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**Conference Room Paper 5: Report of the UNAIDS PCB Field Visit
to Zimbabwe**

INTRODUCTION

A Delegation from the UNAIDS Programme Coordinating Board (PCB), including all members of the PCB Bureau, undertook a field visit to Zimbabwe 2-4 June 2015. The Delegation included members from Morocco, Poland, Switzerland, Ukraine, United Kingdom and Zimbabwe, as well as representatives of the PCB NGO Delegation and UNAIDS Cosponsors, participating from the global, regional and national level. The Delegation met with a range of stakeholders engaged in Zimbabwe's multisectoral response to HIV, senior officials from several ministries (health, education, gender, social welfare), parliamentarians, development partners, the UN country team, and civil society with a focus on youth and affected populations and the private sector, in urban and rural settings in Victoria Falls and Harare. The Delegation interacted with children in a life-skills and sexuality education class, adolescents living with HIV, community groups, and sex workers, truck drivers, medical personnel and peer educators in workplace programmes at a power station and a colliery hospital.

The visit was a valuable opportunity for Board representatives to observe the AIDS epidemic and response of a country with a generalized epidemic, and which, despite remarkable achievements in the response to HIV, has 15% of its population living with HIV.

The mission was organized jointly with the National AIDS Council and came at a strategic time when Zimbabwe is also chairing the Africa Union (AU) and the Southern African Development Community (SADC).

The visit demonstrated the value of an integrated multisectoral response (and the support of the Joint Programme through the Joint Team) in support of the national AIDS response, in the context of support for overall development efforts from the UN Country Team (UNCT) led by the UN Resident Coordinator.

The complexity of the epidemic in Zimbabwe enabled a very comprehensive programme for the visit. This illustrated many of the issues that are central to the update and extension of the UNAIDS Strategy and the next UBRAF, which will be a key agenda item for the 36th meeting of the PCB, taking place 30 June to 2 July 2015, in Geneva. Delegates agreed that the visit offered PCB delegates the opportunity to feed back to the governing body the realities of the epidemic and the work of the Joint Programme on the ground.

Key issues addressed during the visit:

- Political leadership at all levels and the sense of unity of purpose among all stakeholders—a sense of being in this together--and a clear recognition of the need to accelerate (fast track) response efforts and investments.
- Innovative approaches: the AIDS tax levy already introduced in 2000; community led approaches to the delivery of treatment, care and support services; public-private partnerships, including very effective workplace programmes; and the cost-effectiveness

of the response.

- Challenges of sustainable financing in the context of a country with limited fiscal space but commitment to ending the AIDS epidemic as a public health threat by 2030 and the fast tracking of the response.
- The need for a strong focus on effective HIV prevention, particularly with regard to empowerment of women and girls.
- The necessity of reaching youth in an overwhelmingly young country demographically and the different strategies needed for urban and rural settings.
- The importance of engagement of the private sector and scaling up the successful public private partnerships.
- Cost effective service delivery models and peer education among communities.
- Coordinated and effective UN support to the national HIV response under the leadership of the Resident Coordinator.
- The evidence of a multi-sectorial approach to the AIDS response.

BACKGROUND TO THE AIDS RESPONSE IN ZIMBABWE

1. The PCB field visit to Zimbabwe provided a valuable opportunity to understand the particular challenges of the AIDS response in a landlocked, high-impact country, which has a largely young population. 41% of the some 13 million inhabitants are young people below the age of 15 and two thirds of the population is under the age of 25 years.
2. Zimbabwe has one of the largest HIV burdens in Southern Africa (and in the world) with a generalized epidemic in which an estimated 1.4 million adults and children are living with HIV. The predominant mode of HIV transmission is sexual transmission. Approximately 7% of the epidemic stems from transmission of HIV from mother to child.
3. Since the epidemic's peak in around 1997, adult HIV prevalence has almost halved from nearly 30% to around 15% in 2014, and new HIV infections have declined by over 50%. The country has seen a reduction of 75% in new HIV infections among children born from mothers living with HIV in the last decade. HIV related deaths have also been reduced by over 60% as a result of a successful treatment and support programme.
4. Zimbabwe also continues to experience high levels of HIV/TB co-infection, with rates of 82%. Considerable progress has been made towards an integrated TB/HIV response. As of 2011, 92% of all TB patients notified during the year had an HIV test result, 85% of the TB patients living with HIV received cotrimoxazole and 71% received antiretroviral treatment.

