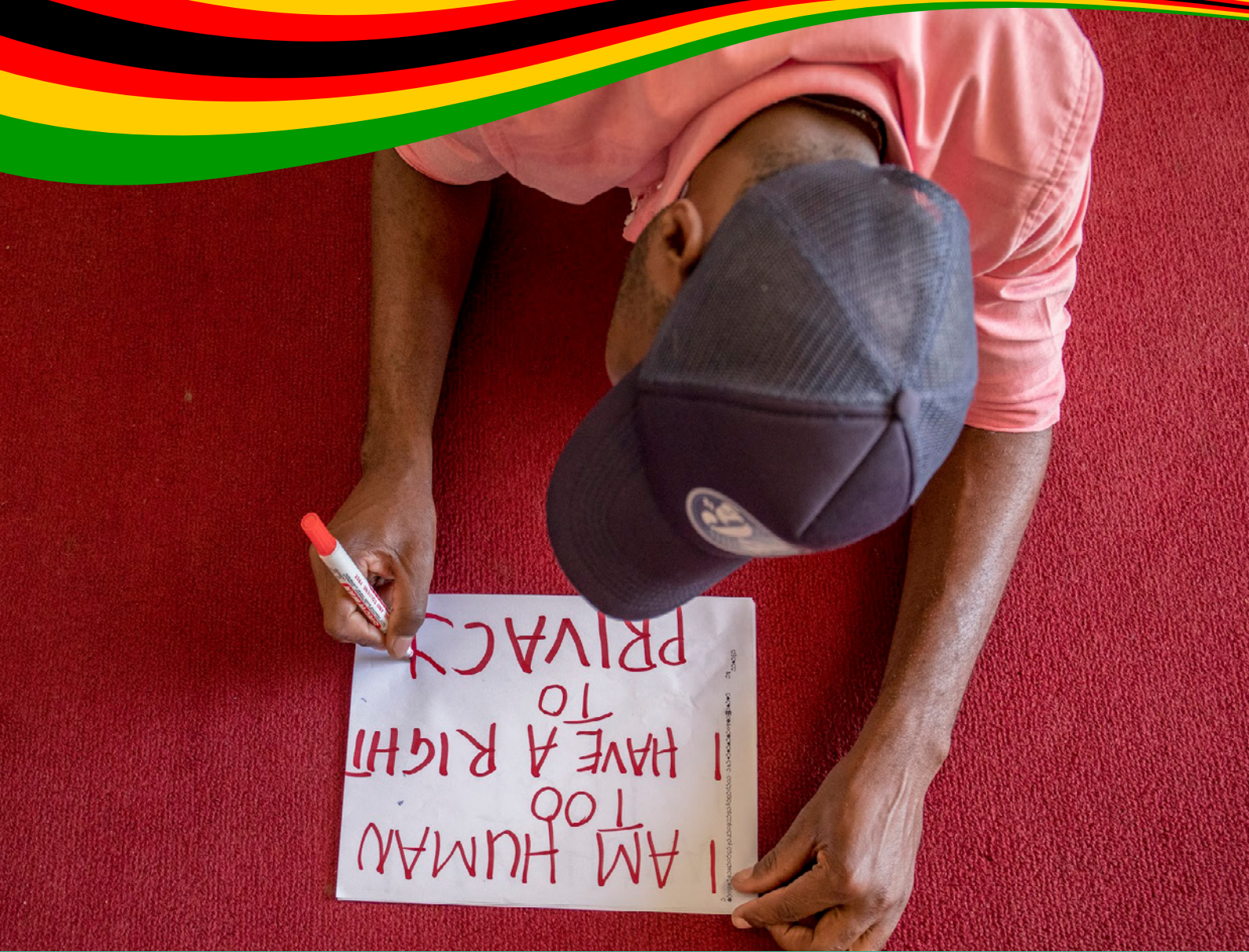
HIV and Social Protection Assessment in Zimbabwe



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July 2020

Acronyms and abbreviations

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
AMTO	Assisted Medical Treatment Order
ART	Anti-Retroviral Treatment
BEAM	Basic Education Assistance Module
DFID	Department for International Development
DREAMS	Determined Resilient Empowered AIDS-free, Mentored, and Safe women
DSW	Department of Social Welfare
FDMP	Food Deficit Mitigation Programme
GALZ	Gays and Lesbians of Zimbabwe
GDP	Gross Domestic Product
HDF	Health Development Fund
HIV	Human Immunodeficiency Virus
HSCT	Harmonised Social Cash Transfers
ILO	International Labour Organisation
ISALs	Income Savings and Lending Schemes
LGBTQ+	Lesbian, Gay, Bisexual, Transgender and Queer Community
MOPSE	Ministry of Primary and Secondary Education
MoPSLSW	Ministry of Public Service, Labour and Social Welfare
NAC	National AIDS Council
NATF	National AIDS Trust Fund
NCMS	National Case Management System
NGOs	Non-Governmental Organisations
NHS	National Health Strategy
NSPFF	National Social Protection Policy Framework
NSSA	National Social Security Authority
PA	Public Assistance
PEP	Post Exposure Prophylaxis
PLHIV	People living with Human Immunodeficiency Virus
PrEP	Pre-exposure Prophylaxis
PWD	Persons with Disabilities
PWP	Public Works Programme
TORs	Terms of Reference
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WB	World Bank
WCIF	Workers Compensation and Insurance Fund
WFP	World Food Programme
WHO	World Health Organisation
ZAN	Zimbabwe AIDS Network
ZNNP+	Zimbabwe National Network of People Living with HIV

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Acknowledgements

This assessment is the result of a collaboration of various institutions and individuals who all made essential contributions to the work presented in this report. The National AIDS Council (NAC) is grateful to the Joint United Nations Programme on HIV and AIDS (UNAIDS) for all the financial, logistical and technical support which was valuable in the undertaking of this assessment. Substantial strategic and technical input was also provided by Charles Birungi of the UNAIDS. Also, special meantion goes to Raymond Yekeye of the NAC who provided oversight and ably chaired the core study,analysis and report writing team (the Core Group). The NAC acknowledges the data, insights and support received from stakeholders and colleagues, including representatives from Government of Zimbabwe line ministries, departments and agencies, United Nations agencies and Networks of People Living with HIV and AIDS namely Zimbabwe National Network of People Living with HIV (ZNNP+), Zimbabwe AIDS Network (ZAN) and Zimbabwe People Living with HIV Coordinating Board. The NAC is also grateful to the consultants, Abel Blessing Matsika and Mutale Wakunuma, who supported this assessment

Foreword

The Government of Zimbabwe is committed to achieving the targets of international and regional agreements by setting ambitious goals within national policies and strategies with the aim to end the AIDS epidemic as a public health threat by 2030. Notably, concerted multisectoral efforts from all stakeholders have borne fruit with new HIV infections declining by 44% between 2010 and 2019. Also, AIDS-related deaths have declined by 61% over the same period. This is commendable. However, a lot of work still needs to be done to improve the HIV and AIDS situation in the country.

Over the last four decades, it has increasingly become clear that HIV and AIDS tend to drive people into poverty and also deepen inequalities in society. Generally, , there is a growing recognition that the national AIDS response is most effective when there are strong social protection programmes. To this end, social protection is particularly relevant to the national HIV response given that the scheme addresses the needs of key and vulnerable populations such as adolescent girls and young women; children; pregnant and lactating mothers living with HIV; persons in prisons and in other closed settings; migrants; refugees; displaced persons; orphans and other children made vulnerable by AIDS; people who inject drugs; sex workers; men who have sex with men; people with disabilities; and the aged.

This HIV and Social Protection Assessment aims to contribute to the discourse on how social protection can help reduce the likelihood of acquiring HIV, improving access and adherence to treatment as well as minimising the detrimental effects of the epidemic on individuals, families, communities and the national economy. This is even more urgent given the collision of the HIV and COVID-19 pandemics. These pandemics are major development challenges, with serious economic and social impacts requiring an inter-linked and dual approach to controlling the health pandemics while responding to their economic and social effects.

The information gathered from the assessment and described in this report is intended to support decision-making in strengthening the HIV-sensitivity of social protection programmes to better reach people living with HIV and those at risk of getting affected or infected by HIV. The findings will also help in the implementation of national strategies and programmes, including the fourth National HIV and AIDS Strategic Plan 2021-2025, investment cases, concept notes for funding and other social protection programmes. Undoubtedly, looking into the future, HIV-sensitive social protection will remain an indispensable part of any coordinated policy response to the unfolding crises as it increases resilience, contributes to preventing poverty and inequality whilst acting as a powerful economic and social stabiliser in times of crises and beyond.

I, therefore, urge all sectors, government ministries, departments and agencies, development partners, private and civil society organisations to join hands in the implementation of the recommendations emerging from this assessment to ensure that social protection programmes are HIV-sensitive. I would also like to thank all those who participated in this assessment, as the process was a reflection of joint efforts and collaboration in contributing towards the building back together of social protection measures through adaptationand flexibilityso as to address the social and economic effects of the HIV and the novel Corona Virus which casuse COVID-19.

Dr Bernard Madzima
Chief Executive Officer, National AIDS Council of Zimbabwe

Executive summary

This report is on an assessment undertaken to establish the extent to which Social Protection Programmes in Zimbabwe are HIV sensitive. Overall, Zimbabwe's social protection scope is fairly broad with a range of social protection schemes and programmes operational across the country. These include measures to provide financial security, social inclusion and access to social services. Zimbabwe's social protection instruments are clustered under social assistance; livelihood support and social support and care programmes; labour market interventions; and insurance-based contributory programmes.

To underwrite the programmes, both the legal and policy frameworks provide for social protection implementation. Section 30 of Zimbabwe's 2013 constitution obligates the state to "… take all practical measures, within the limits of the resources available to it, to provide social security and social care to those who are in need." The National Social Protection Policy Framework (NSPPF) provides a framework for the provision of social protection in the country.

This assessment is the first-ever attempt by the country to systematically understand how social protection and HIV and AIDS programmes are effectively linked. The assessment comes at a critical point in Zimbabwe's HIV and AIDS response, and could be critical in harmonizing the social protection and HIV sectors as Zimbabwe prepares its Global Fund Proposal. This period is crucial to introducing and integrating HIV and social protection for the purposes of catalyzing HIV prevention, mitigating impacts and reducing barriers to access health services for persons living with or affected by HIV and AIDS.

HIV-sensitive social protection ensures that the unique vulnerabilities and needs of PLHIV, at risk of HIV and of HIV affected households are integrated into social protection provision. Ensuring that social protection is HIV-sensitive will not only mitigate the socio-economic impact of HIV on PLHIV and their households, but it can also help the country to proactively think about access to social protection by PLHV. Hence, the overall purpose of this assignment was to conduct a social protection assessment with the aim of establishing availability, gaps, service providers, geographic coverage and whether the social protection schemes in Zimbabwe are HIV sensitive.

Analytical Framework and Approach

To conduct the assessment, the consultants used the UNAIDS methodology for the Social Protection and AIDS Assessment. This involved the development of the inception report, a literature review of key policy, programme and global literature on the subjects of HIV and AIDS, Social Protection and Health and virtual primary data collection using the HIV and Social Protection Assessment Tool developed by UNAIDS.

