



Zimbabwe

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KEY POINTS

1. Zimbabwe's HIV prevention and treatment efforts, including the initiation of new patients on ART, were essentially suspended in the second half of 2008 because of ongoing political and economic turmoil and a strike among health workers that started in October 2008 and closed many of the country's leading hospitals for more than three months.
2. The number of home deliveries increased in 2008, largely in tandem with the freefalling economy. As a result, far fewer mothers and their children had access to crucial antenatal care and prevention of vertical transmission services.
3. Health care workers and civil society actors appear not to be consistently and fully aware of infant feeding guidelines and are therefore unable to help women make realistic and fully informed decisions.

RESEARCH PROCESS AND METHODOLOGY

The research process included interviews with health ministry officials, hospital staff, managers of NGOs, representatives of UN agencies, medical practitioners, HIV-positive women who recently accessed the prevention of vertical transmission program, and PLWHA involved in advocacy work. Two focus group discussions were also conducted, in Gweru (10 people) and Chitungwiza (eight people). Members of the country team also reviewed key policy documents and monitored the local media for policy changes. (Note: Unless specified otherwise, "\$" refers to US dollar amounts.)

1. BACKGROUND INFORMATION

An estimated 131,000⁵⁹ patients were on ART in Zimbabwe by the end of 2008, a number that falls far short of that year's national target of 180,000. Of those on ART, 74,474 were women and 11,488 were children⁶⁰. One of the reasons that more women than men are on ART is that prevention of vertical transmission is a primary entry point to ART in Zimbabwe, and prevention of vertical transmission, until recently, was arguably the best-performing HIV prevention and treatment program.

The country's HIV prevention and treatment efforts were essentially suspended in the second half of 2008 because of ongoing political and economic turmoil and a strike among health workers that started in October 2008 and closed many of the country's leading hospitals for more than three months. By the fourth quarter of 2008, no other services, such as diagnostic tests and treatment of OIs, were being offered; as a result, no new patients were being initiated on ART.

In January 2009, Minister of Health and Child Welfare Dr. David Parirenyatwa announced that the government planned to place 290,000⁶¹ people on ART by December 2009, a target many dismissed as impractical given past failures and resource constraints. As one health ministry official noted, "We cannot put 160,000 people on treatment in less than 11 months." Unfortunately, the need continues to climb across the country. It is estimated that 1.3 million people are living with HIV and

59 2008, fourth quarter report. Summary presentation to the Operations and Disbursement Committee of the NAC Board.

60 Interview with Dr. Owen Mugurungi, head of the MoH's AIDS and TB Unit.

61 Dr. David Parirenyatwa, Minister of Health and Child Welfare, cited on Zimbabwe Broadcasting Corporation (ZBC) news bulletin, 5 January 2009.

“Zimbabwe’s health professionals are working under intense pressure and stress. They have too much to do, poor pay, a critical lack of supplies. What they are meant to do as doctors is just impossible.”

Peter Iliff, Zimbabwe Association of Doctors for Human Rights

that at least 260,000 are in need of ART now⁶². National HIV prevalence among people aged 15 to 49 is 15.6 percent; the comparable figure among women is 21.1 percent⁶³.

The constantly deteriorating economic situation has made life extremely hard for PLWHA, even those who are already on ART. Health centres have started charging fees in foreign currency, thereby pushing health services further out of reach for most people in an economy where the majority earn the local currency and live on less than \$2 a day.

Meanwhile, a cholera outbreak that killed more than 3,000 people between August 2008 and January 2009 diverted attention and resources from other health needs. This has resulted in further neglect of the crumbling health system, including HIV/AIDS services.