5. The third Zimbabwe National HIV and AIDS Strategic Plan is ambitious and reflects Zimbabwe's commitment to end the AIDS epidemic as a public health threat by 2030, including achievement of the 90-90-90 targets by 2020. By 2018, it strives towards three major targets:
 - a. To reduce HIV incidence among adults and adolescents by 50% from 0.98% in 2013 to 0.49% by 2018.
 - b. To reduce HIV-related mortality by 80% for both adults and children by 2018.
 - c. To increase domestic financing of the HIV response to 30% by 2018

Objectives of the Programme Coordinating Board visit to Zimbabwe

6. The goals and objectives for this field visit were to:
 - observe the realities of the HIV epidemic in a high- prevalence country;
 - demonstrate the value of an integrated, multi-sectoral response and the role of the UNAIDS-led UN Joint Team in support of the nationally-owned response;
 - demonstrate innovative approaches in the AIDS response, including the national AIDS trust fund; community- led approaches to the delivery of treatment, care and support services; public-private partnerships, workplace programmes; and,
 - enable delegates to report back to the PCB on epidemic realities and the work of the Joint Programme.

TUESDAY, 2 JUNE

Meeting with the Resident Coordinator a.i. and the UN Country Team

7. The Resident Coordinator a.i. and Representative of UNICEF, Mr Reza Hossiani, welcomed the Delegation and explained the very close collaboration between the UN Joint Team on AIDS, led by the UNAIDS office, and the NAC in all aspects of strategic planning of the response, including the organization of the PCB Field Visit. The Resident Coordinator provided an overview of the UN's engagement with Zimbabwe and the key challenges faced in supporting a complex country. He explained that HIV is one of six top level priorities for the Zimbabwe UN Development Assistance Framework for 2016-2020 and had been an area of much progress in recent years. From 2011 to the end of 2014, achievements included 15% reduction in HIV incidence and 35% reduction in mortality, including achieving an 89% survival rate of people living with HIV (including children) on antiretroviral treatment.

8. He specifically highlighted the elimination of new HIV infections among children and keeping their mothers alive as a flagship programme for the UN's support to the government of Zimbabwe, which, in 2014 alone, had helped reaching 57,662 women living with HIV with antiretroviral prophylaxis to reduce transmission from mother to child.
9. The Resident Coordinator a.i. also explained that the HIV response provides the best model for coordination and coherence in terms of UN assistance to the country. He affirmed that the HIV response remains a helpful pathfinder for joint UN action and support to other national programmes.
10. Key issues discussed with the country team included:
 - The challenges of the sustainability of the AIDS response in an economy with limited fiscal space and in the current context of low economic growth, and how this may impact the fast tracking of the AIDS response through 2020;
 - The need to clearly understand the HIV-related needs of different age groups within a very young population, including breakdown by 10-14, 15-19, and 20-24 years of age;
 - Treatment access for adolescents is lagging behind. How to use innovative methods to reach youth also inside and outside the formal education system;
 - The need to ensure a full and comprehensive strategy for reaching youth rather than project based interventions;
 - The almost complete absence of HIV services in Zimbabwean prisons as a significant gap in the national HIV response. Importance of scaling up of social protection, including cash transfers-currently only reaching 30% cent of those in need;
 - The need for sensitive sexuality education, including the use of culture and music to address issues around behavior change and stigma and discrimination;
 - The role of faith based organizations in the response; and
 - The legal environment and broader stigma and discrimination that are barriers to access to health services including in relation to sex work and with regard to men who have sex with men.

Visit to Kuwadzana High School #1, Harare

11. The Delegation visited Kuwadzana High School #1 in a high-density suburb on the edge of Harare to interact with pupils aged 13-18 years old, to see some of the elements of the life skills and sexuality education programme, and to discuss the needs of young people and challenges they experience. Young people in Zimbabwe are a high risk

population. Youth in Zimbabwe are more likely to become infected by HIV before their 25th birthday than any other age group. A particular concern is that HIV prevalence is almost three times higher among women aged 15 to 24 (11%) than among men of the same age (4.2%).

