ZIMBABWE

PEOPLE LIVING WITH HIV STIGMA INDEX 2.0 | 2022

ZNNP+

NATIONAL AIDS COUNCIL ZIMBABWE
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THE PEOPLE LIVING WITH HIV STIGMA INDEX

Foreword

The first case of HIV in Zimbabwe was detected in 1985 and the virus spread to be a generalized pandemic among the people in the country. In the face of this pandemic, efforts and resources have been invested in the national HIV response.

The country has made commendable efforts towards meeting the global, regional and national targets to the HIV response and in some instances these targets are missed due to several factors. Stigma and discrimination have been identified as the main hindrances to achieving these targets. When people test HIV positive, they face stigma and discrimination from various sectors of the society including educational, workplaces, internal, family, community, and healthcare settings. This leads to people living with HIV shying away from accessing services and leading to opportunistic infections leading to death. This has prompted global efforts to measure the extent of stigma and discrimination among PLHIV to design anti-stigma and discrimination interventions.

The stigma index is a framework developed by and for people living with HIV. In Zimbabwe the first stigma index study was conducted in 2014 and it noted that 65% of PLHIV experienced one or more forms of stigma and discrimination. The follow up study was conducted in 2022 to assess the reduction of stigma and discrimination among PLHIV. The 2022 study indicated an increase in stigma and discrimination,69.7% of PLHIV experienced one form or the other of stigma and discrimination. The 2014 study noted inadequate investments towards stigma and discrimination reduction programmes. There is need for more concerted efforts to deal with this issue so that we meet the target of ending AIDS by 2030.

The UNAIDS Global AIDS Strategy (2021-2026) recognizes Stigma and discrimination as a major cause of inequalities to access services and that there is need for new and bolder approaches in addressing these inequalities. The global response is at risk of missing the 2030 targets significant investments are not made into approaches that close the gaps that are preventing progress towards ending AIDS.

The Zimbabwe National Network of People Living with HIV (ZNNP+) present the findings of the Stigma Index Study 2.0 (2022) to guide the designing of programmes and interventions that work to address stigma and discrimination. We call for strengthened multi-sectoral partnerships that ensure that no one is left behind as we work to end challenges that are affecting the national HIV and AIDS response, stigma and discrimination being one of them.

I trust the Stigma Index report and results will immensely contribute to improved access to HIV services by people living with HIV in Zimbabwe.

(Mr.) Tatenda Makoni

ZNNP+ Executive Director

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ASO	AIDS Support Organization
CBO	Community-based Organization
CeSHHAR	Centre for Sexual Health and HIV AIDS Research Zimbabwe
FSW	Female Sex Workers
GALZ	Gays and Lesbian Association of Zimbabwe
GIPA	Greater involvement of people living with HIV and AIDS
GNP+	Global Network of People Living with HIV
HIV	Human Immunodeficiency Virus
ICW	International Community of Women Living with HIV
IPPF	International Planned Parenthood Federation
MICS	Multiple Indicator Cluster Survey
MOHCC	Ministry of Health and Child Care
MRCZ	Medical Research Council of Zimbabwe
MSM	Men who have sex with men
NAC	National AIDS Council
PLHIV	People Living with HIV
PWID	People who inject drugs
PWUD	People who use drugs
TIRZ	Trans and Intersex Rise Zimbabwe
UNAIDS	The Joint United Nations Programme on HIV/AIDS
VBS	Venue-based sampling
WSW	Women who have sex with women
WHO	World Health Organization
ZDHS	Zimbabwe Demographic Health Survey
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan 2021–2025
ZNNP+	Zimbabwe National Network of PLHIV

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Acknowledgements

The successful completion of the Zimbabwe PLHIV Stigma Index 2.0 was achieved through the support and guidance of numerous individuals and institutions. We express our gratitude to the Zimbabwe National Stigma Index Steering Committee, which provided leadership, guidance, and oversight throughout the entire process.

Most importantly, this study would not have been successful had it not been for the hard work and commitment displayed by people living with HIV who took part in this study, and participated as research assistants.

Additionally, we would like to acknowledge the indispensable technical guidance and support from the Global Network of People living with HIV (GNP+), which empowered, built capacity, and prepared ZNNP+ to provide leadership to the PLHIV Stigma Index 2.0. Further, we appreciate UNAIDS Zimbabwe, USAID, and PEPFAR, for providing funding and technical support to this initiative and making it a success..