The tool was circulated to 20, purposively selected respondents from the Government of Zimbabwe, the National AIDS Council, UN Agencies and Networks of People Living with HIV and AIDS namely Zimbabwe National Network of People Living with HIV (ZNNP+), Zimbabwe AIDS Network (ZAN) and Zimbabwe People Living with HIV Coordinating Board. To augment the first round of data collection, the consultants developed a

Key Informant Interview Guide to supplement the data received through the virtual data collection. The virtual assessment tool and the KII Guide were designed to collect information on the HIV and AIDS, Health and social protection programmes currently under implementation in Zimbabwe, the extent to which the programmes are HIV sensitive and the barriers to access, that keep PLHIV and affected households from accessing them.

To analyse the data, the consultants used thematic analysis to extract the key issues from the findings from the key informant interviews and the HIV and social protection assessment data collection tool. The analysed data were used to inform the content and thrust of the report.

A key challenge to the completion of the assessment was the timing during which it was taken, which coincided with the global COVID-19 pandemic and the antecedent travel restrictions imposed by countries to manage the spread of the virus. The lockdown travel restrictions imposed in Zimbabwe and adherence to social distancing guidelines made it impossible to conduct the field visits, face to face key informant interviews, focus group discussions as well as convening an HIV and Social Protection Assessment workshop as the consultants had proposed in their inception report.

Findings

The NSPPF is only marginally HIV sensitive. While it was found both through the ratings by the study participants and an analysis of programme sensitivity that HIV and AIDSand its relationship to poverty and vulnerability were incorporated in the policy, , the assessment found that the policy was not sufficiently HIV sensitive. The majority of participants scored the policy's HIV sensitivity at four out of ten (average 4.6). However, there were, arguments indicating that the policy's reference to vulnerability was sufficient to encompass HIV and AIDS, yet potentially resulting in stigma and lack of inclusivity, particularly because of more emphasis given on HIV in a framework that is not exclusively an HIV and AIDS framework. It was also acknowledged that the key elements section contained in the policy could arguably be a significant part of the design and implementation of social protection and as such enable social protection programmes to reach persons living with or affected by HIV and AIDS.

A diverse range of social protection programmes are operational in Zimbabwe and are implemented by different actors including the government, UN Agencies and civil society organisations. On the whole,Zimbabwe recorded a total of 36 Social Protection programmes (35 currently operational) classified under seven categorisations including Social Assistance, Public Works, Fee Waivers, In-kind Transfers, Social Care Services, Labour Market Interventions and Social Insurance. An analysis of the active programmes (based purely on the number of programmes that are HIV sensitive rather than the quality of the sensitivity) shows that programmes under the categorization of Public Works and Fee Waivers are both 100% HIV sensitive, while social insurance programmes show the least sensitivity to HIV and AIDS.

Operational health schemes in Zimbabwe show that despite the socio-economic context stifling the provision of adequate health services, Zimbabwe has stayed committed to ensuring that HIV prevention, treatment and care programmes are available following the 2016 'Treat All Policy'. Zimbabwe is pursuing Universal Health Coverage through the National Health Strategy 2016-2020 as a way of tackling extreme poverty, social exclusion and gender inequity.

Zimbabwe maintains a fair number of health schemes to provide for PLHIV. Some of these programmes include the Health Development Fund (HDF); the Workers Compensation and Insurance Fund (WCIF); the National AIDS Trust Fund (NATF); the Assisted Medical Treatment Orders; and an ART programme. There are also available private sector schemes that support PLHIV. Two age-based schemes also cater for

children and the elderly; particularly free medical services for children under the age of 5 and free medical services for the elderly respectively. Lastly, to cover the informal economy which, to a large extent remains uncovered, the NSSA introduced a Voluntary Informal Sector Scheme which includes a Health Insurance Scheme and a Maternity Protection Scheme.

Several Barriers exist that hinder PLHIV, children and adolescents, prisoners, the working poor, particularly workers in the informal economy and key populations (men having sex with men and sex workers) from accessing social protection programmes. The barriers are different for different groups as well as for key and vulnerable populations. The barriers range from stigma, discrimination, structural barriers, access to information, mobility, poverty, discrimination, unemployment and precarious working conditions.

Recommendations

To improve the HIV sensitivity of Social Protection Programmes, the following were the recommendations given:

1. HIV sensitivity: Enhance HIV sensitivity of Social Protection Programmes from design through planning, implementation and evaluation by ensuring meaningful and active participation of different stakeholders at each stage.

2. Granular data: Generate HIV-specific data through regular and systematic HIV-sensitive analysis to understand inequalities and barriers to accessing social protection programmes.

3. Coordination: Enhance mechanisms for HIV and Social Protection Coordination to guide harmonization of the two policy fields, ensuring representation of people living with, at risk of and affected by HIV for more effective horizontal and vertical coordination between HIV and Social Protection.

4. Meaningful engagement and participation: The country will need to ensure the meaningful participation of people living with HIV as well as key populations in important processes that inform policy design, implementation and evaluation of social protection programmes.

5. Sustainable Financing: The government needs to facilitate resource mobilization for dedicated funding for HIV-sensitive social protection secured through a co-financing approach.

6. Life cycle approach to the provision of HIV Sensitive Social Protection: Because the groups typically excluded or facing significant barriers to access HIV sensitive social protection programmes are the ones that need them most, moving towards the life cycle approach will not only reduce stigma but also cater for diverse demographics on a universal basis.

7. Further research: As the data gap relating to the interaction between HIV, AIDS and Social Protection in the context of Zimbabwe, is abundantly clear, it will be prudent to invest in further research and generation of information to inform decision making and programme design.

Introduction

Through consistent and committed government leadership, Zimbabwe has registered a significant decline in HIV and AIDS prevalence. According to a 2019 UNAIDS report, significant progress has been made since 2010. New HIV infections decreased from 62 000 in 2010 to 38 000 in 2018[1] and deaths from AIDS-related illnesses fell from 54 000 in 2010 to 22 000 in 2018. Several factors have contributed to these important achievements, including reduced risky sexual behaviour, prevention of mother-child-transmission, increased use of condoms and scale-up of the national HIV treatment programme.

Zimbabwe is making remarkable progress towards the UNAIDS 90-90-90 targets; in 2018, 90% of PLHIV in the country were aware of their status and more than 95% of those diagnosed were on treatment[2]. However, rates of infection continue to be high with current statistics placing the prevalence at about 13%, although statistics on prevalence vary widely with most of the data estimating the number of persons - adults and children - living with HIV and/or AIDS between 1.2 to 2.0 million (GAM country report (2018), WHO (2005), Avert (2018)). The 2015 Demographic Health Survey places HIV prevalence at 13.8% among women and men age 15-49 (16.7% among women and 10.5% among men).

Similar to other countries in Southern Africa, the HIV epidemic in Zimbabwe has a precarious relationship with socio-economic development (Shelton et al., 2005). The epidemic is notorious for ravaging the most productive age group, thereby decimating a key demographic group that contributes significantly to the growth of the economy. This has left a number of households vulnerable and exposed, even more, to poverty and risk. According to a World Bank Social Protection Policy note (2014), 8% of households in Zimbabwe are recorded as having a chronically ill member, mainly due to HIV and AIDS (World Bank Social Protection Policy Note, 2014). A household member who is chronically ill can reduce the household income levels by as much as 30 to 35%, causing the households to be vulnerable (Barnett and Whiteside, in Gandure, 2009). Owing to this, impact mitigation constitutes a significant portion of the national HIV response. At the global level, greater thinking around mitigating impact has given rise to the discourse on social protection programming that is sensitive to HIV and AIDS. HIV-sensitive social protection ensures that the unique vulnerabilities and needs of people living with HIV, at risk of HIV and HIV-affected households are integrated into social protection provision.

The National Social Protection Policy Framework (NSPPF) provides a rich and comprehensive framework for the provision of social protection in Zimbabwe. The country's social protection scope is fairly broad with a range of social protection schemes and programmes that include measures to provide financial security, social inclusion and access to social services. The NSPPF identifies HIV and AIDS in its core values and key elements. The policy is cognizant of the effects that HIV and AIDS affected households are exposed to. tTherefore, it provides for households that are made vulnerable as a result of the epidemic; ensuring that such households receive careful consideration, based on equity and social justice principles as well as sensitivity to special groups.

1 https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/zimbabwe
2 Ibid

The definition of social protection in Zimbabwe is drawn from the Zimbabwe Economic Development Strategy (ZEDS, 2007) and contained in the NSPPF as "...a set of interventions whose objective is to reduce social and economic risk and vulnerability and alleviate poverty and deprivation". This is anchored on the transformative framework that classifies social protection into protective, preventive, promotive and transformative categorizations.

This assessment comes at a critical point in Zimbabwe's HIV and AIDS response and could prove critical in harmonizing the social protection and HIV sectors. The scope to do this does exist as the NSPPF includes people living with HIV and AIDS in the categorization of special vulnerable groups. Zimbabwe is currently developing its Global Fund proposal which will determine the character of the AIDS response over the next five years. This period is crucial to introducing, firming up or integrating HIV sensitive Social Protection, for purposes of catalyzing HIV prevention, mitigating impacts and reducing barriers to access for persons living with or affected by HIV and AIDS. In addition, this assessment is being undertaken during a period when the world has been hit by an unprecedented pandemic, the novel corona virus (COVID-19) global pandemic, which has virtually locked down the world and exposed the vulnerability that results from the failure to proactively provide social protection for vulnerable segments of the population.

Ensuring that social protection is HIV-sensitive will not only mitigate the socio-economic impact of HIV on people living with the virus and their households, but can also help the country to proactively think about access to social protection by persons living with HIV. Given Zimbabwe's socio-economic context, HIV sensitive social protection could be a key instrument in reversing poverty trends as well as playing a major role in the national AIDS response.

In view of the above, UNAIDS in Zimbabwe is supported the Government of Zimbabwe working with the National AIDS Council (NAC) and the Ministry of Public Service, Labour and Social Welfare (MoPSLSW) to undertake the assessment. The assessment is intended to review the current social protection landscape and determine the extent to which it is HIV sensitive and the barriers exist to prevent access to these programmes for persons living with HIV and AIDS. This assessment follows immediately after a comprehensive review of the social protection sector, conducted by OPM on behalf of the Government of Zimbabwe.

Figure 1: What is Meant by HIV-Sensitive Social Protection

What is meant by HIV-Sensitive Social Protection

"HIV-sensitive social protection programmes acknowledge and take action in addressing and removing barriers that exclude or make accessibility difficult for key population groups who are often marginalized by society or governmental systems—in particular sex workers, people who inject drugs, men who have sex with men, transgender people and, in some contexts, migrant populations. These actions could include the training of social protection service providers, reviewing and adapting policies and procedures that may create barriers and specific programmes designed for particular key population groups." (UNAIDS 2014)


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Analytical framework and approach

The assessment was undertaken over two months, between March and May 2020. While the overarching methodology was the UNAIDS' Social Protection and AIDS Assessment model, the implementation veered somewhat from the anticipated steps and processes to complete the assessment. This was made inevitable by the timing of the assessment which coincided with the global COVID-19 Pandemic and the antecedent travel restrictions imposed by countries to manage the spread of the virus. The lockdown travel restrictions imposed in Zimbabwe and adherence to social distancing guidelines made it impossible to conduct the field visits, key informant interviews, focus group discussions as well as convening an HIV and Social Protection Assessment workshop as the consultants had proposed in their inception report. Despite the COVID-19 disruptions to the methodology the consultants approached the assignment in line with the qualitative methodology suggested in the Terms of Reference (TORs).