12. The pupils performed several dramatic skits, including on the MDGs, education as a right, but also on the importance of non-discrimination towards people living with HIV. Messages around empowerment, skills building and abstinence were among those under discussion. Other issues emphasized included:
 - Importance of HIV testing and being tested, organized around the message that learning one's HIV status is the "beginning of a new life";
 - Pharmaceutical production in Africa – the importance of not being dependent;
 - The importance of self-awareness and self-confidence and the ability to negotiate intimate relations;
 - Many children suggested that it was easier to talk about sex in school with peers than at home while some stated that their mothers were the most appropriate person to talk about sex with.

Visit to the Newlands Clinic in Harare

13. The Delegation visited the Newlands Clinic and Newlands Clinic Training Centre where state of the art HIV treatment innovation takes place, including referral of complicated cases from other clinics, NGOs and community organizations. The clinic is an outpatient, nurse-based, family-centered HIV care and treatment centre. It receives the majority of its staff and service funding from the Swiss charitable foundation Swiss AIDS Care International but receives all its antiretroviral medicines from the Ministry of Health and Child Care. All programme data is reported through the Ministry's Health Information System, allowing all patient data to be analyzed centrally.
14. The Clinic provides comprehensive care and treatment to people living with HIV in the disadvantaged, marginalized urban and peri-urban communities of Harare and Chitungwiza. This includes the poor, the unemployed, adolescents, orphans and vulnerable children. Parents, caregivers of children, teachers and nurses are prioritized for care and to support the essential services of education and health in Zimbabwe. The Newlands Clinic is regarded as a model of best practice and public-private partnership by the AIDS and TB Unit, Ministry of Health and Child Care and efforts are under way to establish similar centres based on this model in other parts of the country. Newlands

Clinic Training Centre has been conducting training and institutional capacity-strengthening activities for public sector health professionals since 2009.

15. PCB delegates interacted with staff at all levels at the clinic and discussed the following issues:
- The importance of building health worker capacity;
 - Collaboration with NGOs and community based service providers to deal with referred patients, including for viral load testing;
 - Scale-up of nurse-led opportunistic infection/antiretroviral treatment service clinics in Zimbabwe.
 - The functioning of the electronic medical record system (ePOC) and the linkage to national data analysis.
 - Retention rate – the clinic has excellent loss-to-follow-up statistics at less than 0.5%. There are challenges in rolling out third line antiretroviral treatment. Current number of patients on third line therapy is very small; and
 - Dependence on donor-driven initiatives for this type of clinic.

Meeting with development partners and private sector

16. In a meeting co-chaired by the Permanent Secretary of Health, Dr Gwinji, the delegation discussed the challenges of the need to fast track the AIDS response over the next five years at a time where international resources are flattening and with limited fiscal space in the national economy. The private sector engaged actively in the meeting, emphasizing the responsibility that the private sector has already taken in Zimbabwe with regards to service delivery to workers, their families and surrounding communities. Also emphasized was the awareness that even more is needed from the private sector during the fast track period.
17. Current annual funding of the AIDS response from all public sources is around US \$360 million. Annual resource needs are projected to increase to nearly US \$600 million by around 2018, and over US \$700 million each year from 2023 onwards, given current cost structures. While the response in Zimbabwe was widely seen by most actors as efficient, efficiency gains could stabilize resource needs at around US \$550 million annually.
18. The meeting was also an opportunity for the delegations to learn about the National AIDS Trust Fund, which is resourced by a taxation levy introduced in 2000. The Fund is the major contributor of domestic funding to the national HIV response, and stands as a

significant financing innovation which in recent years has been emulated by countries such as Kenya and Tanzania. 15% of the response is now funded from national sources, however domestic spending increased by 40% from 2011 to 2014. The Government is committed to increase the share of domestic funding to 30% by 2018.