2. STATUS OF SERVICE DELIVERY AMONG AND FOR WOMEN

For a long time prevention of vertical transmission was the only strength of the otherwise severely weakened Zimbabwean health care system. The advent of provider-initiated counselling and testing (PICT), introduced in 2007 and currently being rolled out, bolstered and temporarily improved uptake of the prevention of vertical transmission program. The government estimated prevention of vertical transmission coverage to be around 80 to 90 percent towards the end of 2008⁶⁴, but the rapid scale-up was interrupted by the health workers’ strike and the worsening economic situation. That development further jeopardizes the stated goal of 100 percent prevention of vertical transmission coverage in the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2006-2010.

According to the 2008 fourth quarter report by the chief executive officer of the National AIDS Council (NAC), Dr. Tapuwa Magure, the number of women visiting antenatal clinics declined towards the end of the year. Also, the number of newborns exposed to HIV who receive nevirapine or other ARV prophylaxis is much lower in comparison with the number of mothers who were offered ARV prophylaxis. This gap has two main causes: limited follow-up of women who give birth at home, and many pregnant women’s limited access to ARV prophylaxis for their newborns.

Such shortcomings in program delivery can be seen in the brief analysis below of each of the four components of the country’s prevention of vertical transmission program: primary prevention; prevention of unplanned pregnancies; prevention of mother-to-child HIV transmission; and care and support for mothers and babies.

62 Dr. David Parirenyatwa, Minister of Health and Child Welfare, 2007.

63 UNAIDS Fact Sheet, World AIDS Day 2007.

64 Interview with Dr. Owen Mugurungi, head of the MoH’s AIDS and TB Unit.

PRIMARY PREVENTION

According to Albert Manenji, finance director at the National AIDS Council (NAC), Zimbabwe's behaviour-change strategy focuses on the promotion of condom use and abstinence. Implementers of the strategy assess the drivers of HIV in each community and then design appropriate responses. Activists, however, believe HIV prevention efforts among women are hindered by the severely limited availability of women-controlled prevention mechanisms, notably female condoms.

Concerns have also been raised about the effectiveness of prevention efforts among young girls in the current economic and political context. Hege Wagaan, a partnership advisor at UNAIDS in Zimbabwe, observed that although in the past girls could obtain useful prevention information at school through subjects such as life skills, such services have been compromised by a high drop-out rate among girls and the mass turnover of trained teachers. The link between the deterioration of the education system and the impact of HIV prevention efforts cannot be ignored.

Mary Sandasi, director of the Women and AIDS Support Network (WASN), noted as well that the deteriorating economic environment and lack of employment opportunities had forced an increasing number of women and girls into commercial sex work, thereby increasing their vulnerability to HIV infection. The impact of HIV prevention efforts has also been hobbled by the mass migration of people to neighbouring countries; this diaspora has exposed many children to sexual abuse and neglect by guardians. In addition, some of the young people are sexually abused en route to neighbouring countries. Young people in such situations are highly vulnerable to HIV infection in an environment where post-exposure prophylaxis is not easily available and accessible to victims of sexual assault⁶⁵.

PREVENTION OF UNPLANNED PREGNANCIES

The difficult environment has also affected family planning services such as access to contraception to prevent unintended pregnancies among HIV-positive women. Women and girls rarely have consistent access to condoms and other secure forms of contraception because distribution systems are failing, largely due to human resource challenges.

Women in Chitungwiza said they could no longer get free contraceptives from clinics because they were being diverted to the parallel market by corrupt health care workers⁶⁶. Rosa Nyathi, an activist, further noted that the increased use of foreign currency in the economy had worsened the situation; she said, for example, that a Norplant implant at a government hospital currently cost \$32⁶⁷.

65 Interview with Mary Sandasi, executive director of the Women and AIDS Support Network (WASN).

66 Focus group discussion with women from Utano Community Center, Chitungwiza, 28 January 2009.

67 Interview with Rosa Nyathi, an activist at the Zimbabwe HIV/AIDS Activists' Union (ZHAU).

Officials within the MoH said that the greatest weakness of the country's national family planning program was its dependence on external funding. The program virtually folded after donors started scaling back aid because of the political environment.