Lastly, special mention goes to the University of Zimbabwe team, the institution that served as a research partner for the study. In particular, we thank members from the Faculty of Medicine and Health Sciences, Family Medicine, and Global and Public Health Unit. The following organizations provided representatives who served as Steering Committee members in support of this initiative.

Zimbabwe National Stigma Index Steering Committee members

Organization	Group/network represented
Gays and Lesbians Zimbabwe (GALZ)	LGBTI
Zimbabwe Council of Churches (ZCC)	Religious groups
Zimbabwe AIDS Network (ZAN)	ASO – Technical support
International Coalition of Women Living with HIV (ICW) Zimbabwe	Women PLHIV
Africaid	Children and adolescent PLHIV
Centre for Sexual Health and HIV and AIDS Research Zimbabwe (CESHHAR)	Technical support/sex workers
Zimbabwe HIV and AIDS Activist Union Community Trust (ZHAAU-CT)PLHIV	PLHIV
Zimbabwe Civil Liberties and Drugs Network (CLDN)	People who use drugs
Zimbabwe Association for Crime Prevention and Rehabilitation of the Offender (ZACRO)	Prison inmates
Women Against All forms of Discrimination (WAAD)	Sex workers
National AIDS Council Zimbabwe (NAC)	National coordination, PLHIV
Population Services International (PSI)	Technical support/LGBTI, prison inmates, and sex workers
UNAIDS Zimbabwe	Technical and Financial Support

University of Zimbabwe	Technical support, research institution, academia
Ministry of Health and Child Care (MoHCC)	Technical support
International Labour Organization (ILO)	Labour and technical support
USAID/PEPFAR	Technical and financial Support
Zimbabwe National Network of People Living with HIV (ZNNP+)	Secretariat

Executive Summary

The HIV prevalence in Zimbabwe has been declining over time, but remains high. Zimbabwe has a generalized HIV epidemic with an adult prevalence of 12.8% and an incidence of 0.5% (MOHCC, 2020). The country's HIV and AIDS response identifies stigma and discrimination as key barriers to accessing HIV services and attaining full health and human rights. The Zimbabwean government's efforts to combat stigma and discrimination are contained in the Zimbabwe National HIV and AIDS Strategic Plan IV (2021–2025), which recognizes the imperative to generate data in order to support stigma and discrimination monitoring and programming. To this end, the Zimbabwe National Network of PLHIV (ZNNP+) conducted the PLHIV Stigma Index 2.0 in 2021, a comprehensive study of the stigma and discrimination experienced by PLHIV in Zimbabwe. This follows the first PLHIV Stigma Index study, which was commissioned in 2013 and completed in 2014. This report documents the results of the PLHIV Stigma Index 2.0 study in Zimbabwe, and changes in stigma and discrimination since the 2014 study.

Methodology

The preparation and implementation of the PLHIV Stigma Index 2.0 study was guided by the principle of 'greater involvement of people living with HIV' (GIPA), involving PLHIV in the administration of the study. A cross-sectional study was conducted in all 10 provinces of Zimbabwe with 1,400 participants. The participants were grouped into the following categories: (i) general PLHIV and (ii) key populations, which included male and female sex workers, men who have sex with men (MSM), transgender people, and people who use or inject drugs (PWUD/PWID). The study also ensured that women, young people (18-24 years), and people with disabilities were included. The study was conducted over a period of two months in 2021. The study employed the PLHIV Stigma Index 2.0 questionnaire, which was developed by the Global Network of People Living with HIV (GNP+), the International Community of Women Living with HIV (ICW), and UNAIDS. The questionnaire collected data on respondents' demographics, disclosure, experiences of stigma and discrimination based on their HIV status, non-HIV related stigma, internalized stigma and resilience, interactions with health care services, and understanding of human rights and effecting change.

Key findings

Demographics: The mean age of the respondents was 40.4 years. The gender distribution of the sample was 52.9% female, 41.4% male, and 2.4% transgender. Key populations were represented in the group: 3.5% MSM, 3.3% bisexual people, 13%

female sex workers, 6% male sex workers, and 9.5% PWUD/PWID. The majority of the respondents (60%) reported that they had reached secondary school level of education and 37% were unemployed.