19. The major sources of international funding for HIV programming in Zimbabwe have been multilateral (mainly the Global Fund to fight AIDS, Tuberculosis and Malaria (Global Fund), but also UN agencies); and bilateral, particularly the US government (PEPFAR). The Delegation discussed the following issues with the partners:

- The need for a sustainability transition plan, in particular through the fast track period;
- The actual contribution to the response of the private sector may be larger than currently reflected – not all of the contribution is directly measurable;
- The important contribution of wellness and psychosocial support is underestimated;
- The risk that the ambition to reach a further 400,000 people living with HIV with treatment in addition to the current 770,000 will ‘crowd out’ HIV prevention;
- That Zimbabwe’s response is considered to one of the most cost effective in Africa;
- Thinking ahead: alternative ways of resourcing the response including patients in formal employment paying for antiretroviral treatment through medical insurance programmes.

Youth - meeting youth organizations and networks of young people living with HIV (Zvandiri)

20. Zimbabwe has the sixth highest total annual adolescent AIDS-related deaths globally: in 2013, 7,700 adolescents died from AIDS-related causes in Zimbabwe. The reason for this high mortality rate among adolescents is related to later initiation into care and poorer treatment outcomes.

21. The PCB Delegation met with a range of youth civil society organizations in Harare, including networks of young people living with HIV but also advocacy networks of young people living with disabilities, young sex workers and young men who have sex with men, in a meeting organized by Zvandiri, a community-based HIV treatment, care and support programme for children, adolescents and young people aged 6-24 years. Zvandiri aims to equip children and young people living with HIV with the knowledge, skills and confidence to cope with their HIV status and to live happy, healthy, fulfilled

lives. It achieves this by increasing access to quality treatment, care and support for children, young people and their families through innovative models of community care and support linked closely with the national public and private health and child welfare systems.

22. Organizations of people living with HIV, including youth organizations, increasingly engage in service provision, mobilization in relation to behaviour change programmes, condom promotion, HIV testing, accessing treatment and voluntary medical male circumcision - sometimes at the expense of their advocacy and watch dog role.
23. The Delegation discussed that Zimbabwe has come a very long way in the AIDS response through its public health approach to HIV risk including addressing the vulnerability of all key affected populations, with a commitment to non-discriminatory access to health services. Some political sensitivities remain in addressing rights issues, particularly concerning behaviours which are criminalized such as sex work and men having sex with men. The youth groups representing men who have sex with men brought forward issues of stigma and discrimination experienced when accessing services. Other issues discussed included:
 - How UNAIDS has been providing a platform to youth groups to share their experience;
 - How members of the group has been able to influence the post 2015 development agenda through the PACT;
 - Access to comprehensive sexuality education – where do young people access information about sex and sexuality: Peers, school, family;
 - How to more effectively reach youth out-of-school and in rural areas with sexuality education. Social media is effective in cities – less so in rural areas;
 - Young sex-worker and men who have sex with men talked about stigma as barrier for access to health services – according to them, a widespread issue for LGBTI;
 - How to engage religious leaders – in particular where they influence young people not to take antiretroviral medicines;
 - Peer to peer counselling amongst young people is key, not only to HIV prevention, but also to ensure adherence to treatment;
 - When disjointed, the youth movement is not taken seriously – needs resources to organize itself.

Meeting with the Permanent Secretaries of Health and Women, Gender and Community Mobilization, as well as the senior officials from ministries of Education and Labour and Social Welfare

24. The response in Zimbabwe is truly multisectoral and has full commitment from all relevant ministries. The Delegation met with the Permanent Secretaries of Health Dr Gwinji, and Women, Gender and Community Mobilization, Dr Gumbo, as well as senior directors from the Ministry of Labour and Social Welfare and of the Ministry of Primary and Secondary Education.
25. The Permanent Secretary of Health stressed that 90% of HIV infections in Zimbabwe stem from sexual transmission and that women and adolescents are particularly vulnerable to HIV infection. A key strategy across ministries is the roll out of voluntary HIV counselling and testing including piloting of self-testing. But the focus on women is also central. Women's access to food and nutrition reduces risk of HIV infection and Zimbabwe's experience also shows that if women are not economically empowered they are at higher risk of becoming infected with HIV. Social protection in the form of cash transfers for children currently targets 1.8 million vulnerable children, although the full number are not able to be reached with current resources.
26. The representative of the Ministry of Education informed the Delegation about a curriculum review undertaken at the end of 2014. Consideration is being given to ways of making HIV knowledge and life skills examinable. However it remains a challenge since 90% of teachers are not trained in this part of the curriculum.
27. The Delegation was impressed with the multisectoral response and the coordination and search for synergies across ministries. Other issues discussed with the representatives of ministries, included:
- The need to further scale up HIV testing –currently 56% of the population are estimated know their HIV status;
 - That scaling-up HIV testing is key for a fast-tracked response;
 - The need to address stigma and discrimination in health care settings;
 - That civil society needs to be part of all key committees – direct link to their influence from early demands for treatment;
 - The efforts underway to determine size of key populations in context of last Global Fund submission; and
 - How to best engage churches and traditional leaders in a constructive way?