The initial step in undertaking the assessment was the development of the inception report which detailed the consultants' understanding of the assignment and the proposed approach to conducting it.

This was followed by a literature review of key documents which included policy, programme and global literature on the subjects of HIV and AIDS, Social Protection and Health. The virtual data collection exercise was preceded by a review of relevant literature. A comprehensive, stand-alone report was produced, based on the findings from the literature as an initial product of the assessment to inform the Global Fund Proposal development process.

Primary data collection was conducted using the HIV and Social Protection Assessment Tool developed by UNAIDS. This tool was circulated to 20, purposively selected respondents from the Government of Zimbabwe, the National AIDS Council, UN Agencies and Networks of People Living with HIV and AIDS namely Zimbabwe National Network of People Living with HIV (ZNNP+), Zimbabwe AIDS Network and Zimbabwe People Living with HIV Coordinating Board. An additional layer of the data collection was a follow up on all respondents that submitted completed assessment tools. The follow up was based on a tailored Key Informant Interview Guide, designed by the team of consultants, based on the overarching structure of the UNAIDS Assessment Tool. Interviews were conducted with Government of Zimbabwe line Ministries, UN Agencies, including UNAIDS, UNICEF, WFP and ILO, the National AIDS Council, Zimbabwe National Network of People Living with HIV (ZNNP+), Zimbabwe AIDS Network and Zimbabwe People Living with HIV Coordinating Board. The virtual assessment tool and the KII Guide were designed to collect information on the HIV and AIDS, Health and social protection programmes currently being implemented in Zimbabwe, the extent to which the programmes are HIV sensitive and the barriers to accessing social protrection services for PLHIV and affected households.

To analyse the data, the consultants used thematic analysis to extract the key issues from the findings from the key informant interviews and the HIV and social protection assessment data collection tool. The analysed data were used to inform the content and thrust of the report.

The initial draft report was shared by email with UNAIDS and the review team for the assessment. This was done to solicit feedback from key stakeholders. The review team was composed of NAC, UNAIDS, Ministry of Public Service, Labour and Social Welfare (MoPSLSW) and ZNNP+. The final validated findings were then shared in a high level meeting of stakeholders relevant to HIV and AIDS and Social Protection in Zimbabwe. This was done to elicit high level support for the initiative to ensure Social Protection is more HIV sensitive.

Purpose of the Assessment

The findings of the assessment are intended to provide recommendations on how to better incorporate HIV in social protection programmes in Zimbabwe. The recommendations will also assist on how to expand the inclusion of eligible people living with, at risk of and affected by HIV into government social protection programmes. The assessment is designed to be a multi-actor process in order to ensure that the diversity of expertise enriches the perspectives and lays bare the intricate and varied realities and needs of people living with HIV and AIDS, households affected by HIV and AIDS, key populations and excluded groups.

Objectives of the assessment

The overall purpose of this assignment was to conduct a social protection assessment with the aim of establishing availability, gaps, service providers, geographic coverage and whether the social protection schemes in Zimbabwe are HIV sensitive. The specific objectives of the Social Protection and HIV assessment were as follows:

I. To conduct a comprehensive review and analysis of available social safety nets for PLHIV in Zimbabwe across all age groups and geographical locations.
II. To establish whether PLHIV, adolescent girls and young women at risk of HIV, key populations and other people at risk of contracting HIV are accessing existing social protection schemes.
III. To document the key barriers PLHIV and most at risk persons face in accessing social protection and recommend pragmatic and feasible remedial measures to eliminate these identified barriers
IV. To produce a social protection assessment report that will inform planning, resource mobilisation and delivery of social protection interventions aligned to the Global Fund Grant implementation in Zimbabwe.
V. To provide a comprehensive mapping of social protection services currently offered in the country clearly outlining the geographical and programmatic gaps.
VI. To complement the general social protection assessment done with a particular focus on HIV risk, vulnerabilities of PLHIV and identifying the gaps and proposals to address such.

Background and Context

Overview of HIV and AIDS in Zimbabwe

In Zimbabwe, the HIV epidemic remains one of the most critical public health and socio-economic concerns. With a prevalence of approximately 13%, there is still a long way to go to ensure that afew of the country's its population is affected by HIV and AIDS. Since the detection of the first case in the early 1990s, the country has increasingly emphasised prevention and treatment, particularly with the focus of the pre-2015 global 90-90-90 agenda. An increased focus on prevention and treatment would ideally lessen transmission and reduce prevalence rates. The population groups most vulnerable to HIV and AIDS in Zimbabwe are women, young people, sex workers and men who have sex with men. Although data for these vulnerable populations is hard to come across, these are the groups indicated in literature as populations disproportionately impacted by HIV/AIDS in Zimbabwe.

Gender is a critical consideration in Zimbabwe, as according to the Extended Zimbabwe National HIV and AIDS Strategic Plan III (ZNASP3) the epidemic remains largely feminized with women and girls bearing most of the burden and risk of HIV. An estimated 730 000 women were living with HIV in Zimbabwe and in the same year 19 000 women became HIV positive compared to 14 000 men[1]. Pervasive socio-economic inequality within relationships and marriages drives the high HIV infections among women. In this context, there is need to address gender vulnerability in relation to HIV and AIDS through social protection provision. Moreover, with a generalized epidemic, in Zimbabwe, most new infections occur as a result of unprotected heterosexual contact. The data also indicates that approximately one third of all new HIV infections in people above the age of 15 in Zimbabwe were among young people under the age of 24. There were 9000 new infections among young women; more than double the number of new infections among young men (4200[2]).

Prevention

With many tools for HIV prevention at the country's disposal, Zimbabwe has made manifest progress in reducing prevalence. New HIV infections decreased from 62 000 in 2010 to 38 000 in 2018 and deaths from AIDS-related illnesses fell from 54 000 in 2010 to 22 000 in 2018[3]. The cocktail of responses has ranged from education and information, condom distribution, VMMC, PEP and PrEP. As Lopman et. al (2007[4]) note, sexual risk behaviour is changing; condom distribution has increased, young people are delaying their sexual debut and there has been a reduction in numbers of casual partnerships.

As it relates to social protection, a number of researchers have predicted a shift in risk from the more affluent to the more indigent sections of the population, as the HIV epidemic progresses (Halperin DT and Epstein H., 2004[5]). If the projections hold true, the concern is that HIV would become an endemic of poverty in Zimbabwe (Lopman et. al, 2007[6]). This

1 UNAIDS 'AIDSinfo'

2 Ibid
3 https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/zimbabwe
4 Lopman B, Lewis J, Nyamukapa C, Mushati P, Chandiwana S, Gregson S. HIV incidence and poverty in Manicaland, Zimbabwe: is HIV becoming a disease of the poor?. AIDS. 2007;21 Suppl 7(Suppl 7):S57-S66. doi:10.1097/01.aids.0000300536.82354.52
5 Halperin DT, Epstein H. Concurrent sexual partnerships help to explain Africa's high HIV prevalence: implications for prevention. Lancet. 2004;364:4–6.
6 Lopman B, Lewis J, Nyamukapa C, Mushati P, Chandiwana S, Gregson S. HIV incidence and poverty in Manicaland, Zimbabwe: is HIV becoming a disease of the poor?. AIDS. 2007;21 Suppl 7(Suppl 7):S57-S66. doi:10.1097/01.aids.0000300536.82354.52

puts into context the delicate relationship between HIV and the socio-economic condition of individuals and households. Thus, this relationship must be understood from the perspective of social protection and HIV and AIDS, not only for impact mitigation but also as a catalyst for prevention.

Treatment

Access to Anti-Retroviral Treatment (ART) has increased significantly in Zimbabwe. According to Avert.org[7], 95% of all people who are aware of their HIV positive status are on treatment which translates to about 88% of all HIV positive individuals in the country. As of 2018, an estimated 1,086,674 people were receiving antiretroviral treatment. However, access to treatment is still limited for certain groups and demographics, and data on specific populations' access to treatment is scarce, due to legal barriers.

Most links made between Social Protection and HIV treatment refer to treatment uptake and adherence. As Temin (2010) observes, there is evidence that social transfers have beneficial outcomes on nutritional recovery for care recipients that are on HIV and/or TB treatment. In developing economies, Temin (2010) found that HIV infected persons commence treatment at points when their CD4 counts are extremely low and by which point the wasting caused by HIV exacerbates the under-nutrition[8].

Fairly new data drawn from Uganda demonstrating how cash transfers help improve treatment adherence and also drawn from Malawi show that commencement of Voluntary Counseling and Testing points to the possibility of contributing to access to treatment and greater outcomes. Having adequate food could similarly help care recipients to better tolerate medication, making the availability of food a fundamental requirement for adherence.

The range of social health protection measures such as social health insurance, removal of user fees, e.t.c., that increase the reach of healthcare, remain pertinent for affording treatment, and have been applied in Zimbabwe to different extents. However, major concerns still remain about low coverage of some of these schemes as they are rarely provided on a universal basis and where contributions are required a significant portion of the poor and workers in the informal economy are left out. This was pointed out by one of the key informants in the assessment as cited below:

Figure 2 - Respondent Quotation

> *"The National Social Protection policy is fairly HIV sensitive and so are some of the programmes which PLHIV benefit from. However, these are not provided to all PLHIV…"*
> Study respondent living with HIV

One of the main gaps in providing comprehensively for access to treatment and adherence is failing to provide cover for transport costs which often keeps the ultra-poor from accessing health facilities and the associated services. Difficulties in accessing food by recipients of care also affect treatment and adherence to ART. Though there is a food deficit mitigation programme its coverage is not universal for recipients of care.

Health System Response

The Health Service Act provides the overarching legal framework for Zimbabwe's healthcare system. The state of the health system is a key consideration as it has a bearing on the delivery of HIV services and performance of programmes intended to reverse the trajectory of the epidemic (Chevo and Bhatasara, 2012[9]).. In response to the pandemic, Zimbabwe's health system has subsidized medical costs for PLHIV (WHO, 2015[10]).

7 Ibid
8 Temin, M. 2010. HIV-Sensitive Social Protection: What Does the Evidence Say? UNAIDS, UNICEF, IDS.

9 Chevo, T. and Bhatasara, S. 2012. HIV and AIDS Programmes in Zimbabwe: Implications for the Health System. International Scholarly Research Network ISRN Immunology Volume 2012, Article ID 609128, 11 pages doi:10.5402/2012/609128
10 WHO. 2015. "A comparative analysis of national HIV policies in six African countries with generalized epidemics". WHO. Retrieved

In 2018, approximately 95% of HIV positive expectant mothers in Zimbabwe received ART for prevention of transmission from mother to child (Avert.org, 2020[11]).