Disclosure: The majority of respondents said their family members (73.2%) and spouses (67%) knew their HIV status. Most key population subgroups had also disclosed to their family members (70% transgender, 42% MSM, 70.9% sex workers, and 45.1% PWUD). The largest incidence of involuntary disclosure occurred in the school environment, and mostly by classmates (47.1%) and teachers/ administrators (38.1%).Involuntary disclosure was also common with authority figures (31.3%).

Stigma experience among key populations: Stigma due to HIV status was experienced by 32 of the 33 transgender respondents, 77.7% of sex workers (n=258), and 13 of the 21 respondents who identified as MSM. Members of the key populations also experienced stigma not related to their HIV status.

Internalized stigma: Internalized stigma was experienced by 48.4% of female respondents, 52% of male respondents, and 24 of the 33 transgender participants. Overall, those in the younger age group (18-19 years) reported the most internalized stigma (57.5%).

Interactions with health care services: For those respondents who had discontinued ART in the past year, 17.9% said it was for stigma-related reasons. Being gossiped about (9.9%) and having heard other people talk about their HIV status without their consent (7.7%) were the most common forms of discrimination experienced at health facilities. Similar numbers of participants reported these negative experiences from staff when seeking general health care services. Among key populations, stigma during interactions with the health services was experienced by 17 of the 33 of transgender respondents, 28 of the 49 MSM, and 35.7% of sex workers.

Sexual and reproductive health: The most common negative experiences when receiving sexual and reproductive health care were being advised not to mother/father a child (1.5%) and being told that they needed to use a specific type of contraception to receive ART (1.6%). Women (2.2%) were four times more likely than men, to be told not to mother/father a child. Respondents reported a range of ways in which health care workers stigmatised them as mothers due to their HIV status, including using a particular infant feeding method (3.2%), using a specific contraceptive method (3.1%), and taking ART during pregnancy (3%).

Knowledge of laws protecting PLHIV from discrimination: Overall, 74% of the respondents indicated that they knew of existing laws in Zimbabwe that protect PLHIV from being discriminated against. However, a significant proportion (22%) did not know of the existence of such laws, with women being slightly less aware (25%) than men (18%).

Stigma and discrimination experienced for reasons other than HIV status: Overall, 48.5% of participants reported that they had experienced stigma and discrimination not related to their HIV status. Some of this stigma was associated with gender identity, sexuality, drug use, and sex work. The most common forms of discrimination among members of key populations due to their identities were verbal harassment, exclusion from family gatherings, and gossip or discriminatory remarks from family members.

Conclusion

Overall, the PLHIV Stigma Index 2.0 study revealed that there are still gaps in addressing HIV-related stigma and discrimination in Zimbabwe. The most common experiences of discrimination were; being excluded from social gatherings, gossip, verbal abuse, and physical abuse. Stigma exists at many levels and in many environments, including the family, health institutions, and the community at large. The study' results also show that Zimbabwe has made major strides in ensuring that PLHIV' have access to HIV treatment and care services with close to 100% of respondents reporting that they had access to treatment. There is also evidence that resilience levels among PLHIV is high, which is important for their physical and psychological well-being. Looking into the future, HIV programming in Zimbabwe should prioritize creating an enabling environment to reduce stigma and discrimination against PLHIV to sustain and enhance their health outcomes and quality of life.

Recommendations

Panel 1. Recommendations

National AIDS Council

- To use existing structures to widely disseminate the study results to participating districts, stakeholders, and communities countrywide.
- To include HIV-related stigma and discrimination indicators into Zimbabwe's official HIV response monitoring and evaluation systems, to monitor and evaluate progress over time.
- To continue sensitizing key sectors of society such as law enforcement agents, religious leaders, community gatekeepers, media, and health care service providers on anti-stigma and anti-discriminatory strategies and actions.

Ministry of Health and Child Care

- To promote human rights and services that are people-centred and HIV-sensitive within the public health delivery system.
- To continuously sensitize and train health care workers on individuals' right to access healthcare services without stigma and discrimination.
- Key population and vulnerable population movements
- To increase commitment towards combating stigma affecting key populations, as they are faced with "double stigma". These key populations include the MSM, bisexual people, transgender people, sex workers, PWUD/PWID.
- To strengthen existing services for key populations within the existing public health services and facilities in Zimbabwe.

Communities and families

- To promote and encourage HIV status disclosure to intimate partners and within families to foster adherence and informed decision-making.
- Young people living with HIV
- To link young people living with HIV to appropriate agencies where they can get safe havens to share their concerns and be empowered through life skills
- To increase focus on psychosocial needs of young people living with HIV as they transition into adulthood to eliminate internalized stigma.