Parliamentary Portfolio Committee on Health and Parliamentary Thematic Committee on AIDS

28. The importance of enabling legal environments has frequently been discussed in the PCB as has the importance of scaling up national investment in the AIDS response. Both require foresight from Parliament and the establishment of the 3% AIDS levy is a tangible example of leadership by Parliament in Zimbabwe. In terms of accountability to the people, parliamentarians also play a central role and are frequently in very close contact with communities in their constituencies.
29. The Delegation met with parliamentarians from the most relevant parliamentary committees in relation to the HIV response, namely the Parliamentary Portfolio Committee on Health and the Thematic Committee on HIV. The parliamentary committees represent all political parties elected to the plenary chamber and are the working groups in which much of the in-depth work of parliament is carried out.
30. The role of the Portfolio Committee is to examine the expenditure, administration and policy of the relevant government department. The Delegation interacted with Dr Ruth Labode, Chair of the 15-member Parliamentary Committee on Health and Senator Timveos, chair of the Thematic Committee on HIV as well as Dr Paul Chimedza, MP member of the Health Portfolio Committee. Key questions discussed included:
- How have other countries engaged in public health approaches to sensitive issues where legal reform is not immediately possible (e.g. experience from a Zimbabwe study tour including parliamentarians to India to observe their response to sex work)?
 - A very recent court ruling in Zimbabwe High Court put an end to arrests based on soliciting for sex/loitering – this momentum for law reform should be capitalized upon; and
 - How can parliamentarians’ role as key partners in improved accountability be strengthened?

WEDNESDAY, 3 JUNE

Meeting with truckers and service providers at truck stop

31. The PCB Delegation met service providers at a truck stop and truckers close to the border triangle between Zimbabwe, Botswana and Zambia in Victoria Falls. While the truckers referred to their profession as constituting the “veins of Africa”, there was clear awareness that the many days away from home, sometimes six months in a row, often led to risk behaviour, notably in their becoming clients of sex workers. SADC, with support from the Global Fund, has developed “wellness centers” situated at border sites,

which provide basic health services with HIV prevention, STI treatment, HIV counselling and testing, condom distribution, and referrals to community health facilities when required. The approach is integrated and focuses on truck drivers from the SADC region who travel through border towns, sex workers who sell sex to the truckers, and the surrounding communities who often interact and may have sexual relations with the truckers or the sex workers.

32. The Delegation observed that the facilities, including the clinic at the truck stop were very basic, and not up to a standard that would encourage people seek health services. The delegation noted that the provision of HIV-related services at the truck stop has been intermittent, with service provision stopped for months at a time. The service providers understood that this was due to lack of continuity in resource provision somewhere in the funding chain. The Delegation considered whether it would be possible to make improvements with support from resources from major shipping or trucking companies. The Delegation noted that, surprisingly, the number of positive HIV tests did not reach the average country prevalence and none of the tested truck drivers (of a total population tested that month of 240) were found to be living with HIV. Other issues raised included:

- The lack of harmonization of antiretroviral medicine regimens across the SADC region poses a major obstacle to mobile populations – in particular those that are living with HIV;
- Referral of foreign truckers to their own countries for HIV-related services means limited follow-up;
- Possible introduction of self-payment for medical services; and
- That some small investment to pave the truck lot and enable better sanitary and kitchen facilities could make the truck stop more attractive and increase access to services offered.