PREVENTION OF HIV TRANSMISSION FROM MOTHER-TO-CHILD

In line with the ZNASP, HIV testing is routinely offered to every woman who receives antenatal care. This effort has been further supported by the introduction and roll out of PICT, which assumes HIV tests will be administered unless women specifically “opt out”. Therefore, treatment is offered to all women who test positive for HIV and are not on ART. Most women receive a single dose of nevirapine during labour, while their babies receive liquid nevirapine within 72 hours after birth.

Dr. Owen Mugurungi, head of the MoH's AIDS and TB Unit, said that a more efficacious regime is being pilot-tested at selected centres. Under this arrangement, an HIV-positive expectant mother receives AZT from 28 weeks until delivery, coupled with a single dose of nevirapine during labour. The baby receives a single dose of nevirapine after birth and both the mother and child get Combivir (AZT+3TC) for seven days following birth. Mugurungi added, “All pregnant women should be offered HIV counselling and testing as well as a CD4 count test for those who are HIV-positive. If the CD4 count is 350 or below, they are immediately initiated on treatment.”

The prevention of vertical transmission program is institution-based and links women to facilities from the lowest community health centre to the highest referral hospitals as part of a continuum of services. It has been integrated into all ANC units, and staff who conduct deliveries have been trained in counselling, testing and drug administration. Clients have an option to choose between the maximum and the minimum package. The maximum package consists of counselling, testing, provision of ARV drugs and monitoring of the patient, while the minimum package only offers counselling⁶⁹.

An assessment of what is happening on the ground revealed that the quality and level of prevention of vertical transmission services offered at rural and urban health centres differs, with most services concentrated in urban areas even though 70 percent of the population is rural-based. For example, in Kwekwe district only two of the seven prevention of vertical transmission sites that offer the maximum comprehensive package are in rural areas.⁷⁰

68 Interview with Dr. Owen Mugurungi, head of the MoH's AIDS and TB Unit.

69 Interview with Gretel Mahere, a district nursing officer in Kwekwe, and focus group discussion with members of Volcano of Hope Support Group in Gweru.

70 Interview with Gretel Mahere, a district nursing officer in Kwekwe.

The overall public prevention of vertical transmission program has been severely compromised since early 2008 because of the collapse of the health delivery system, a situation characterized by lack of resources, dilapidated infrastructure and staff shortages. Many interviewees noted that when the country's systems were functioning effectively, the prevention of vertical transmission program was among the best in the southern African region. When it was operating well, structures were in place and they were supported by policy. Staff were trained and there was good monitoring while the MoH provided constant feedback and gathered data about the status of the program at each stage of the comprehensive care provision. However, by January 2009 the program was mostly a shadow of its former self across the entire country, even in the largest cities.

CARE AND SUPPORT FOR WOMEN, THEIR CHILDREN AND THEIR PARTNERS

In 2003, Zimbabwe introduced a PMTCT+ program, which looks beyond protecting infants from HIV and focuses more broadly on the provision of treatment and care for mothers and their families. However, this program has not been very effective due to resource constraints. Dr. Ima Chima of EGPAF pointed to a paediatric ART survey conducted by her organization revealing poor linkages between prevention of vertical transmission and ART sites. In addition, she said, there is no way of following up children who have been exposed to HIV⁷¹.

Mugurungi said the Clinton Foundation is supporting the purchase of paediatric drugs and that although the medicines are available, infant diagnosis remains a challenge. PCR tests, for example, are only available at a few central hospitals. Efforts are being made to follow up on babies born to HIV-positive mothers so that their status can be checked when they come for immunization. If the baby is HIV-positive, ART is initiated immediately.