Civil Society Organizations

- To increase awareness, sensitization, capacity building, and empowerment of PLHIV to seek redress when their rights are infringed on.
- To design client-centred and differentiated packages to tackle stigma at different levels, e.g., community, family, church, workplaces, and schools.
- To adopt a rights-based HIV programming approach at the national and community level.

Ministry of primary and secondary education

- To increase awareness among teachers due to their interactions with the young people at school.
- To strengthen school health programmes to include stigma education.

1 Introduction

1.1 PLHIV Stigma Index

People living with HIV (PLHIV) continue to experience disproportionate economic, psychosocial, and structural adversities. Stigma, in particular, continues to adversely impact the lives and health outcomes of PLHIV, thereby impeding progress towards ending the HIV epidemic (Friedland et al., 2020). HIV-related stigma and discrimination have been widely recognized as major barriers to accessing HIV prevention, treatment, care, and support services. HIV-related discrimination is usually rooted in stigmatizing attitudes and beliefs about populations, behaviours, practices, sex, illness, and death. Discrimination can be institutionalized through existing laws, policies and practices that negatively focus on PLHIV and marginalized groups, including criminalized populations.

The PLHIV Stigma Index is a research process that utilizes a standardized questionnaire to gather scientific evidence of stigma and discrimination among PLHIV. The PLHIV Stigma Index was developed in 2008 by GNP+, ICW, IPPF, and UNAIDS on the foundational principle of 'greater involvement of people living with HIV and AIDS (GIPA). The GIPA Principle places PLHIV at the centre of the research process as both interviewers and interviewees. These individuals drive how the information is collected, analysed, and utilized. The evidence generated by PLHIV Stigma Index studies is then used to inform HIV policy, PLHIV rights advocacy efforts, and stigma reduction interventions.

The global PLHIV Stigma Index initiative led to various countries adopting the methodology as a common approach to assessing the extent of stigma and discrimination among their population of PLHIV. In 2018, the original PLHIV Stigma Index was replaced by an updated and strengthened tool, the PLHIV Stigma Index 2.0. The new survey was developed to reflect shifts in the epidemic and global response, placing greater emphasis on the intersectionality of stigma among PLHIV communities and creating a standardized methodology to effectively capture empirical evidence on the types, extent, manifestation, and impact of stigma and discrimination. The rigorous research tool, as applied in this study, aims to:

i. Broaden understanding of the extent and forms of stigma and discrimination faced by PLHIV in Zimbabwe.

ii. Foster change by empowering PLHIV as individuals, networks, and local communities. This is achieved both through the GIPA-centred data gathering process and the study outcomes as the data is used to advocate for changes in laws, policies, programmes, and practices.

1.2 Definitions

Stigma and discrimination: Stigma is 'an attribute that is deeply discrediting' and results in the reduction of a person or group 'from a whole and usual person to a tainted, discounted one' (Goffman, 2009). This results in 'the reduction of the life chances of the stigmatized person through discriminatory actions'. Stigma marks people as different and disgraced, denying individuals' dignity, respect, and the right to fully participate in their community. It may impede access to education, work, or much needed health care. It may also preclude marriage and the opportunity to bear and raise children.

HIV-related stigma refers to the negative beliefs, feelings, and attitudes towards PLHIV, groups associated with PLHIV (e.g., the families of PLHIV), and other key populations at higher risk of HIV infection (i.e., people who inject drugs, sex workers, men who have sex with men, and transgender people). This happens as HIV-related stigma often builds upon and reinforces other existing prejudices and stereotyping, such as those related to gender, sexuality, and race. For instance, HIV-related stigma is related to already stigmatized identities emanating from sexual orientation, and behaviours, such as sex work and drug use. Consequently, society categorizes PLHIV into a marginalized group, which can lead to loss of status internalized stigma, discrimination, and abuse.

Internalized stigma describes the sense of shame that some PLHIV may be induced to feel about being HIV-positive. Internalized stigma can lead to low self-esteem, a sense of worthlessness and depression, withdrawal from social and intimate contact, and/or self-exclusion from accessing services and opportunities out of shame.

HIV-related discrimination refers to the unfair and unjust treatment (by act or omission) of an individual based on their real or perceived HIV status. Discrimination in the context of HIV also includes the unfair treatment in other social contexts and of other key populations, such as sex workers, people who use or inject drugs, men who have sex with men, transgender people, and people in prisons and other closed settings. In some social contexts, these groups can include women, young people, indigenous people, migrants, refugees, and internally displaced people.

