Zimbabwe is making steady progress in reducing new HIV infections. It has also taken the lead in Africa and beyond, by galvanising political commitment to HIV prevention. Civil society organisations are heartened by steps such as the new size estimation studies and proposed minimum service packages that show an increased focus on key and priority populations. However, progress is fragile in a context where stigma is widespread, key populations face violence, and young women are denied their right to sexual and reproductive health. In order to meet the prevention targets, the government needs to work alongside civil society to introduce reforms, address these and other structural barriers, and invest more in programmes for key populations.
Conduct strategic assessment of prevention needs and identify barriers to progress

Zimbabwe updates its analysis of the HIV epidemic regularly through annual and periodic surveys. Indicators are also reviewed regularly and include people living with HIV, and adolescent girls and young women. However, men who have sex with men, transgender people, and people who use drugs are rarely included. This is due to the outdated data collection tools and an environment that continues to criminalise these groups. National population size estimates for men who have sex with men are now underway following a similar study with sex workers in 2017.

In 2017 Zimbabwe assessed its current HIV prevention programming. Key populations networks and civil society organisations (CSOs) were able to contribute to this process by participating in technical working groups.

Enhance prevention leadership, oversight and management

The National AIDS Council (NAC) is responsible for coordinating work on HIV prevention. The Global Fund and PEPFAR are also supporting strategic staff within the Ministry of Health and Child Care (MoHCC) to work on this issue. The government has revitalised the National Prevention Partnership Forum, a national body meeting quarterly to provide updates on HIV programmes, and open to all partners working on HIV prevention.

Political will has significantly shifted in support of population-specific interventions. The NAC is now actively supporting interventions for men who have sex with men, sex workers and other key populations, and new staff have been hired to coordinate this work.

Introduce legal and policy changes to create an enabling environment

Priorities for legal and policy changes were absent from the 100-Day Action Plan – which outlined immediate actions following the launch of the Road Map.

While HIV prevention programmes aimed at adolescent girls and young women have been strengthened, very little attention has been given to the removal of structural barriers that prevent young people from accessing services. The existence of inconsistent laws and policies on age of consent for sexual and reproductive health services and information, and a failure to provide comprehensive sexuality education in schools continue to hinder progress.

Key populations remain highly politicised and there is still a reluctance to tackle the repressive laws around homosexuality, sex work and personal drug use. However, recently decision makers have begun to open up opportunities for dialogue. The NAC has also recruited two Key Population Officers to support and coordinate key population interventions and together with UNDP is supporting a Legal Environment Assessment. This is part of a wider strategy to understand and address the restrictive policy environment in Zimbabwe. CSOs are hopeful that recent political changes will help revitalise action and investment to address these challenges.

Develop or revise national targets and road maps

Zimbabwe recently endorsed a new set of national prevention targets that include sex workers, men who have sex with men and prisoners but not transgender people and people who use drugs. Current prevention strategies have been revised in line with Zimbabwe National HIV and AIDS Strategic Plan 2015-2018.

While this is a step in the right direction, key challenges remain. Little attention has been given to the development of sub-national targets. The lack of robust data for key population groups makes this process challenging. Although the new National Prevention Strategy and Operational Plan will help shape sub-national targets, it is incomplete.
Develop national guidance and intervention packages, service delivery platforms and operational plans

Previously there were no minimum service packages for key population groups. In consultation with these groups the MoHCC has now developed one, along with a training manual for health care workers. But it is still unclear whether the final packages will include interventions on stigma, discrimination and gender-based violence, as well as biomedical interventions. It is also unclear whether these new packages will be gender transformative in their approach or include harm reduction services but they present a good starting point.

In consultation with key population groups, specific clinics have been identified to provide services for men who have sex with men and sex workers, with some staff members trained on this issue. The government has also committed to scaling-up biomedical interventions including pre-exposure prophylaxis (PrEP) provision for key populations and “Test and Treat” approaches but so far no operational plans have been shared. PrEP coverage remains low in relation to demand and is currently only available in a few districts.

Assess available funding and develop strategy to close financing gaps

The government continues to rely heavily on international funding, especially for prevention programmes aimed at key populations. Existing funds support targeted clinics and drop in centres and includes peer education schemes for men who have sex with men and sex workers. Domestic funding for prevention is largely generated from the National AIDS Trust Fund (AIDS Levy), administered through the NAC. However, at present only 10% of the funds raised are allocated to HIV prevention.