Meanwhile, patients are being “herded” to church-related mission hospitals in rural areas, where health care workers generally display a better work ethic than do those in urban facilities. This is so even where public facilities that are supported by the Global Fund are better equipped and resourced than the mission hospitals, especially in the wake of the long strike that ended (at least technically) in January 2009⁷². The Global Fund currently supports facilities in 22 districts, all in rural areas. Money made available through Round 8 will be used to expand Global Fund-supported facilities into other districts, including in urban areas.

71 Dr. Ima Chima, findings from the Elizabeth Glaser Paediatric AIDS Foundation's National Paediatric ART Site Survey 2007. Presentation at Safaids Discussion Forum.

72 The health care workers' strike that began in October 2008 officially ended in January 2009. However, reports through March 2009 indicate that although health personnel are showing up for work again, they are not necessarily working. This implies that the strike persists for all intents and purposes.

Over the years, efforts have been made to establish referral systems linking clinics specializing in prevention of vertical transmission, VCT, OIs, TB, and STIs, all of which are entry points for expanded care. Anyone who tests positive at any of these points receives psychosocial support and is referred for ART⁷³. In addition, the MoH now has prevention of vertical transmission focal persons in some districts.

However, according to Bernard Nyathi, president of the Zimbabwe HIV/AIDS Activists Union (ZHAAU), the referral systems are not working well due to limited resources.⁷⁴ For example, the government ART program did not enrol new patients during the health workers' strike; therefore, it is pointless to refer people to centres where they cannot be treated. Lack of treatment access means there is little incentive for getting tested, including for pregnant women.

SUCCESS STORIES

All health care services, including those related to prevention of vertical transmission, are struggling to prevent further decline in access and effectiveness. There are some success stories that deserve mention, however, including the following (all of which were mentioned by respondents):

- According to Manenji from NAC, no patients are required to pay for services at facilities in rural areas that benefit from the Global Fund and Expanded Support Program (ESP), which is a pool fund by a number of bilateral donors (see below). This has resulted in universal access targets being reached in some districts; for example, in January 2009 there was no one on the ART waiting list in Matabeleland South province. (It is important to note, however, that this is the province that has seen the largest number of young people crossing into South Africa and Botswana for economic reasons.)
- Prevention of vertical transmission services in Chitungwiza reportedly are working well because male partners are involved in programs. Where men are incorporated into programs, incidents of violence and stigma are reduced. The mother is also assured of support should she decide not to breast-feed⁷⁵. The MSF polyclinic in Epworth has a counselling centre that seeks to include all family members, including fathers, mothers and children. This has worked well in helping families support each other, accept their HIV status and enrol for prevention of vertical transmission – although the program is overloaded⁷⁶.

73 Dr. Ima Chima, findings from the Elizabeth Glaser Paediatric AIDS Foundation's National Paediatric ART Site Survey 2007. Presentation at Safaids Discussion Forum.

74 Interview with Bernard Nyathi, president of Zimbabwe HIV/AIDS Activists Union (ZHAAU).

75 Focus group discussion with women from Utano Community Center, Chitungwiza, 28 January 2009.

76 Interview with Bernard Nyathi, president of the Zimbabwe HIV/AIDS Activists Union (ZHAAU).

“You cannot run a PMTCT program independently from the overall health program. If the health system falls apart, the PMTCT program will also fall apart.”

Hege Wagaan, a partnership advisor at UNAIDS in Zimbabwe

- Betseranai, an NGO in Mberengwa district, uses “PMTCT champions” to mobilize pregnant women and their partners for HIV testing. The use of locally recruited people living with HIV is appropriate and cost effective for the geographical area they cover. They use methodologies appropriate for the level of education and cultural context of the communities they work in. They also promote healthy behaviours in communities in terms of infant feeding.
- Zimbabwe still has one of the best networks for prevention of vertical transmission in the region. It is the only country in southern Africa to record a reduction in HIV prevalence, from over 30 percent in the 1990s to 15.6 percent in 2007, and prevention of vertical transmission contributed towards this. Most HIV-positive mothers who got advice about nevirapine and breast-feeding managed to prevent transmission to their infants, according to Dr. Paul Chimedza, a medical practitioner who specializes in HIV treatment⁷⁷.

