] 2011-2015

Nutrition

It is widely accepted that nutritional health is essential for PLHIV to maximise the period of asymptomatic infection, to mount an effective immune response to fight opportunistic infections
and to optimise benefits of ART. Several programmes have reported high mortality in the first 90 days of ART treatment correlated strongly with low body mass index (BMI<16). HIV exacerbates under nutrition through lack of food intake, increased energy needs, and reduced absorption of nutrients. This can hasten the progression of HIV and worsen its impact by weakening the immune system, increasing susceptibility to opportunistic infections and by reducing the effectiveness of treatment. The malnutrition?infection complex which is an outcome of HIV and AIDS is a significant factor among Zimbabwe National HIV and AIDS Strategic Plan 2011-2015 adults, but more severe among children. Furthermore, poor nutrition in children is associated with risk of children?s faltered growth, impaired mental development and even death.

Food and nutritional insecurity increases the mobility and migration patterns of individuals seeking for food. Mobility and migration place people in risky situations and behaviours such as involvement in transactional and commercial sex. Socially marginalised and economically disadvantaged women also, tend to stay in sexually abusive and violent relationships.

*Adapted from the Zimbabwe National HIV and AIDS Strategic Plan [ZNASP II] 2011-2015

Psychosocial Support
Youth and Adolescents
Adolescent Sexual and Reproductive Health
Life Skills
Entrepreneurship and Empowerment
ICTs and SRHR

Rights and Responsibilities

Youth Participation

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