Overall, the prevention budget remains low and health spending falls short of the targets outlined in the Abuja Declaration. Activities for key populations and adolescent girls and young women remain inadequate. Government commitment to combination prevention also remains weak – PrEP is only available in a few districts, stigma and discrimination programmes are underfunded and structural barriers remain. There have been no financing dialogues on HIV prevention but the government has recently launched a new National Health Financing Strategy and Policy to support resource mobilisation.

Establish or strengthen programme monitoring systems

The government monitors progress on HIV prevention at district, provincial and national level based on data from clinic registers. This monitoring tends to focus on government-led programmes run though health care facilities. As a result, data tends to be disease specific and does not necessarily capture gender or key population-specific issues.

CSO’s involvement in this process is not clearly defined due to their limited involvement in development and review of prevention targets and indicators. The electronic data monitoring system is still at pilot phase in selected districts and is not available to CSOs. Community-based monitoring systems are almost non-existent and where they do exist civil society engagement is limited. Community-based monitoring tends to involve medical practitioners rather than representatives of key populations.

Develop capacity building and technical assistance plan

Zimbabwe is yet to develop a comprehensive capacity building and technical assistance plan aligned to the Road Map. Some CSOs have been invited to advise on new service packages for key populations but there has been no attempt to comprehensively document Zimbabwe’s technical assistance needs or to map existing expertise.

Establish or strengthen social contracting mechanisms for civil society implementers and expand community-based responses

There are no formal mechanisms allowing the government to subcontract local CSOs, which leads to competition over available donor funding between government and CSOs. The NAC is the Sub Recipient for all Global Fund grants after UNDP who remains the Principal Recipient. CSOs have strongly contested the funding selection process and called for a new social contracting process.

While the government acknowledges civil society’s role in supporting key populations, they do not formally contract them to do so. Government investment in community-led interventions is limited and as a result these activities are largely voluntary.

Strengthen national and international accountability

District and provincial review forums are held quarterly to reflect on progress and provide recommendations for programme delivery. But national platforms for accountability remain weak due to poor coordination, for example between the National Key Population Forum and National Prevention Partnership Forum. While CSOs are encouraged to participate, often they have little influence over the allocation of resources.
Recommendations

We welcome the political commitment of the Zimbabwean government and the steps taken in recent months to push HIV prevention higher up the country’s agenda. As civil society and community organisations we commit to partner with government on these efforts. In order to meet the global and national targets, we believe Zimbabwe should prioritise the following actions:

1. Initiate new population size estimation studies that include all key populations, including transgender people and people who use drugs. The process must be open and transparent and include key population-led organisations.

2. Meaningfully engage civil society – in particular key population groups – in setting and endorsing new prevention targets at sub-national levels. National targets should also be revised to include transgender people and people who use drugs.

3. Provide clarity on the role of the National Prevention Partnership Forum in the management and oversight of prevention programming.

4. Commit to an action plan for policy and legal changes needed to address the structural barriers facing key populations such as the criminalisation of homosexuality, sex work and personal drug use.

5. Ensure that laws and policies support the provision of sexual and reproductive health services and information and comprehensive sexuality education in schools, so that adolescent girls and young women can better access HIV prevention.

6. Ensure civil society organisations are formally involved in the delivery of prevention programmes. To help achieve this, the National AIDS Council should actively engage them in the development of its annual work plan.

7. Develop a national, costed technical assistance plan aligned to the priorities of the Road Map.

8. Host a multi-sector financing dialogue to analyse the funding gap and seek ways to scale up investment in combination HIV prevention.

9. Strengthen the national accountability mechanisms, including investment in community-based monitoring tools and initiatives.

Methodology

As a member of the Global HIV Prevention Coalition, the International HIV/AIDS Alliance has played a leading role in convening civil society and community organisations. Activists from 22 countries participated in interactive workshops to learn, share and agree advocacy priorities. As part of this process activists worked in teams to analyse their country’s progress on HIV prevention. Some country teams continued their collaboration and developed shadow reports based on responses to a standard questionnaire developed by the Alliance. These reports voice the priorities of civil society organisations and offer an alternative to official assessments.

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For national progress reports see: hivpreventioncoalition.unaids.org

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Our partners

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