Meeting with staff at the BEAT AIDS Clinic

33. BEAT AIDS is a Zimbabwean registered non-governmental organization operating in Hwange District. It partners with the Ministry of Health and Child Care to provide HIV treatment and care in 13 rural health clinics servicing 53 rural villages and six non-serviced outreach sites. Using resources from its fundraising efforts principally in the US, the Clinic has procured sophisticated HIV viral load analyses (HIV-1 RNA PCR) and Early Infant Detection equipment. Access to these diagnostic technologies will be key for Zimbabwe's achievement of the 90-90-90 targets. The Clinic performs HIV rapid 20 minute testing and rapid 20 minute CD4 (T-cell) analyses, but is also engaged in classic

HIV prevention activities such as HIV awareness raising and efforts to eliminate HIV-related stigma.

34. The Clinic will also offer rapid diagnosis of TB and MDR-TB. HIV and TB co-infection is a major public health threat that directly jeopardizes the success of scaling up HIV treatment to the people of Zimbabwe because each disease speeds up the progression of the other, doubling the risk of death.
35. The Delegation was impressed with the quality of the Clinic and its state of the art services. but Also discussed was the challenge of dependence on international donations to establish such types of clinics to deal with multiple complex cases referred from NGOs and smaller and less sophisticated clinics, as well as the need for effective referral and coordination systems with mainstream Ministry of Health services. The Clinic's practice to ensure all people testing positive for HIV are immediately put on treatment directly at the clinic was underlined as a strength. The delegation also discussed the slower rate of rolling out paediatric treatment, which is lagging behind.

Visit to community-based antiretroviral treatment refill groups

36. The PCB Delegation visited and participated in a peer education session of a community group focusing its efforts on antiretroviral treatment refill and another community wishing to establish a similar group. This was an opportunity to see how Zimbabwe has been using community delivery systems to scale-up antiretroviral treatment in all areas of the country also difficult to reach rural areas in a very cost-effective manner.
37. With an estimated 1.4 million people (adults and children) living with HIV in Zimbabwe, reaching the 90-90-90 targets poses significant challenges. Intermediate targets have been established with the number of people living with HIV receiving antiretroviral treatment to increase to 943,000 in 2015 and more than 1,070,000 in 2016. It is unlikely that antiretroviral treatment provision through traditional health clinics cannot take Zimbabwe to these ambitious targets. Zimbabwe is looking for alternative service modalities that can decongest health facilities, bring services closer to the end user, reduce the amount of time spent in queues at facility waiting for treatment refills, reduce transport costs for people living with HIV and ensure that hard-to-reach populations get their treatment refills on time.
38. The community antiretroviral treatment refill groups have proven to be a simple but highly effective community treatment model of care that simplifies treatment access, and improves patient retention on antiretroviral treatment in an inexpensive way that benefits both members of the group and health facilities. The Delegation witnessed the community dialogue between representatives of an established Community refill group in Tsholotsho District (some 200kms distant) and the local rural community in Chisuma in Hwange District. The Delegation learned how the group organized itself to have six to

ten clients living with HIV who have been receiving antiretroviral treatment for at least six months and are clinically stable, to take turns to go and pick up their medicines every month. It also impressed the Delegation that evaluation shows that each group saves its members some US \$128/year in travel costs and 570 hours of time. Critically, this has shown to lead to improved treatment adherence and in some groups 100% retention after nine months of follow up with virological suppression in 99% of people eligible for viral load testing. The Delegation also discussed:

- Challenges for Zimbabwean migrant workers living with HIV who, because of lack of harmonization in SADC, collect treatment from the group in their home district in Zimbabwe even if working in South Africa;
- How to ensure that data collected by nurses in charge of follow-up is delivered to Ministry of health?