1.3 Study background

1.3.1 HIV epidemic and HIV-related stigma in Zimbabwe

Zimbabwe is a landlocked country located in the Southern African region, bordering Zambia to the northwest, Mozambique to the northeast, South Africa to the south, and Botswana to the southwest. Administratively, the country is divided into 10 provinces, two of which are urban (Bulawayo and Harare) and eight of which are rural (Manicaland, Mashonaland East, Mashonaland Central, Mashonaland West, Matabeleland North, Matabeleland South, Masvingo, and Midlands). There are 63 districts in these 10 provinces. Approximately 33% of the population live in the urban areas, whilst 67% live in the rural areas (Zimbabwe National Statistics Agency, 2013). Zimbabwe has a total population of 13,061,239 people (6,280,539 males and 6,780,700 females), and a population growth of 1.1% annually. The country has a relatively young population with 41% under 15 years of age.

Zimbabwe has a generalized HIV epidemic and although HIV prevalence has been declining over time, it remains high. For instance, HIV incidence rates among adults aged 15-49 years declined by 51% from 0.99% in 2010 to 0.49% in 2019 (MOHCC, 2020). By 2020, HIV prevalence among adults was 12.9% (15.3% among women and 10.2% among men), incidence was 0.5%, and viral load suppression was 76%. It was estimated that 86.8% of the total population (88.3% of women and 84.3% of men) know their HIV status. It is also estimated that 84.2% of PLHIV (86.2% of women and 80.9% of men) who are eligible for antiretroviral therapy (ART) are on treatment.

The first AIDS case in Zimbabwe was reported in 1985, after which more people began to present with illnesses that were suggestive of an HIV infection (e.g., herpes zoster, severe respiratory infection, persistent generalized lymphadenopathy, and diarrhoea associated with weight loss). See Annex 1 for a more detailed history of Zimbabwe's HIV/AIDS epidemic. In the initial years of the epidemic, when there was no cure or significant treatment available, there was a general association of the signs and symptoms of the epidemic with witchcraft, establishing a long history of stigmatization of PLHIV (WHO, 2002).

The Zimbabwe Demographic and Health Survey (ZDHS) asks respondents about whether they stigmatize and discriminate against PLHIV. The ZDHS (2015) showed that 22% of women and 20% of men who were perceived to be knowledgeable about HIV had discriminatory attitudes towards PLHIV. The same report indicated that 6% of women and 9% of men felt that children living with HIV should not to be allowed to attend school together with HIV-negative children. At the community level, the report showed that 19% of women and 16% of men should not buy vegetables from a trader with HIV. A more recent population-based study, the Multiple Indicator Cluster Survey (MICS, 2019), found that 40% of women and 45% of men aged 15-49 years reported discriminatory attitudes towards people living with HIV such as:

i. not buying fresh vegetables from a shopkeeper or vendor who is HIV-positive, and
ii. thinking children living with HIV should not be allowed to attend school with children who do not have HIV.

The state response to the HIV/AIDS epidemic is captured in the Zimbabwe National HIV and AIDS Strategic Plan 2021–2025, which identifies stigma and discrimination as key barriers for PLHIV to access HIV services and attaining full health and rights. Therefore, Zimbabwe's HIV response strategy prioritizes ending stigma related to HIV and AIDS, and particularly for key populations (sex workers, MSM, transgender, and PWUD/PWIDs), students, health care workers, leaders, and communities (National AIDS Council, 2020).

The Zimbabwe National HIV and AIDS Strategic Plan 2021–2025 recognizes that it is important to generate data to support stigma and discrimination monitoring and programming. Hence, the PLHIV Stigma Index has been introduced as a key intervention to establish stigma and discrimination prevalence among PLHIV, since the first study was commissioned in 2013. Published in 2014, the first Zimbabwe PLHIV Stigma Index found that 65.5% of PLHIV in Zimbabwe experienced at least one form of stigma and discrimination. The 2014 Study Report further noted that other forms of HIV and AIDS related stigma and discrimination included: exclusion from social gatherings (21%), physical harassment and or threats (19%), physical assaults (8.6%), discrimination by partners (15%), psychological pressure and manipulation (12.1%), exclusion from family activities (11.7%), exclusion from religious activities or places of worship (10.6%), sexual rejection (7.5%), and discrimination by other people living with HIV (7.5%).