BARRIERS TO COMPREHENSIVE SERVICE DELIVERY

Human resource shortages are the major barrier to women accessing prevention of vertical transmission services. While most public-sector health care workers who remain in the country are committed and conscientious, they are trying to function in extremely difficult circumstances. Many of them cannot even make it to work because their monthly salaries cover perhaps four days of transport fares.

Although efforts have been made to improve the remuneration of health workers through the harmonized retention scheme for workers, it is not likely to curb the brain drain. A scheme supported by the Global Fund, the Expanded Support Program (ESP) and other donors involved in health care systems strengthening aims to address distortions in the system where health workers at donor-funded institutions often earn more than their public-sector counterparts. Initiated in August 2008, the scheme covers 22,000 health care workers at various levels and pays an additional allowance to their monthly salary. Although the allowances initially were quite substantial, their value has been sharply eroded by the increased use of foreign currency in the economy. As a result, the current allowances have been described as “miserable” and still do not allow most recipients to cover basic living expenses.

A severe shortage of financial resources has also thoroughly crippled the health delivery system, resulting in a shortage of drugs and equipment as well as the inability to maintain and replace outdated and dilapidated facilities and infrastructure. Frequent stock-outs are experienced in public health centres and clients sometimes have to buy drugs, which should be provided for free.

⁷⁷ Interview with Dr. Paul Chimedza, a medical practitioner who specializes in HIV treatment.

Misappropriation of drugs is also a problem. A month's supply of drugs for triple-combination therapy costs about \$200 in the private sector, but is provided free of charge in the public sector. Seizing an opportunity to make money, some workers within the public sector pilfer drugs, reagents and other commodities for resale on the informal market after turning away patients by alleging stock-outs. Another supply-related problem results from the fact that some hospitals use the WHO staging system to place patients on ART, while others are more stringent and insist on CD4 count and liver function tests before placing patients on treatment. As a result, patients flock to hospitals that have less stringent requirements, leading to stock-outs due to demand.

Economic and social obstacles are also important in terms of women's ability to fully utilize all available services. The number of home deliveries increased in 2008 largely in tandem with the freefalling economy. High transport fares and hospital fees, both charged in foreign currency, compounded by the protracted strike by health care workers, have forced women to seek alternative services.

Delivery of services depends on availability and access. While there are government and NGO programs providing free ARVs, frequent stock-outs are experienced at rural health centres. In some cases where treatment is required, therefore, clients have no choice but to buy nevirapine (and many cannot afford it). Health workers at some facilities have resorted to issuing nevirapine to pregnant mothers so they can take the tablet at home once they go into labour. This causes problems as mothers at times take the tablets when they are in false labour, and sometimes other family members (often her husband) will take the nevirapine due to lack of adequate knowledge.

After delivery, women are then supposed to take their newborns to the health facility within 72 hours for the baby's nevirapine dose. However, some fail to raise the money for transport, an increasingly common situation because most services in Zimbabwe can now be obtained only by paying with US dollars or South African rand. Some have sufficient funds for transport, but still cannot reach health centres because transportation is hindered by poorly maintained roads. There is usually no follow-up of women who give birth at home, and many of them do not have access to ARV prophylaxis for their newborns.

It became clear soon after the initiation of the prevention of vertical transmission programs that social and cultural barriers also would hinder uptake. Ensuring male partner involvement and finding creative roles for men is important because failure to secure their support can diminish adherence. NAC, through its partners, is advocating for male participation in the program in order to protect spouses in the context of cultural issues such as breast-feeding⁷⁸.

78 Interview with Albert Manenji, NAC.

3. HIV TESTING: ACCESS AND OTHER ISSUES

Most VCT centres, commonly known as New Start Centres, in Zimbabwe are run by Population Services International (PSI). Facilities are largely accessible and available to the public, particularly in urban areas. However, uptake remains low and, according to the television program “Positive Talk”, only 20 percent of Zimbabwe’s adult population knew their HIV status in 2008⁷⁹.