Additionally, the state has used law and policy measures to address discrimination and facilitate access to treatment. However, the economic downturn that has distressed most social and economic sectors in Zimbabwe has not spared the health system (UNAIDS, 2018[12]). The provision of healthcare services has been severely affected by the economic context, majorly affecting access and quality of healthcare as well as the well-being of PLHIV. Ultimately, most health indicators have either stagnated or deteriorated and where there are improvements, these remain minimal. The health system, which is supposed to assist in improving these health indicators, is plagued by underfunding and staff retention challenges.

Financing

Primarily, health sector financing in Zimbabwe is covered by the state, users (individual or households), employers and development partners. According to ZEPARU (2014) as at 2010, 39% of health financing was paid by households, followed by employers (21%), external funders (19%), and Government (18%). This data demonstrates that there is a high out-of-pocket demand on users of the health care system which could be catastrophic to household incomes. The reduced health expenditure by government is insufficient to guarantee adequate access and quality of health care. The high user-borne costs are also indicative of limited social insurance mechanisms. This also constitutes one of the most formidable barriers to access to health care, particularly among poor households and those in the informal economy.

Official Development Assistance has contributed significant resources to the AIDS fight in Zimbabwe. Foreign donor funds account for over 65% of HIV spending. For HIV and AIDS financing, Zimbabwe has ten times fewer resources for AIDS per capita than other countries in sub-Saharan Africa. Political commitment and sustainable financing of the AIDS response are critically required to apply existing knowledge and methods effectively.

Barriers Faced by Key and Vulnerable Populations

The barriers that key and vulnerable populations face in Zimbabwe range from economic to cultural, social and legal barriers. All these come into play to keep important population groups from accessing the required HIV and AIDS services. Women, for instance, are kept back by the age-old socio-cultural constraints and gender norms, and sex workers in Zimbabwe are stigmatized and face discrimination that precludes them from accessing prevention and treatment options. A study in Bulawayo corroborated this finding revealing that male sex workers in Zimbabwe reported experiencing additional barriers to HIV/AIDS assistance due to the increased stigma of homosexuality and sex work. Lastly, men who have sex with men are legally excluded as Zimbabwe criminalizes sexual relations between men. This is contained in section 73 of the Criminal Law Act. This also extends to the way the government recognizes the gay community in policy and strategic documents on the AIDS response. The gay community is not formally recognized by the government as a key population for HIV prevention and care. The non-governmental organization GALZ reports that official statistics for same-sex transmission are not collected by the government. Restrictive aspects within the legal system combined with stigmatizing social norms pose barriers to treatment access for these communities. A 2016 study addressing access to general health services in Zimbabwe suggests that further education on LGBTQ+ issues in the healthcare sectoras well as sensitivity training for clinical interviewers are crucial to addressing existing barriers to treatment for key and vulnerable populations, for example, members of the LGBTQ+ community and sex workers.

2020-04-27.
11 Avert.org. 2020. HIV and AIDS in Zimbabwe. Available at https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/zimbabwe
12 UNAIDS (2018). GLOBAL AIDS RESPONSE PROGRESS REPORT 2018 - FAST-TRACK COMMITMENTS TO END AIDS BY 2030


I HAVE A RIGHT
TO HAVE A
FAMILY

Overview of Social Protection in Zimbabwe

Zimbabwe's current socio-economic environment gives rise to a variety of risks and vulnerabilities. The extent of poverty is dire with 2017 estimates placing poverty in Zimbabwe at 71% of the poverty line. The distribution of poverty also shows a significant divide between rural and urban with extreme poverty being approximately 30% in rural areas compared to 6% in urban areas.

Legal and Policy Framework

In Zimbabwe, social protection places a heavy emphasis on poverty reduction. However, the National Social Protection Policy Framework (NSPPF) attempts to extend social protection beyond the poverty alleviation focus to make it a more comprehensive transformative framework. With this, different vulnerable and excluded groups are identified as target populations for social protection. These typically include women, persons with disabilities, people living with HIV, children, the elderly as well as key and vulnerable populations. Nonetheless, with time there is increasing recognition that beyond its poverty reduction capacity, social protection can help achieve broader national development objectives and human capital development outcomes. For instance, when social protection is linked to access to essential services such as health and education, it is anticipated that socio-economic and human capital development will be attained.

Most social protection schemes in Zimbabwe are implemented by the government, with support from cooperating partners. The mandate for social protection sits with the Ministry of Public Service, Labour and Social Welfare (MoPSLSW). A few informal or community-led schemes are also found in Zimbabwe. Social protection instruments include social assistance programmes, livelihood support and social support and care programmes, labour market interventions and insurance-based contributory programmes. In the policy, programmes are placed under five distinct pillars including social assistance, social insurance, labour market interventions, livelihoods support and social support and care. However, the policy acknowledges that the prolonged weak economic performance has had detrimental effects on the provision of social protection services in Zimbabwe. This has translated into low coverage of population groups that should benefit from social protection.

The legal framework too guarantees the right to social protection. Other than Zimbabwe having signed onto several international and regional instruments that promote social protection, the country has enshrined the right to social protection in its national constitution. Section 30 of Zimbabwe's constitution obligates the state to "… take all practical measures, within the limits of the resources available to it, to provide social security and social care to those who are in need." According to the NSPPF, the right to Social Protection is also upheld in the Bill of Rights from sections 80 through 84, although the guarantee is only explicitly mentioned in section 82 (c) under rights to the elderly and in section 84 conferring rights to veterans of the liberation struggle. However, while Zimbabwe does recognize social protection in the constitution, it is not a justiciable right.

The NSPPF recognizes the impact that HIV and AIDS have on human capital development and the potential to exacerbate vulnerability at the household level and also plunge households into poverty. A study by Senefeld and Polsky (2006)

found that households with a member living with HIV and/or AIDS suffered higher livelihood insecurity than their unaffected counterparts[1].

Social Protection Programmes

Programme-wise, Zimbabwe has a range of formal contributory and non-contributory programmes and some informal social protection programmes.

Formal Non-contributory Programmes

Formal non-contributory programmes include the ***Basic Education Assistance Module (BEAM)*** established in 2001, a means-testing public scheme that provides school fees for children from poor and vulnerable households; the ***War Victims Compensation Fund*****:** The War Victims Compensation Act of 1980 provides for compensation for injuries or the death of persons, which was caused by the war of liberation; the **War Veterans Fund:** War Veterans Act (Chapter 11:15) of 1996 provides for assistance to war veterans and their dependents; veterans of the armed struggle receive monthly payouts and their children's school fees are paid for from the fund; the ***Assisted Medical Treatment Order (AMTO),*** a means-testing non-contributory scheme financed by the Government of Zimbabwe through the Department of Social Welfare to pay health bills of indigent persons; the ***Harmonised Social Cash Transfers (HSCT)*** *which* is a poverty targeted intervention focused on labour-constrained households, introduced in 2011 largely at the instigation of development partners. Other programmes

1GAM ZIMBABWE COUNTRY REPORT Reporting Period: January 2017 - December 2017, https://www.unaids.org/sites/default/files/country/documents/ZWE_2018_countryreport.pdf

Senefeld, S; and Polsky, K. 2006. Chronically Ill Households, Food Security, and Coping Strategies in Rural Zimbabwe. In AIDS, poverty, and hunger. Gilespie, Stuart (Ed.). Chapter 7. Pp. 129-140. Washington, D.C.: International Food Policy Research Institute (IFPRI). http://ebrary.ifpri.org/cdm/ref/collection/p15738coll2/id/129569

include the ***Food Deficit Mitigation Programme (FDMP),*** the ***National Case Management System (NCMS),*** a tool for child protection coordination and implementation; ***Support to Older Persons,*** a public non-contributory means-testing scheme funded by the Government which caters for the needs of institutionalised older persons above the age of 65 years; ***Public Assistance (PA)***, a programme established in 1989 that provides grants to 'destitute' or 'indigent' persons meeting one of several criteria; the ***Support to Persons with Disability*** grants to institutions housing persons with disability countrywide to make provision for their welfare and rehabilitation and the ***Drought Relief Public Works Programme (PWP)*** which provides free cash assistance to the elderly, chronically ill and persons with disability. The able-bodied benefit on condition that they participate in community projects for a 15-day working month. The only HIV-specific programme of the non-contributory programmes is the ***Free HIV drugs in public institutions for People Living with HIV*** which is funded by the AIDS levy introduced in 1999 and administered by the National Aids Council.

Other than the non-contributory programmes, Zimbabwe also has a range of formal contributory programmes including the Social Security Schemes administered through the ***National Social Security Authority (NSSA)***. NSSA currently runs two compulsory schemes: the Pension and Other Benefits Scheme (POBS), also known as the National Pension Scheme, and The Accident Prevention and Workers' Compensation Insurance Fund. Other than the NSSA schemes, Zimbabwe also has ***Private Medical Aid schemes*** which are employment-based contributory schemes where both employers and employees contribute. They are aimed at providing access to health services by employees when they fall ill.

Informal Social Protection Arrangements

Three main informal social protection arrangements are recorded in Zimbabwe which include ***Burial Societies, Income Savings and Lending Schemes (ISALs)*** and ***Zunde raMambo/Insimu yeNkosi.*** Burial Societies target those in the informal economy and involve pooling resources together to provide financial assistance to members in the event of death or illness. *ISALs* are another form of informal social protection arrangement in which a group of people come together to save money every month and borrow against these savings at low interest rates. Lastly, the ***Zunde raMambo/Insimu yeNkosi*** is a traditional method of caring for orphans in Zimbabwe that is one of the responsibilities of traditional leaders. This is a collective field that is worked by the community under the leadership of the Chief and the Village Heads for the benefit of indigent persons, specifically orphans.

HIV, AIDS and Social Protection

Other than the Free HIV drugs in public institutions for People Living with HIV, two main programmes are explicitly programmed to address HIV and AIDS. These are the **Determined Resilient Empowered AIDS-free, Mentored, and Safe women (DREAMS)** and the **Expansion and Scale-Up of HIV-Sensitive Social Protection.** These are discussed below. DREAMS is a project under PEPFAR which focuses on HIV and AIDS interventions targeting Adolescent Girls and Young Women (AGYW). The **Expansion and Scale-Up of HIV-Sensitive Social Protection i**s a UNICEF ESARO supported programme which is being implemented in Malawi, Mozambique, Zambia and Zimbabwe[2]. In Zimbabwe, activities under the initiative focuson strengthening the existing child protection case management system and ensuring effective linkages between the Harmonized Social Cash Transfers (HSCT) and access to additional services.

2 Evaluation of Expansion and Scale-Up of HIV-Sensitive Social Protection in Eastern and Southern Africa

2 Evaluation of Expansion and Scale-Up of HIV-Sensitive Social Protection in Eastern and Southern Africa 2014-2018 Report. UNICEF,2018

Social Protection in the Informal Sector

People working in the informal economy are vulnerable to impoverishment, hunger and disease as they lack the necessary social protection coverage and support mechanisms if they lose their livelihood. Their vulnerability is mainly due to low and erratic income patterns and very difficult working conditions. Most of the informal business operations face regulatory hurdles that classify them as 'illegal' and are subjected to frequent harassment from law enforcement agents. The current COVID-19 induced national lockdown measures have severely affected the operations of the informal economy thereby depriving them of the participant's sources of income. This has exacerbated the vulnerability of people dependent on the informal economy for their livelihoods. At a regional level, the COVID-19 pandemic has affected the informal economy by curtailing cross-border trade. Informal cross-border trade (ICBT) constitutes a major form of informal activity in most African countries (FAO, 2017[3]), Zimbabwe included.