1.3.2 ZNNP+ and the PLHIV Stigma Index

As the current secretariat to the PLHIV Stigma Index steering committee, the Zimbabwe National Network of PLHIV (ZNNP+) has led the community mobilization efforts for Zimbabwe's Stigma Index studies. ZNNP+ conducted the first PLHIV Stigma Index study in 2014 (ZNNP+, 2014). In 2021, ZNNP+ assembled a diverse team of PLHIV to implement the Zimbabwe PLHIV Stigma Index 2.0 study.

ZNNP+ was the first network of PLHIV established in Africa, which has led to the birth of other networks in the region. The network is a national umbrella body whose mandate is to represent and coordinate the interests of over 5000 diverse networks and support groups for PLHIV. With a membership of over 50,000 PLHIV, ZNNP+ oversees vibrant advocacy structures at the ward, district, provincial, and national levels. There are community cadres and volunteers in all districts supported by offices in all of the 10 provinces.

The ZNNP+ programmes are aligned to the Strategic Plan 2021–2025, which consists of four strategic pillars (Figure 1). The supporting programmes are described in Annex 2.

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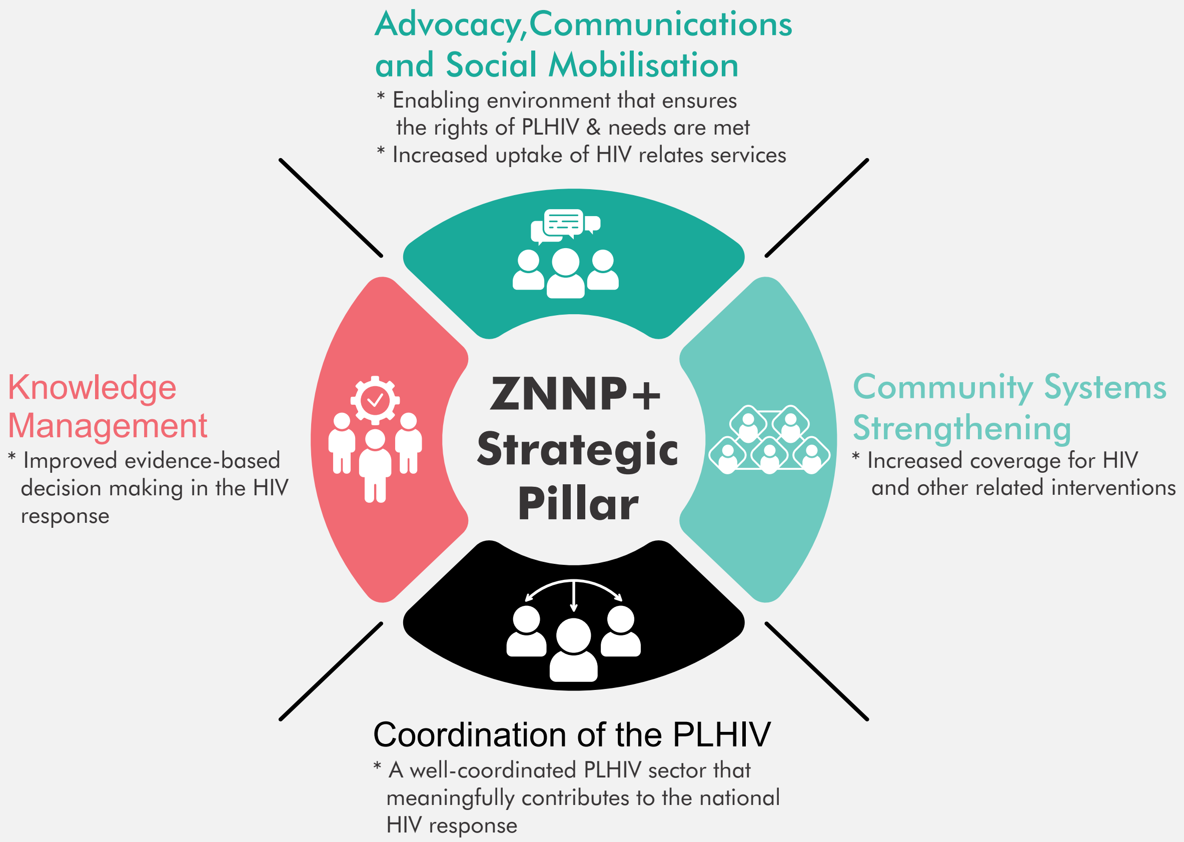
Figure 1. **ZNNP+ Strategic Pillars**