THURSDAY, 4 JUNE

Visit to sex worker outreach project: CESHAAAR

39. The Delegation visited the CESHAAAR outreach site for sex workers in Hwange. Female sex workers are a key population at risk of HIV transmission in the country. Sex workers and their clients together are estimated to account for approximately 12% of new HIV infections in Zimbabwe. Moreover, surveys conducted of selected sex work populations in the towns of Mutare, Victoria Falls and Hwange have shown that in 804 women tested, HIV prevalence was found to be 59.8% (around four times higher than women attending antenatal clinic, and the general population). The research also showed that sex workers experience low access to services and high stigma and discrimination by health providers.
40. The Delegation was also informed about a larger study of more than 2000 sex workers in 14 districts in preparation for a study of PrEP among sex workers, which found HIV prevalence of 56% among the sex worker population, with an estimated annual incidence at 10%. Of sex workers who were living with HIV, 60% knew their status and 40% knew their status and were on antiretroviral treatment.
41. When interacting with the Delegation, sex worker representatives explained that HIV prevalence is very high within this population due to the high numbers of partners, inadequate access to quality services, and their general marginalization. The Delegation particularly appreciated the community meeting where sex workers divided into smaller groups with older sex worker representatives and younger sex worker representatives. The issues discussed included:

- The socioeconomic challenges faced by women and girls in Zimbabwe may increase involvement in sex work and increase the risks to HIV infection. All the sex work representatives in the meeting said that they had entered sex work for financial reasons, to feed their children and pay school fees. Most expressed a preference for alternative means for income generation;
- The need for age-appropriate sexuality education – most of the women said they had started sex work at 13 or 14 years of age without knowing about HIV nor how to prevent HIV infection;
- That, according to the sex worker representatives, most of the clients are local men – many who may already be married and many try to negotiate sex without a condom;
- Differing experiences with law enforcement officials: older sex workers in the group spoke about harassment, including demands for free, unsafe sex and confiscation of revenue. but, in some cases, younger sex workers in the group reported supportive attitudes from protection services in the police;
- How social protection such as the BEAM scheme (education allowances for vulnerable children) is not availed to children of sex workers – local committee focus social protection on orphans and those in “mainstream” jobs; and
- The linkages between focused projects for sex workers with the broader healthcare system.

Visit to the Zimbabwe Power Company

42. The Delegation visited the Hwange Power station of the Zimbabwe Power Company, which is the largest coal-fired power station in Zimbabwe. About 1000 staff members are housed by the station, which has three clinics (one in the industrial setting and two peripheral), two pre-schools, two primary schools and a secondary school. These facilities also benefit the surrounding communities.
43. A sectoral HIV policy in the energy sector was developed, based on ILO guidance and support, and launched in 2010 with the participation of workers, employers and the National Employment Council of the Energy Sector. Under the policy, peer educators in the sector have been trained, as have nurses from workplace clinics, in particular in provision of rapid HIV testing to facilitate HIV testing in workplace clinics.
44. The engagement and the efficacy in communication of peer educators were noticed by the Delegation and it was clear that the power station has a vibrant workplace HIV and wellness programme. The Delegation interacted with peer educators, workers, representatives of the workers’ union, health clinic staff and management of the power

station. It was also evident that the workplace programs reach otherwise hard-to-reach communities of professional and non-professional workers who ordinarily do not come into contact with regular health programmes. The HIV programme included advocacy for and scale up of voluntary HIV testing and counselling, condom programming, training of peer educators in workplaces and advocacy for uptake of male circumcision. In addition, the monitoring and reporting of HIV activities in the world of work has been strengthened and feed into national monitoring and evaluation programmes. The Delegation noted that workers living with HIV had generally continued in their employment at the power station and were apparently reached by the workplace programmes. Issues discussed at the visit included:

- Impact of an industry-wide and industry-monitored national HIV policy to ensure effective HIV programmes at the workplace;
- Need for private sector to systematically budget for HIV programmes at the workplace programmes – should not be external funding – a corporate responsibility;
- Peer education remains key – this is where the most HIV prevention and care efforts are achieved and is a unique opportunity for addressing difficult issues, including HIV-related-stigma and discrimination;
- Career planning for HIV positive workers;
- The need to strengthen business and labour leadership participation in national development planning; and
- Possible expansion of engagement of private sector efforts, for example, school scholarships for children in the community and support to programmes for sex workers.

Visit to the Hwange District Hospital

45. The Delegation also visited the medical facilities in Hwange town, which is a ‘company town’ with facilities run by the large Hwange Colliery Company. Similarly to the power company, there exists a sector-wide policy for the mining sector approach to HIV, based on ILO guidance. The percentage of workers living with HIV passing through the clinic was as high as 25%, indicating the clear need for the company to be a partner of its workforce in responding to HIV.
46. The company’s programme to deliver antiretroviral treatment, using medicines provided by the Ministry of Health, in public private partnership, has had a clear impact. From 2013 to 2015 the number of HIV-related deaths among workers had been reduced by half.