Despite the high number of people earning a living from the informal sector and the associated vulnerabilities, Zimbabwe does not currently have fully operationalised regulated national schemes for the informal sector. However, the National Social Security Authority (NSSA) through Statutory Instrument (SI) 50 of 2018 promulgated the establishment of a national regulated scheme for the informal sector. The Informal Sector scheme comprises three voluntary schemes - Informal Sector, Health Insurance and Maternity Protection. It will also include a retirement grant, survivor's grant, invalidity pension, invalidity grant and maternity cover as benefits. The Health Insurance and Maternity Protection Schemes will cover health needs and are also intended to cover access to HIV related services.

3http://www.fao.org/3/a-i7101e.pdf

Financing

Financing remains a key constraint for social protection. According to the Zimbabwe expenditure review (World Bank, 2016), Zimbabwe's expenditure on social protection nears 5% of GDP, which puts it ahead of many countries in the region. However, on close analysis, the distribution of social protection expenditure reveals that the larger share of this expenditure barely reaches indigent populations (67% of the social protection share funds civil service pensions which constitutes only 1.3% of the population[4]). To the contrary, programmes that cover the poor and vulnerable rely significantly on funding from donors, which itself has remained in steady decline over the years. Added to this, inefficiencies resulting from fragmentation, systemic and programmatic procedures, increase administrative costs even for programmes that would otherwise reach the intended beneficiaries[5].

4 Government of Zimbabwe; World Bank. 2016. Zimbabwe Public Expenditure Review: Volume 5. Social Protection. World Bank, Washington, DC. © World Bank. https://openknowledge.worldbank.org/handle/10986/27903 License: CC BY 3.0 IGO.
5 Ibid

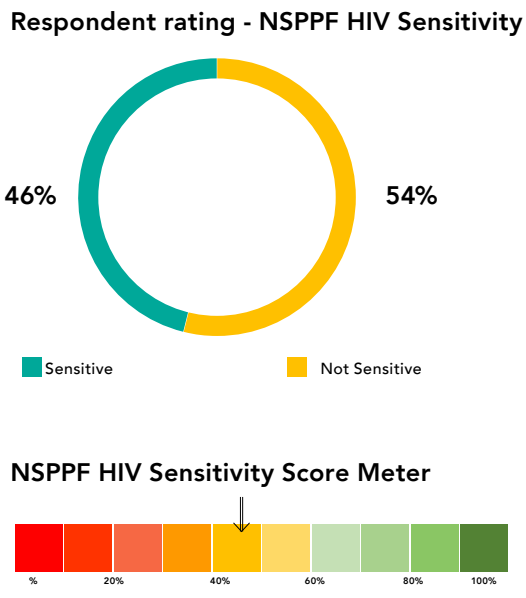

YOU

Findings

HIV-sensitivity of the Social Protection Policy

In general, the NSPPF in Zimbabwe does provide a comprehensive framework for holistically addressing vulnerability and poverty, using the transformative framework, which encompasses protection, prevention, promotion and transformation. However, using a Likert scale, study participants felt that the policy was not sufficiently HIV sensitive with the majority scoring its HIV sensitivity at four out of ten. Overall, the policy was found to be minimally HIV sensitive, receiving an average score of 4.6 out of a possible 10 points. This is represented in the Figure 3 below:

Figure 3 - Average Rating - NSPPF Sensitivity



Also, the key elements section contained in the policy could arguably be a significant part of the design and implementation of social protection and as such enable social protection to reach persons living with or affected by HIV and AIDS. However, the policy falls short on some counts that would make it perfectly sensitive to HIV and AIDS. For example, while there is a recognition that HIV does put households at risk and erodes the incomes of households, the pillars of the policy barely ever identify such households or persons as deliberate programme targets. Within the pillars, HIV and AIDS are not explicitly mentioned in the objectives which could suggest a blindness to responding to HIV and AIDS.

There were, however, arguments indicating that the policy's reference to vulnerability was sufficient to encompass HIV and AIDS particularly because a greater emphasis on HIV in a framework that is not exclusively an HIV and AIDS framework may result in stigma and reduce its inclusiveness.

Existing Social Protection Schemes

Regarding the programmes and schemes under social protection, a diverse number of programmes are operational in Zimbabwe and are implemented by a range of actors including the government, UN Agencies and civil society organisations. Similarly, the programmes target different segments of the population, depending on what the programme objectives are. Some of

the listed beneficiaries includeadolescents, women, the elderly, persons with disabilities, PLHIV – both youths and adults.

The benefits offered in these programmes are also diverse and are aimed at yielding different outcomes. These benefits are both monetary and in-kind benefits such as sanitary pads, food rations and cash transfers or allowances.

Target Beneficiaries of Social Protection Programmes

In terms of selection of beneficiaries, different programmes apply different selection criteria to reach a selected portion of the population. The range of selection methodologies includes community-based targeting, proxy means tests, geographic and categorical targeting. Table 1 below presents this in further detail.

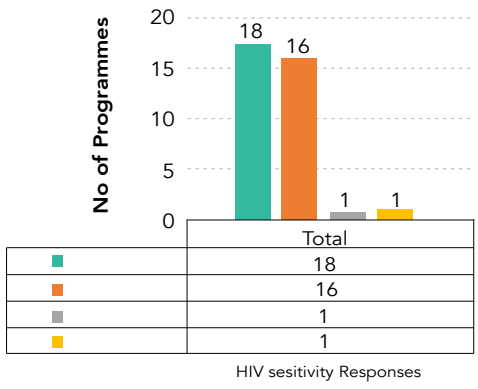
					Benefit Provided
SOCIAL ASSISTANCE					
CASH TRANSFERS	EXECUTING AGENCY	TARGET GROUP	HIV Sensitivity	TARGETING MECHANISM	Benefit
Public Assistance	MoPSLSW / DSW	Support to elderly and disabled poor and indigent families	YES	Means-tested	Cash transfers
Harmonized Social Cash Transfer	MoPSLSW/ DSW	Food poor labour constrained households	YES	Proxy Means Test	Monthly cash transfers
Transfers to Heroes' Dependents	MoPSLSW/ DSW	Surviving spouses and minor children of National Heroes	No	Categorical	Cash transfers, medical/ miscellaneous assistance
Support to Children in Difficult Circumstances	MoPSLSW/ DSW	Orphans, physically and mentally handicapped, homeless and delinquent children in institutions	No	Means tested	Monthly cash transfers and material assistance (e.g. wheelchairs)
PUBLIC WORKS					
Food Mitigation Programme	MoPSLSW/ DSW	Food poor labor endowed households	Yes	Geographic and self-targeting	Cash in return for work
Public Works Programmes	USAID, WFP, DFID, WB, NGOs	Food poor labor endowed households	Yes	Geographic and self-targeting	Cash in return for work
FEE WAIVERS					
BEAM	MoPSLSW/ DSW	School age children	Yes	Community	Fee waivers for primary and secondary education; secondary examination fees
Assisted Medical Treatment Order	MoPSLSW/ DSW	indigent persons over sixty, handicapped, long-term ill, dependents of destitute, OVCs	Yes	Categorical and means tested	Fee waivers for intermediate and tertiary health services
IN-KIND TRANSFERS					
School Feeding	MOESAC	Students in food insecure areas	Yes	Geographic	Cooked meal

					Benefit Provided
Food distribution	GVT/NGOS/ WFO	Rural and Urban	Yes	Geographic	Dry rations
Seasonal Targeted Assistance	WFP	Rural transitory food insecure	Yes	Geographic and community	Food rations
Health and Nutrition Safety Net	WFP	Malnourished HIV/AIDS, TB, pregnant women and children 0 – 5 years old	Yes	Categorical	Food rations
Public Assistance Paupers Burial	MoPSLSW/ DSW	Deceased paupers	Yes	Means tested	Burial Grant
Bus Warrants	MoPSLSW/ DSW	Transport	No longer available	National	Transport
Agricultural Input Support Scheme	MOA	Households in Rural Areas	No	Not available	seed and fertilizer (coupons and in-kind)
Assistive Devices	MoPSLSW/ DSW	Disabled Persons	NO	Categorical	
Transfers to Refugees	MoPSLSW/ DSW	Refugees	YES	Categorical	Material and cash transfers
SOCIAL CARE SERVICES					
Homes for the Elderly	MoPSLSW/ DSW	Elderly	No	Categorical	Institutional Grants
Homes for the Disabled	MoPSLSW/ DSW	Disabled	No	Categorical	Institutional Grants
Homes for Children	MoPSLSW/ DSW	Vulnerable Children	No	Categorical	Institutional Grants
Children living on the streets	MoPSLSW/ DSW	Children living on the streets	No	Categorical	
Psychosocial Support for Children	MoPSLSW/ DSW / UNICEF/NGOs	Vulnerable Children	No	Categorical	
Foster Care	MoPSLSW/ DSW	Vulnerable Children	Yes	Categorical	
Children on the Move	MoPSLSW/ DSW	Vulnerable Children	No	Categorical	
LABOR MARKET PROGRAMMES					
Vocational Training Centers	MOYIE	Unemployed youth	Yes	Self-targeted	Skills training
Youth Entrepreneurship	MOYIE	Unemployed youth	Yes	Self-targeted	Entrepreneurship Training and Micro-finance
Second Chance Education	MOESAC	Out of school children and youth	Yes	Self-targeted	
National Employment Center	MoPSLSW/ DSW /DL	Unemployed job-seekers	No	Self-targeted	Job search assistance
Micro Enterprise Development Programme	MoPSLSW/ DSW	Self-employed	No	Self-targeted	Micro-finance
SEDCO		Self-employed	No	Self-targeted	Micro-finance

					Benefit Provided
Disability Loans	MoPSLSW/ DSW	Persons with Disability	No	Categorical	Loans
Maintenance of Disabled Persons	MoPSLSW/ DSW	Persons with Disability	No	Categorical and means tested	Disability aids, training, project loans
SOCIAL INSURANCE					
Pensions and Other Benefits Scheme	NSSA	Formal sector working persons between ages 16 and 65 years who are citizens or residents of Zimbabwe	No	Contributory	retirement, invalidity, survivor's pensions or grants, funeral grant, maternity benefit
Accident Prevention and Workers' Compensation Scheme	NSSA	All workers except in government and private domestic employment are covered by the scheme.	No	Contributory	Cash benefit to employees and their dependents when an employee is injured or killed in a work-related accident
Civil Service Pensions	MoPSLSW	Public service employees	No	Contributory	Lump sum once off payments and monthly payments upon retirement to persons employed by the state.
State Service Disability Benefits Act	MoPSLSW	Civil servants including Police, Armed Forces and the Prison Service		Categorical	Provided as a result of death or injury to persons employed by the State

Based on the table above, Zimbabwe has a total of 36 social protection programmes of which 35 are currently operational. Of the 35 operational social protection programmes, 16 are HIV sensitive, while 18 are not classified as HIV sensitive and 1 is undetermined as there was no response for it. This indicates that 46% of the programmes are HIV sensitive and this correlates with the perspectives of the respondents on the sensitivity of the NSPPF. This is depicted in figure 4 below.