Advocacy,Communications and Social Mobilisation

* Enabling environment that ensures the rights of PLHIV & needs are met
* Increased uptake of HIV relates services

Knowledge Management

* Improved evidence-based decision making in the HIV response

Community Systems Strengthening

* Increased coverage for HIV and other related interventions

Coordination of the PLHIV

* A well-coordinated PLHIV sector that meaningfully contributes to the national HIV response

MISSION: To improve th Quality of Life People Ling with HIV
VISION: An Environment where People Live Positively

The ZNNP+ objectives are informed by and derived from the Strategic Plan 2021–2025, and these are:

- To create an enabling environment that ensures the rights and needs of PLHIV are met.
- To increase coverage and uptake of HIV treatment and other related services.
- To have a well-coordinated community of PLHIV that meaningfully contributes to the national HIV response.
- To have improved, evidence-based decision making in the HIV response.

1.4 Scope of the study

A total of 1,400 adult PLHIV were recruited to participate in the study through a venue-based sampling method. The study sample included a diverse group of PLHIV in terms of age, sexual orientation, and gender identity, as stipulated by the PLHIV Stigma Index guidelines. A detailed overview of the sampling approach and the sample characteristics are provided in the Methodology section 2.1 and Findings section 3.1, respectively.

The PLHIV Stigma Index 2.0 questionnaire was administered in a structured interview format by trained volunteer interviewers, who were recruited from the local population of PLHIV. The data was captured digitally on tablet devices, after which it was sent to research partners at the University of Zimbabwe for quantitative analysis.