One reason for the low uptake to date is that many people – particularly women who may be economically disadvantaged – cannot afford even the nominal fee for rapid testing charged by New Start Centres. Several activists also complained that VCT centres do not provide follow-up services themselves but instead refer those who test positive to the public health system for further attention, even when they know treatment is not available there.

4. INFANT FEEDING GUIDELINES AND TRENDS

The MoH’s guidelines on infant feeding recommend exclusive breast-feeding for six months followed by abrupt weaning and solid foods – or, for those who can afford it, exclusive breast-feeding for three months followed by formula feeding. The guidelines discourage mixed feeding⁸⁰.

The shortage of trained staff means that many pregnant women do not receive sufficient (if any) advice on infant training. Moreover, even women who are fully aware may not be able to comply with recommendations and/or be consistent with their feeding methods. Zimbabwe is in the midst of a prolonged famine in which more than half the population is in need of food aid. Women who cannot produce breast milk often find it difficult to obtain formula milk because it is not provided free of charge at most prevention of vertical transmission facilities, especially those in the public sector. In January 2009, 400 grams of formula cost \$10 and lasted three to four days, depending on the baby’s eating habits⁸¹. Some women have resorted to importing formula from neighbouring countries, where it is usually cheaper. However, this option is utilized only by the small number of women who have access to foreign currency and not the majority poor.

In addition, access to safe, clean water remains a problem for people in Zimbabwe, as evidenced by a recent cholera outbreak. A cumulative total of some 100,000 cases of cholera and more than 4,000 deaths had been confirmed between August 2008 and April 2009. The cholera outbreak points to a major challenge in terms of formula feeding because of the need for regular access to clean water to mix the formula. Many HIV-

79 “Positive Talk” television program, 8 February 2009.

80 Interview with Dr. Owen Mugurungi, head of the MoH’s AIDS and TB Unit.

81 Ibid.

positive women therefore have no option but to breast-feed even if they would prefer not to or over a period longer than recommended by most policies.

5. IMPACT OF VIOLENCE AND STIGMA

In 2007, the government enacted the Domestic Violence Act, which protects individuals from gender violence. Prior to this, violence against women was usually treated as a domestic issue and the police would not get involved in protecting women from abusive spouses.

That law is quite new, though, and its passage cannot conceal the reality that violence against women has long been among the most significant deterrents to uptake of prevention of vertical transmission. (Gender-specific violence is in fact one reason that many activists are lobbying to change the official name of the PMTCT program to prevention of parent-to-child transmission [PPTCT], a step that they think might ensure greater male involvement⁸².) As a result of violence or the threat or fear of violence, many women who get tested do not collect their results. There have been reports of women being abandoned after testing HIV-positive and reports of violence linked to a woman's HIV status.

Some respondents pointed to a possible silver lining in the economic crisis. They said it appeared that violence against women in general or because of their HIV status was less of a problem in some communities because people are focusing so intensively on the basics in life, such as getting enough food and other necessities.⁸³

HIV-related stigma remains strong in Zimbabwe, but several respondents said they perceived a lessening of stigma due to increased openness about HIV, particularly when people in leadership positions disclose their status. PSI has been running a campaign against stigma using community role models such as football players and church leaders, among others, who have disclosed their status and are now open about being HIV-positive. Improved access and greater availability—at least until relatively recently—to treatment also has made more people open about their status, a development that helps reduce societal stigma.

6. ASSESSING THE WORK OF GLOBAL AGENCIES

Most UN agencies channel their funding through the government so it is difficult to assess their individual contributions. However, it is clear that agencies such as UNICEF and UNAIDS have maintained a strong presence and contribute significantly in supporting the national response to HIV/AIDS. UNFPA leads the behaviour-change strategy process and covers

⁸² Interview with Hege Wagaan, partnership advisor at UNAIDS in Zimbabwe.