Figure 4 - Number of HIV-Sensitive Social Protection

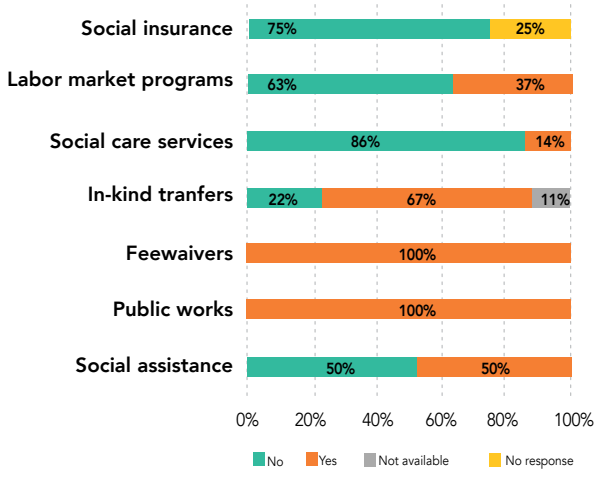


Further, Table 1 clusters programmes into 7 main categorisations, including Social Assistance, Public Works, Fee Waivers, In-Kind Transfers, Social Care Services, Labour Market Programmes and Social Insurance. An added layer of analysis was undertaken to reveal which categories of programmes have more HIV-sensitive programming. The analysis shows that programmes under the categorization of Public Works and Fee waivers are both 100% HIV-sensitive, while social insurance programmes show the least sensitivity to HIV and AIDS. This analysis is based purely on the number of programmes respondents classified as HIV sensitive rather than the quality of the sensitivity. The table and graph below depict this further:

Table 1 - Social Protection Programmes in Zimbabwe

Category	Sensitivity
Social Assistance	50% programmes sensitive
Public Works	100% programmes Sensitive
Fee Waivers	100% programmes Sensitive
In-Kind Transfers	67% programmes Sensitive
Social Care Services	14% programmes Sensitive
Labour Market Programmes	37% programmes Sensitive
Social Insurance	25% programmes Sensitive

Figure 5. HIV-Sensitive Programmes by Categorisation



Operational Health Schemes in Zimbabwe

Regardless of the socio-economic context stifling the provision of adequate health services, Zimbabwe has stayed committed to ensuring HIV prevention, treatment and care programmes are available following the 2016 'Treat All Policy'. The National Health Strategy (NHS) 2016-2020 advances universal health coverage (UHC) as part of broader national efforts to tackle extreme poverty, social exclusion and gender inequity (uhcpartnership.org, undated). The road map to achieve and finance the path to UHC is outlined in the National Health Financing Policy. The policy aims to guide Zimbabwe's health system to move towards Universal Health Coverage (UHC) by facilitating financial risk protection, access to quality essential healthcare services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all by 2030.

With this, Zimbabwe maintains a fair number of health schemes to provide for PLHIV. Some of these programmes include the Health Development Fund (HDF), a multi-donor fund to the health sector in Zimbabwe with a focus on reproductive, maternal, child and adolescent health (RMNCH-A). The objective of the HDF is to reinforce stakeholder attempts to advance healthcare access for women, children and youth in Zimbabwe. Another programme is the Workers Compensation and Insurance Fund (WCIF), a workplace-based programme under the National Social Security Authority. WCIF funds prevention and care for work-related injury. The country also has a National AIDS Trust Fund (NATF) for HIV/AIDS services implemented by the National AIDS Council. Other programmes include the Assisted Medical Treatment Orders by the MoPSLSW. While this facility is not necessarily for PLHIV, it still assists them to access treatment. Also, Zimbabwe has an ART programme centred on facilitating HIV treatment through the provision of free HIV treatment and drugs to all people living with HIV who access services at public clinics and hospitals as well as mission hospitals. Some private sector schemes that support PLHIV are also available. Two age-based schemes also cater for children and the elderly. These include free medical services for children under the age of five and free medical services for the elderly. Lastly, to cover the informal economy which, to a large extent, remains unfunded, the NSSA introduced a Voluntary Informal Sector Scheme which includes a Health Insurance Scheme and a Maternity Protection Scheme.

Barriers to Access HIV Sensitive Social Protection Services

The populations identified as facing the most barriers to accessing HIV sensitive social protection programmes include **People living with HIV, Children and adolescents, Prisoners, People with disabilities, and adolescents**. Other than these groups, the **working poor**, particularly **workers in the informal economy** were also identified as facing barriers to accessing HIV sensitive social protection mainly because of poverty resulting from low and erratic income patterns and very difficult working conditions. In addition, the **aged** and **key populations** including Women, Men having Sex with Men and Sex Workers are seen to face barriers to accessing HIV sensitive social protection services and programmes.

Further, some barriers were seen to exist as a result of geographical situations which affected rural communities, peri-urban and the urban poor. The major barrier to accessing services is fuelled by the lack of money to go and collect the medications which are basically free. Centralisation of the services is also a major barrier. Targeting issues for food and cash transfers also act as barriers since poverty is rampant when resources are spread thinly on the ground, for example, food deficit.

Young people face barriers related to stigma emanating from the negative attitude of health personnel who always seem to question how the young people got infected with HIV. Young people also have difficulties mixing with adults when seeking HIV-related services because young people have unique needs, for example, contraception, counselling e.t.c.

The older persons also face challenges, for example, mobility constraints to travel to health centres, lack of financial resources to cater for transport costs (the majority of the elderly have no incomes and those receiving pensions have been adversely affected by inflation). The older persons also face attitude challenges from health personnel who view older persons living with HIV in a negative way.

Geographical location- the rural and urban divide: Rural areas seem to have challenges accessing services, which has led to innovations, for example, community refill groups to cut on travel time and costs to health centres

This information is summarized in Table 3 below:

Table 3 - Barriers to Access Social Protection Programmes for PLHIV

Population (PLHIV)	Barrier
PWD	Stigma, mobility, structural, access to information
Aged	Mobility, access to information/availability and accessibility to services, stigma because of their age, income poverty
Key Populations	Stigma, discrimination, lack of access to information and services
Adolescents	Lack of access to information and services
Young People	Unemployment which renders them incapable of affording to pay for services.
Geographically disadvantaged groups	Poverty and transport-related constraints, centralization of services
Prisoners	Stigma and exclusion of ex-prisoners
Informal economy workers	Poverty resulting from low and erratic income patterns and very difficult working conditions

Recommendations

Recommendations for Making Social Protection more HIV Sensitive

Enhancing HIV Sensitivity of Social Protection Programmes

Beginning at the first stage of programme design right through to planning, implementation and evaluation by ensuring meaningful and active participation of different stakeholders at each stage.

Generation of HIV-Specific Data

Regular and systematic HIV-sensitive analysis will be essential to understand inequalities and barriers to accessing social protection programmes. This will be an important source not only of data but of lessons on the best ways to integrate HIV into social protection programmes. The analysis should include assessment of the context relating to HIV and AIDS and social protection, inequality and the vulnerability that results from HIV and AIDS. Also useful will be an exploration of the resulting impacts of exclusion from social protection and changes resulting from a sufficient HIV sensitive social protection programming.

Establish Deliberate Mechanisms for HIV and Social Protection Coordination

While it is evident that structures and processes for coordination do exist at the different levels, it is unclear whether a dedicated process has been thought out to guide harmonisation of the two policy fields. It will be important, therefore, to ensure representation of people living with, at risk of and affected by HIV for more effective horizontal and vertical coordination between HIV and Social Protection.

Participation

The country will need to ensure the meaningful participation of people living with HIV as well as key populations in important processes that inform policy design, implementation and evaluation of social protection programmes. This can be achieved through strengthening their participation both within the framework of MIPA and outside the framework. A way in which this can be done is through exposure to training in social protection such as that offered by Transform, an Africa-wide training curriculum on building comprehensive social protection systems

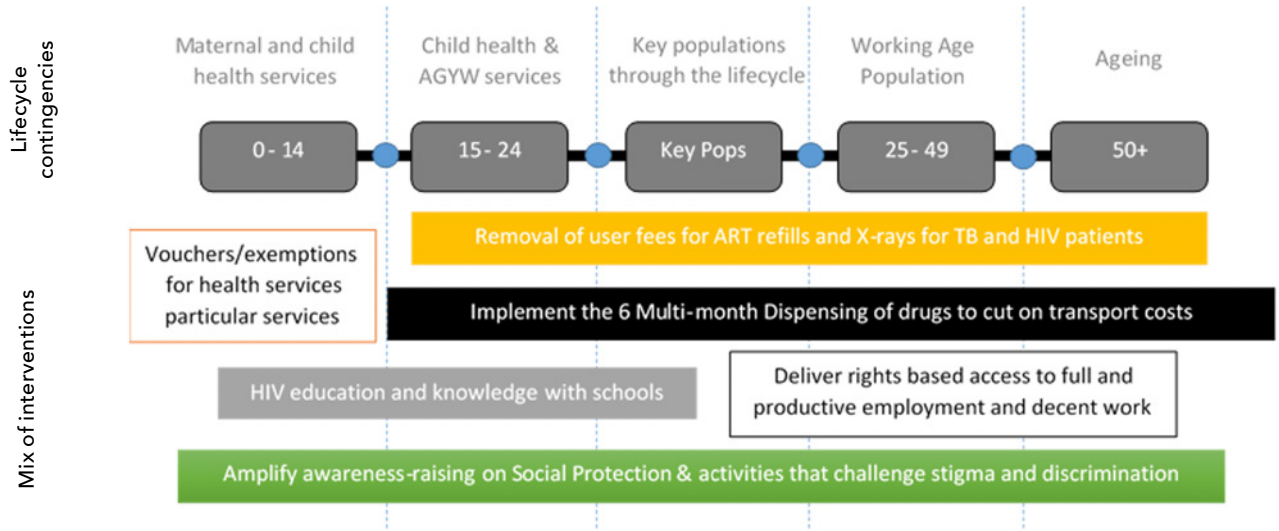
Sustainable Financing

Ensuring the initiative to make social protection more HIV sensitive will require funding that is used to administer HIV sensitive social protection interventions, facilitate the active participation of different stakeholders, allow for evaluation of programmes to show what changes HIV sensitive social protection programmes are bringing about for PLHIV and affected households. The government needs to take more ownership of these programmes, for example, through matching Global Fund funding by identifying other internal funding mechanisms, other than the AIDS levy, in view of the tax burden that the taxpayers are already shouldering. The government can achieve this dedicated funding for HIV-sensitive social protection through a co-financing approach.

Life cycle approach to the provision of HIV-Sensitive Social Protection

One of the core principles of the life cycle approach is the fundamental recognition of the right to social protection for all. Noting that the groups typically excluded or facing significant barriers to access HIV-sensitive social protection programmes are the ones that need them most, moving towards the life cycle approach will not only reduce stigma but also cater for diverse demographics on a universal basis.