Conclusions from the Field Visit

47. The PCB Delegation concluded its visit with a discussion on the key take-away messages and lessons learned. These included:

- A clear sense of unity in the response from all stakeholders – “the response is a common responsibility and we all have our role to play” – from Ministries, NAC; parliamentarians, across provincial and city leadership, the private sector, communities and civil society organizations.
- The unique role of the Joint Programme in supporting mobilization of political will at all levels and allocation of resources for a multi-sectoral response, ensuring engagement of all stakeholders;
- The capacity of UNAIDS to provide the space for political debate on the most strategic approaches to end the HIV epidemic, ensuring the right balance between HIV prevention and treatment, and scale up of cost effective interventions that have been demonstrated to work in specific contexts;
- Fast tracking the response a shared responsibility – Zimbabwe has achieved significant progress in the AIDS response over the past 15 years – yet similar results and scale up will have to be achieved in the next five years to stay on track to end the AIDS epidemic as a public health threat by 2030. Serious challenges persist, notably fiscal space limitations for scale up and how to increase domestic funding (15% today) in an economy with limited growth. A sustainability transition plan, based on shared responsibility with the international community is required for the fast track period and through 2030.
- The domestic investment context, where per capita development assistance for Zimbabwe has been well below that of neighbouring countries, has led to innovation, including in terms of funding mechanisms such as the 3%AIDS levy (a model being studied and copied by other countries), cost efficient community delivery systems, and a strong role for the private sector in delivering HIV services.
- 90-90-90: The Government remains committed to the targets and there is an urgent need to close the treatment gap without crowding out HIV prevention efforts– effective public private partnerships have allowed establishment of a number of state-of-the-art clinics for referral, to ensure parallel scale-up of viral load testing. The Ministry of Health provides the antiretroviral treatment and communities design the most effective nurse-led delivery system in their specific context. Or, in the world of work, the private sector designs the programme with commodities provided from the public sector.

- Impressive private sector HIV service programmes, that benefit workers as well as their families and communities, have been put in place and the national policy framework, based on ILO guidance. This sets a high standard, yet there is still potential, and need, for further private sector resourcing of the response— investment in a healthy and productive workforce.
- Community delivery systems are potentially key to scale-up, in particular in rural settings. Studies demonstrate significant cost savings for the individual, the community as well as for the country –well-functioning, nurse-led models, will be central to further scale-up in the fast track period, but also can serve as a model beyond Zimbabwe.
- Integration: There is a need for the overall balance of support to be considered and to ensure a comprehensive and efficient response. For example, while some donors have shifted away from areas such as paediatric antiretroviral treatment, preferring to direct support through multilateral mechanisms, they have taken up other opportunities such as ensuring that interventions in new focus areas such as women and girls and gender-based violence, to have major impact on the HIV response.
- Prevention: There is a need to strengthen HIV prevention, particularly with regard to sexuality education and empowerment of women and girls. It was observed that there is a need to address social realities being faced by girls and young women. In school settings there is a need to provide realistic advice and empowerment. Among sex workers it was observed that many referred to their economic vulnerability from a young age and the lack of options— social protection efforts need to be ramped up. The Delegation was encouraged by the review of the sexuality education curricula by Ministry of Primary and Secondary Education which is designed to young people’s access to accurate information on HIV and sexuality.
- Addressing social and economic determinants: Buying and selling sex accounts for 12% of new HIV infections. Sex workers met during the visit cited economic reasons for their engagement in sex work and many shared that they are already living with HIV. Studies have shown prevalence of over 55% among sex workers in some areas. There is an urgent need to create alternative income generating opportunities for women and girls.
- Legal environment - the Delegation recognized that Zimbabwe has made significant strides in recent years, including the adoption of a public health approach, including services to reach population groups at risk at the margins of society, and as reflected in a court ruling at the end of May 2015 against the arrest of women for ‘loitering’.