⁸³ Focus group discussion with women at Utano Community Center, Chitungwiza.

“People are being turned away from OI clinics even when their CD4 counts are low. When a health institution, a government-run clinic, turns away a person with a CD4 count of 35, what are we coming to?”

Stanley Takawona, secretary-general of the Zimbabwe HIV/AIDS Activists Union

36 districts⁸⁴. The Global Fund and ESP have been supporting human-resource retention and the ART program, thereby providing access to treatment for rural populations. Donors have introduced outreach to mitigate the challenges associated with prohibitively expensive transport fares. Some NGOs donate testing kits – although often they are accompanied by few or no reagents.

External support has been useful in shoring up an otherwise collapsed health system, although some respondents said the impact of such support is reduced somewhat because services are often duplicated. In this view, the agencies would be more effective from a collective standpoint if they spread their aid over diverse areas in order to have greater impact⁸⁵. Other observers, however, were far more complimentary. They said the agencies have operated relatively well in a very difficult operating environment, and that even limited success is important. A key obstacle to all donors’ recent efforts was the fact that NGOs were not allowed to operate in Zimbabwe for six months in 2008 after being deregistered by the government. That gap slowed down the work of both the organizations and their supporting partners.

7. RECOMMENDATIONS

As noted throughout this case study, Zimbabwe is currently experiencing an almost unprecedented economic and political crisis that has negatively affected all aspects of society, including the health care system. Improving the delivery of prevention of vertical transmission services therefore depends on a wide range of factors that are not easily quantifiable or even recognizable. The following recommendations should be considered with that caveat in mind:

- Civil society should support the MoH in improving communication and public awareness on prevention of vertical transmission by conducting treatment literacy programs that inform the public about vertical transmission, including where and how key services are available. Such programs also should include clear and objective information about the potential risks and benefits of breast-feeding for HIV-positive mothers, thereby helping many clients make better-informed choices for themselves and their children.
- Civil society should serve as a watchdog, monitoring the government’s efforts and ability to fulfil its responsibility of prevention of vertical transmission provision for all in need and ensuring that money allocated towards prevention of vertical transmission is used for that purpose.

⁸⁴ Albert Manenji, National AIDS Council (NAC).

⁸⁵ Interview with Angeline Chiwetani, an activist.

- The MoH should speed up the roll out of a more efficacious prevention of vertical transmission regime; improve delivery of ANC services; and strengthen the health care delivery system, including in regards to HIV care and testing. This should include guaranteeing that ARVs are available to everyone for free, as is done with TB drugs.
 - The MoH and partners should strengthen programs that involve males and other family members in prevention of vertical transmission service delivery. Also, traditional birth attendants should receive periodic training and monitoring to keep abreast of developments in prevention of vertical transmission.
 - The Ministry of Finance should allocate adequate funding to the MoH for strengthening the overall health service. The health sector should get the same prioritization that has been given agriculture.
 - The MoH should seek to ensure that guidelines on infant feeding are widely disseminated among the general population in both urban and rural communities. The ministry should also ensure that health care workers and civil society actors not only are aware of the updated guidelines and all issues related to infant feeding, but have information on strategies to help clients make realistic, fully informed choices.
 - The private-sector response needs to be improved, with workplace programs that cater for entire families rather than individual employees, who after all do not exist in a vacuum.
 - Global agencies should commit more resources towards health programs in Zimbabwe. The country receives the least support in the southern African region but has had the most effective programs with limited resources.
 - The donor community could support the MoH in providing formula to HIV-positive mothers who want or need it as part of the prevention of vertical transmission package. This would ensure that feeding options meet the WHO AFASS conditions. The provision of formula must, however, be accompanied by increased humanitarian support aimed at improving and ensuring access to safe, clean water.
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