Figure 6 - Lifecycle Approach to HIV-Sensitive Social Protection



Further Research

As the data gap relating to the interaction between HIV, AIDS and Social Protection in the context of Zimbabwe is abundantly clear, it will be prudent for the country to invest in further research and generation of information to inform decision making and programme design.

Recommendations Directly Addressing Identified Barriers

Other more pointed recommendations to address specific identified barriers that keep PLHIV from accessing social protection programmes are presented in Table 4 below.

Table 4 - Barrier Specific Recommendations

Population (PLHIV)	Barrier	What Can Be Done
PWD	Stigma, Mobility, Structural, Access to information	Increase awareness of available services and how to access them Outreach services
Aged	Mobility, Access to information/availability and accessibility to services, stigma because of their age, income poverty	Awareness to caregivers and outreach services Form support groups for caregivers
Key Populations	Stigma, Discrimination, lack of Access to information and services	Create KP friendly service providers/health facilities Form support groups to promote adherence
Children	Lack of access to information and services	Awareness on services to caregivers Outreach services
Young People	Unemployment which renders them incapable of affording to pay for services.	Provide documentation to all (especially children and adolescents) as this is a starting point to access services in many cases. Providing national identity cards and birth certificates for governmental recognition of people not receiving social protection services.
Geographically disadvantaged groups	Poverty and transport-related constraints, centralization of services	Expanding categorical geographical coverage of social protection programmes to meet equity needs and other considerations.
Prisoners	Stigma and exclusion of ex-prisoners	Simplifying processes to access HIV-sensitive social protection programmes including establishing one stop delivery points to enable people access comprehensive social protection benefits from one location.
Informal economy workers	Poverty resulting from low and erratic income patterns and very difficult working conditions	NATIF should be made more comprehensive. Starting new schemes to fill the gaps and consolidating multiple schemes into a broader comprehensive programme. Consultations of the informal sector in the conceptualisation and implementation of the envisaged scheme. Appreciation of the informal sector's social security needs and utilising existing structures in the informal sector rather than establishing new structures.


FOREIGNER
4

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ANNEX 1: Full List and Description of Social Protection Programmes

Formal Social Protection Systems

Basic Education Assistance Module (BEAM): Established in 2001, BEAM is a non-contributory means-tested Public scheme that provides school fees for children from poor and vulnerable households. The main source of funding is the Government of Zimbabwe with support from technical partners. The programme pays school fees for orphans and vulnerable children to reduce the number of children dropping out of school, and to rope in children who have never been to school due to economic hardships. It targets children of school-going age (ages 6 – 19) and it is implemented by the Ministry of Public Service, Labour and Social Welfare in conjunction with the Ministry of Primary and Secondary Education.

***War Victims Compensation*:** The War Victims Compensation Act of 1980 provides for compensation for injuries or the death of persons, which was caused by the war of liberation. Compensation also extends to dependents of persons who died as a result of the war. Only war-related injuries or deaths which occurred before 1st March 1980 are considered. The scheme is non-contributory and is financed by the State. This scheme is based upon the realisation that war injuries impaired claimants' capacity to earn income. Those who were dependent upon the persons who died as a result of the war had their source of support cut off hence the need for the State to intervene in providing income maintenance.

***Assisted Medical Treatment Order (AMTO)*:** The AMTO is a means-tested non-contributory scheme financed by the Government of Zimbabwe through the Ministry of Health and Child Care to pay health bills of indigent persons.

Harmonised Social Cash Transfers (HSCT): HSCT is a poverty targeted intervention focused on labour-constrained households, introduced in 2011 largely at the instigation of development partners. It is a means-tested public non-contributory scheme that has been largely donor-funded with technical assistance from UNICEF. The programme makes direct cash transfer to OVC, ultra-poor and labour constrained households. In addition to the HSCT there are other cash-based interventions implemented by other Non-governmental organisations such as Action-Aid and Dan Church Aid.

***Food Deficit Mitigation Programme (FDMP)*:** This is a means-tested public non-contributory scheme financed by the Government with the World Food Programme (WFP) as the technical partner and provides grain to qualifying households.

***National Case Management System (NCMS)*:** The Government of Zimbabwe together with development partners has developed the NCMS system as a tool for child protection coordination and implementation. The NCMS recognizes the multi-sectoral approach as being key in achieving better outcomes for children. Through a single NCMS, various actors and stakeholders are coordinated by Government towards achieving a

common goal. The NCMS is a component of the national social protection system as it attempts to provide services to vulnerable children. The NCMS is a public scheme where the Government and donors finance the programme with UNICEF as a technical partner.

Support to Older Persons: It is a public non-contributory means tested scheme funded by the Government which caters for the needs of older persons above the age of 65 years who are in institutions.

Public Assistance (PA): Established in 1989, the PA programme was derived from the Social Welfare Assistance Act (1998). It provides a grant for a 'destitute' or an 'indigent' meeting one of several criteria. The type of assistance may be financial, with amounts determined by the Director of Social Welfare based on the circumstances of the beneficiary, or in-kind in the following ways: rehabilitation, institutional nursing, boarding or foster home care; counselling services; the provision of orthopaedic and medical appliances; occupational training; pauper burials; the supply of food or clothing; and any other assistance necessary to relieve destitution.

Free HIV drugs in public institutions for People Living with HIV: Provision of free HIV drugs in public institutions funded by the AIDS levy introduced in 1999 and administered by the National Aids Council.

Support to Persons with Disability: Payment of grants to institutions housing persons with disability countrywide to makes provision for their welfare and rehabilitation.

Drought Relief Public Works Programme (PWP): The programme provides free cash assistance to the elderly, chronically ill and persons with disability. The able-bodied benefit on condition that they participate in community projects for a 15-day working month. The programme is self-targeting in which only the poor will participate. The objective of the programme is to supplement and quickly transfer incomes to the poorest households through temporary employment in labour-intensive public works.

Social Insurance Schemes

The National Social Security Authority (NSSA)

NSSA is a Statutory corporate body, constituted and established in terms of the NSSA Act of 1989, Chapter 17: 04 (Government Publishers), and tasked by the Government to administer social security schemes in Zimbabwe on behalf of workers, employers and the government. NSSA currently runs two compulsory schemes: the Pension and Other Benefits Scheme (POBS), also known as the National Pension Scheme, and The Accident Prevention and Workers' Compensation Insurance Fund.

Pension and Other Benefits Scheme (POBS): The POBS is a contributory old-age scheme that is mandatory. The scheme pays old-age pensions, disability pension, survivor's benefits and funeral assistance. It covers all employed persons between ages 16 and 65 years who are citizens or residents of Zimbabwe who work in the formal sector. Domestic and informal sector workers are excluded. Both the employer and the employee contribute 3.5% of the covered earnings respectively (translating into a contribution rate of 7%) up to a ceiling on earnings that is adjusted from time to time.

Accident prevention and Workers' Compensation Insurance Fund (WCIF): The employer funds the WCIF scheme in full. This is an insurance scheme where the employer insures his/her workers against work-related injuries. All workers except, in government and private domestic employment, are covered by the scheme. Contribution premiums are based on industry risk-assessed rates levied on the total wage bill up to a ceiling on earnings. The main

objective of the scheme is to remove from the employer the burden of looking after an injured worker, both in terms of medical expenses and wages during periods of temporary lay-off. The WCIF scheme pays out both short-term and long-term benefits.

***Private Medical Aid schemes*:** These are employment-based contributory schemes where both employers and employees contribute to. They are aimed at providing access to health services by employees when they fall ill.

Informal Schemes

Burial Societies: Burial Societies are a form of informal social protection schemes that target those in the informal economy. They involve pooling resources together to provide financial assistance to members in the event of death or illness. They are generally seen to offer a measure of financial security in the event of bereavement and also cater for some of the other social needs of members.

Income Savings and Lending Schemes (ISALs): *ISALs* are another form of informal social protection scheme that exists in Zimbabwe. Under this arrangement, a group of people come together and contribute a certain amount of money every month and each one of them in turn accesses this money or sometimes goods. Members pool together their resources. While this arrangement exists mainly amongst those in the informal sector, those who are formally employed can also participate. They are mainly meant to cushion members financially and socially so that they do not experience financial and economic duress and they are a source of capital injection to embark on small business projects.

Zunde raMambo/Insimu yeNkosi: There is a traditional method of caring for orphans in Zimbabwe that is one of the responsibilities of traditional leaders, the Chief's *Zunde raMambo* or *Insimu yeNkosi*. This is a collective field that is worked by the community under the leadership of the Chief and the Village Heads for the benefit of indigent persons, specifically orphans. Zimbabwe legislative and policy framework for OVC - the Orphan Care Policy and the National Plan of Action for Orphans and Vulnerable Children- builds on this social protection mechanism.

HIV and Social Protection

The drivers of HIV in Zimbabwe such as food insecurity, poverty, domestic violence and other social issues act as push factors for the social determinants of health hence the need to understand HIV as a social issue. Social protection has been identified as an avenue for addressing the needs of populations affected by HIV as well as the vulnerable and poor at large.[1] HIV-sensitive social protection, which targets populations at risk of HIV infection and vulnerable to the disease's consequences, can utilise cash transfers and other social protection interventions to effectively address structural drivers of HIV risk – including social and economic inequalities – thereby reducing risky sexual behaviour among adolescents and improving access to healthcare.

When HIV-sensitive social protection in the form of cash transfers is combined with interventions such as parental support and adolescent-sensitive clinical care, the effects are even greater in terms of HIV prevention, mitigation, and adherence to treatment.

Determined Resilient Empowered AIDS-free, Mentored, and Safe women (DREAMS): DREAMS project under PEPFAR focuses on HIV and AIDS interventions targeting Adolescent Girls and Young Women (AGYW). The focus to adolescent girls has been necessitated by evidence that higher prevalence rates of new HIV infection are amongst adolescent girls and young women. Thus, the focus on AGYW is for epidemiological reasons as well as to improve the

1 UNICEF and EPRI,2012

well-being of AGYW. By preventing new infections in children, the intergenerational impacts of HIV are likely to be curbed. DREAMS initiatives are focusing on high prevalence areas (districts) and the specific target age group 15-24 years. The initiative which integrates cash transfers, voluntary Counselling and Testing (VCT), health, education, treatment and psychosocial support, provides interventions that are context-specific, with comprehensive interventions not restricted to one specific outcome.

UNICEF ESARO Expansion and Scale-Up of HIV-Sensitive Social Protection in Eastern and Southern Africa initiative in Malawi, Mozambique, Zambia and Zimbabwe[2]: In Zimbabwe, activities under the initiative focused on strengthening the existing child protection case management system and ensuring effective linkages between the Harmonized Social Cash Transfers (HSCT) and access to additional services. Realising that very few cash transfer beneficiary households received some form of HIV-sensitive additional interventions, the project aimed to address prevailing gaps in linking the receipt of cash to additional services to strengthen developmental outcomes for the beneficiaries, particularly in the area of HIV and AIDS. In addition, the project sought to mainstream HIV into social protection and social service programming more broadly. To achieve this, UNICEF improved the HIV-sensitivity of the existing child protection case management system and piloted the establishment of linkages between HIV-relevant services and HSCT in eight districts in phase 1, subsequently expanding to a total of 20 districts in phase 2. UNICEF designed and supported linkages between child care workers who are part of the ongoing case management system and HIV services volunteers known as Community Adolescent Treatment Supporters (CATS) in the most disadvantaged areas to provide access to HIV/AIDS information and services at cash pay points. At cash points-centres where communities come to receive their cash regularly, an information and services tent is pitched with support from one of the UNICEF supported civil society partners.

2 Evaluation of Expansion and Scale-Up of HIV-Sensitive Social Protection in Eastern and Southern Africa
2014-2018 Report. UNICEF,2018

ANNEX 2: ToR HIV and Social Protection Assessment in Zimbabwe

Background

Zimbabwe has one of the highest HIV prevalence rates in sub-Saharan Africa (SSA). At the end of 2018, approximately 1.3 million people were living with HIV (PLHIV), with HIV incidence estimated at 0.5%. HIV prevalence among adults (15–49 years) is 12.7%. Whereas there has been significant progress in reducing new HIV infections and AIDS-related deaths by 38% and 60% respectively between 2010 and 2018, they remain unacceptably high at 38,000 new HIV infections and 22,000 AIDS-related deaths.

From a macro-fiscal perspective, the country has experienced an almost decade-long recession which escalated in 2017 by the tumbling of the local currency against the United States Dollar which had been used as a base currency since 2009. The cost of living, medicines, transport, food, hospitalisation, education and other day to day costs has significantly gone up resulting in decimation of wages and poor service delivery due to industrial action in critical service areas such as health. It is important to note that PLHIV and other vulnerable groups (such as orphans and vulnerable children, widows and widowers, pregnant women, breastfeeding women and their infants) are the most affected by the ongoing economic strife.

Relatedly, in March 2019, Zimbabwe was one of the three countries hit and affected by cyclone IDAI in Chimanimani and Chipinge. The cyclone left thousands of people internally displaced while the country also recorded a huge influx of refugees affected by the cyclone from Mozambique. Health centres, schools, and houses were destroyed including essential medicines like stocks of ARVs, TB and HIV prevention commodities. This, together with the ongoing crisis in Zimbabwe, has a significant impact on the social, economic and mental health and well-being of the general population. It is important to note that while people living with and affected by HIV form part of the general population, the extent of their vulnerabilities because of these conditions is exacerbated. The economic crisis, displacement due to the cyclone, annual droughts and floods expose young girls and women to the risk of new infections through transactional sex for survival as well as vulnerabilities to sexual and physical violence which culminate in mental health issues.

It is in light of the above background that services of consultants (one International and one National) are sought to establish the sensitivity and responsiveness of existing social protection schemes to people affected by and living with HIV. This is critical to inform policy, strategy formulation and the design of interventions. This brief document lays out the Terms of References for the HIV and social protection assessment.

Overview of social protection schemes in Zimbabwe

In Zimbabwe, social protection is recognised in the Constitution (GoZ, 2013) where it notes that "…the State must take all practical measures, within the limits of the resources available to it, to provide social security and social care to those who are in need" (Section 30, in GoZ 2015). It is in this context that the country has a comprehensive legal and policy framework for social protection, including a National Social Protection Policy Framework

(NSPPF) which provides the overarching framework. The NSPPF proposes an extremely broad set of policy options across education, health, poverty alleviation and food security and nutrition clusters. As a consequence, the core objectives of social protection are somewhat diluted. Additionally, the mandate for coordination of social protection and implementation of the main social assistance programmes falls under the Ministry of Public Service, Labour and Social Welfare (MoPSLSW). A coordination structure, the National Social Protection Steering Committee, exists. Also, there are a number of Technical Working Groups that have been established. However, in practice, they are far from optimally functioning.

According to the most recent social protection sector review, the core social assistance programmes include the following:

1. Harmonised Social Cash Transfers (HSCT)
2. Basic Education Assistance Module (BEAM)
3. Assisted Medical Treatment Orders (AMTOs)
4. Public Assistance (PA)
5. Food Deficit Mitigation Programme (FDMP)
6. National Case Management System
7. War Victims Compensation
8. Support to Persons Living with Disabilities
9. Free HIV drugs in public institutions for People Living with HIV
10. Social Insurance Schemes under the auspices of the National Social Security Authority (NSSA) (i.e. a) Pension and Other Benefits Scheme (POBS) and, b) Accident Prevention and Workers' Compensation Insurance Fund (WCIF)).

HIV and Social Protection

Generally, social safety nets for people living with HIV (PLHIV) are necessary for the enhancement of their health given the importance of nutrition to sustain adherence to HIV medicines. As earlier mentioned, the current macroeconomic environment points to a less favourable economic outlook in the medium-term characterised by low growth, high levels of debt and increased inflation. This, in turn, leaves limited resources for operationalisation of programmes and projects that would otherwise sustain the vulnerable populations. Among others, the country has implemented HIV sensitive social protection strategies through traditional leaders to mobilise food and care for OVC due to AIDS.

In 2018, the UN Joint Team strategically using UBRAF country envelope funds allocated to WFP integrated key questions on HIV in the ZIMVAC tool. However, due to the deadlines of the assessment, social protection issues were not adequately integrated. As such, for evidence-based policymaking and planning as well as advocacy, there is urgent need to establish available protection mechanisms, the level of reach and ascertain the degree to which these protection schemes are faring in line with providing social security for the targeted populations. An assessment of these and other provisions with regards to PLWHIV social security is key to understanding the level of protection and the gaps thereof for a more informed HIV response. It is in this context that this assessment is commissioned.

Objective and Purpose of the Assessment

The overall objective of this assignment is to conduct a social protection assessment with the aim of establishing availability, gaps, service providers, geographic coverage and whether the social protection schemes in Zimbabwe are HIV sensitive. Specifically, the purpose of this proposed HIV and Social protection assessment, among others, are as follows:

- Conduct a comprehensive review and analysis of available social safety nets for PLHIV in Zimbabwe across all age groups and geographical locations.
- Establish whether PLWHIV, adolescent

girls and young women at risk of HIV, key populations and other people at risk of contracting HIV are accessing existing social protection schemes.
- Document the key barriers PLWHIV and most at risk persons face in accessing social protection and recommend pragmatic and feasible remedial measures to eliminate these identified barriers.
- Produce a social protection assessment report that will inform planning, resource mobilisation and delivery of social protection interventions aligned to the Global Fund Grant implementation in Zimbabwe.
- Provide a comprehensive mapping of social protection services currently offered in the country clearly outlining the geographical and programmatic gaps.
- Complement the general social protection assessment done with a particular focus on HIV risk, vulnerabilities of PLWHIV identifying gaps and proposals to address such.

Scope of Work

The Consultants will provide technical leadership in conducting the assessment of the social protection schemes in Zimbabwe using the HIV and social protection assessment tool and qualitative tools. They will draw on existing documents and undertake the following key tasks:

A. Inception Phase:

i. Engage with UNAIDS and key stakeholders to establish a mutual understanding related to the client's expectations of the assignment. This will include obtaining a list of key stakeholders and strategic documents for reviewing.
ii. Review the strategic documents.
iii. Develop, share and present a brief Inception Report (no more than 5 pages long plus attachments) with an adapted methodological approach, data collection tools relevant to the proposed approach and Work plan with timelines.
iv. The orientation of a core team of national and development partners on the assessment tools including the HIV and social protection_ assessment tool and use of findings for policy, strategic planning and financing.
v. Develop or adapt the workshop agenda, and PowerPoint presentation.
vi. Conduct field visits and key informant interviews and focus group discussions.
vii. Conduct the HIV and Social Protection Assessment workshops including leading the validation process.

B. Data Collection, Analysis and Reporting:

i. Desk review of key documents.
ii. FGDs in the field and key informant interviews.
iii. Data analysis and development of draft report including clarifying particularly how the assessment report will support the Global Fund grant and the overall AIDS response in Zimbabwe.
iv. Submission of Draft Reports for review by the technical working group, UNAIDS and TSM.
v. Finalisation of the Assessment Report with key findings and recommendations.

Assignment deliverables

The assignment deliverables include:
i. Brief Inception Report with a methodological approach and work plan
ii. Draft Assessment Report for Validation by the technical working group
iii. Final Report with findings and recommendations that includes a costed implementation plan/response plan.

Assignment Outcomes

The main outcome will be the Zimbabwe HIV and Social Protection assessment report which will, in turn, be used to:

- input into the Global fund grant application in early 2020
- create awareness with key partners on social protection so as to include it in proposals and strategic plans
- mobilise resources to address key gaps in social protection with major funding partners
- strengthen the HIV sensitivity of the social protection programme to better reach people living with HIV, at risk and affected by HIV
- strengthen the implementation of the Global Fund grant and the overall AIDS response in Zimbabwe
- mobilise partners working on social protection and establish a coordinating platform through the MIPA programme convened by NAC.

Management Arrangements

On a day-to-day basis, the Consultants will be supervised by the UNAIDS Fast Track Adviser, with the oversight provided by a multi-actor core committee consisting of the NAC, WFP, UNICEF, MoPLSW, MoHCC, a CSO and PLHIV (adult and young person) and ILO.

Assignment Duration

The Consultancy will be over 20 working days not exceeding the end of February 2020 and includes data collection through a workshop on HIV and Social Protection Assessment, data analysis, report writing and validation. Below, is a proposed timeline for key activities.

Table 5: Proposed timelines and key activities[3]

3 These are indicative and are to be jointly agreed between the consulting team, UNAIDS and the Working Group during the inception phase.

Key tasks	*Proposed LoE (in days)*	*By when*
Inception report writing	*2*	*07 February 2020*
Prepare for and facilitate a national SPA workshop	*3*	*13 February 2020*
3. Data collection, analysis and report writing	*11.5*	*25 February 2020*
4. National validation of assessment	*1*	*26 February 2020*
5. SPA report finalisation	*2.5*	*29 February 2020*

ANNEX 3: List of Assessment Participants

1. Childline Zimbabwe
2. International Labour Organisation (ILO)
3. Midlands AIDS Service Organisation (MASO)
4. Ministry of Public Service, Labour and Social Welfare
5. National AIDS Council (NAC)
6. National Social Security Authority (NSSA)
7. UNAIDS
8. UNICEF
9. World Food Programme (WFP)
10. Zimbabwe AIDS Network (ZAN)
11. Zimbabwe National Network of People Living with HIV (ZNNP+)
12. Zimbabwe People Living with HIV Coordinating Board
13. Mr Lovemore Dumba Social Protection Consultant
14. Dr Henry Chikova Social Security Consultant
15. Dr Mildred Mushunje Social Protection Consultant
16. PLHIV (Anonymous)
17. PLHIV (Anonymous)

ANNEX 4: List of Core Group Members

i. National AIDS Council (NAC)
ii. MoPLSW
iii. MoHCC
iv. UNAIDS
v. WFP
vi. UNICEF
vii. ILO
viii. ZNNP+
ix. PLHIV (adult and young person)


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