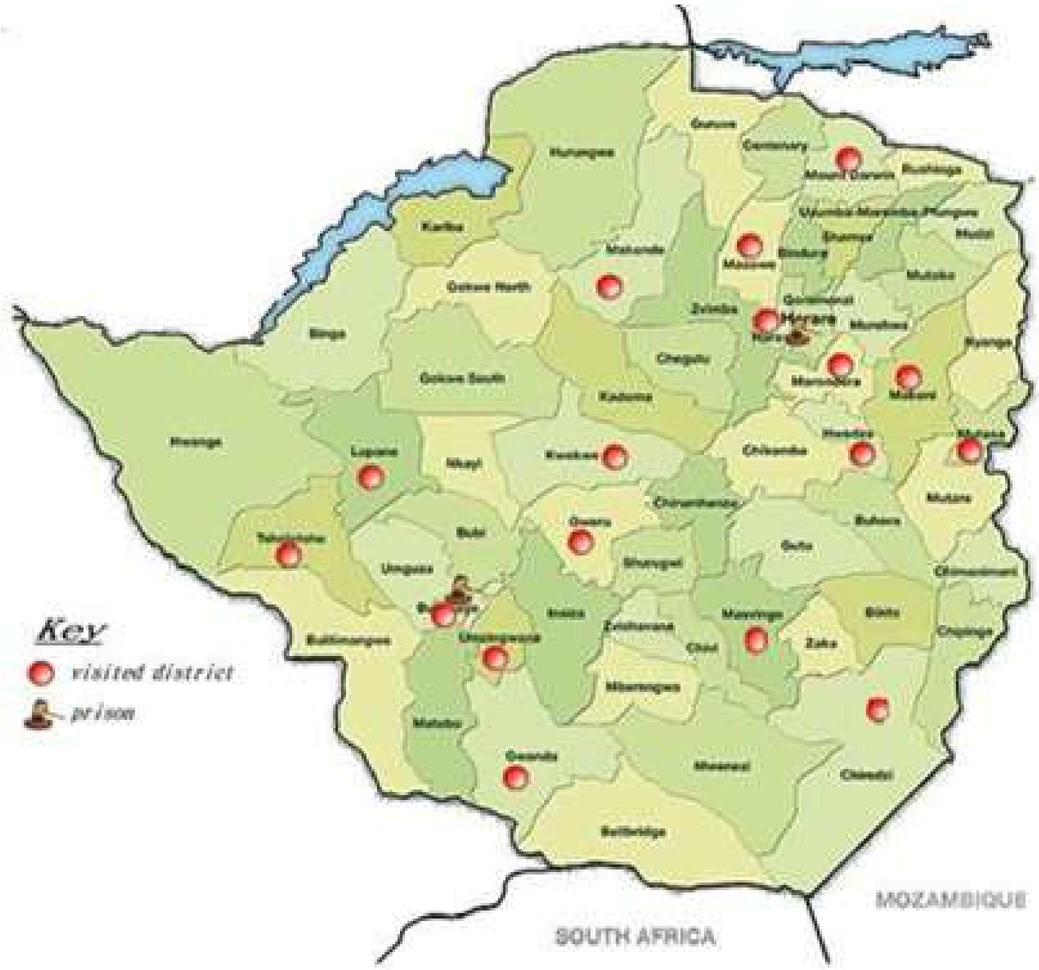
2 Methodology

A cross-sectional, quantitative study of PLHIV was conducted nationally. The following sections discuss the sampling method, research instrument, data collection, ethical considerations, and data analysis.

2.1 Participants

Zimbabwe has 10 provinces, all of which were included in this study. The study was conducted in the 26 districts that were part of the initial 2014 Stigma Index study (Figure 2).

Figure 2. Districts included in the PLHIV Stigma Index 2.0



Participants were sampled from the diverse population of PLHIV in Zimbabwe. This includes women, young people (18-24 years), and key populations (subgroups which consistently experience a disproportionate burden of HIV). The key populations in this study included: men who have sex with men (MSM), male and female sex workers, transgender people, and people who use drugs/people who inject drugs (PWUD/PWID). In addition, the following inclusion and exclusion criteria were applied:

Inclusion criteria

- A person living with HIV
- Able to provide informed consent and aged 18 years or older
- Ability to communicate in English, Shona, or Ndebele
- Awareness of living with HIV for at least 12 months
- Mentally and physically able to give consent and to respond to the study questions

Exclusion criteria

- Incapacitation due to ill health or mental comprehension
- Inability to understand the proceedings of the study and to give informed consent (e.g. individuals who were visibly intoxicated/inebriated could not participate)
- Previous participation in the study
- Key populations not living with HIV

The minimum sample size was determined using the PLHIV Stigma Index 2.0 Sample Size Calculator, which is based on the prevalence of avoidance of seeking health care. This metric is determined by the affirmative responses to two statements from the last study of the Stigma Index questionnaire, which are averaged together: 'I avoided going to a local clinic when I needed to' and 'I avoided going to a hospital when I needed to'.
In the 2014 Zimbabwe PLHIV Stigma Index study, the prevalence of avoidance of seeking health care because of anticipated stigma was estimated to be 2.45% (2.8% avoiding local clinics, 2.1% avoiding hospitals), rounded up to 3.0% for input into Sample Size Calculator. This figure was subsequently increased to 6% to account for selection bias that could have led to underreported prevalence, since almost all participants were members of the ZNNP+ and more likely to receive support than non-ZNNP+ members. Using a nominal precision of 2.5% at 95% confidence interval, the minimum sample size was calculated to be 1,386.

A probability proportional to size sampling technique was used, which is a multi-staged sampling technique where the country is clustered into 10 provinces. The provincial clusters are weighted according to the HIV prevalence per province, which is based on 2019 estimates. Table 1 shows the weighted samples for each province. The provincial weighted sample was distributed equally among the selected districts in that province.

Table 1. Sampling clusters by province

Cluster	Province	HIV Prevalence (%)	Weighting	n-values	Rounding Off n-Values
1	Bulawayo	14.64	0.108718	150.79187	151
2	Harare	11.37	0.084435	117.11135	117
3	Manicaland	10.38	0.077083	106.91412	107
4	Mashonaland Central	10.23	0.075969	105.369	105
5	Mashonaland East	13.52	0.100401	139.25619	139
6	Mashonaland West	11.79	0.087554	121.4374	121
7	Masvingo	12.22	0.090747	125.86609	126
8	Matabeleland North	16.88	0.125353	173.86461	174
9	Matabeleland South	19.83	0.14726	204.24962	204
10	Midlands	13.8	0.10248	142.13976	142
TOTAL					**1386**

To ensure that issues for sub-groups were not overshadowed by generalized stigma and discrimination, in line with the PLHIV Stigma Index guidelines, the target sample distribution among different population groupings was:

i. Key populations: 25% of the total sample size
ii. Young people: 10% of the total sample size
iii. The remaining sample: 60% women and 40% men

The gender distribution is derived from the 2019 figures that show that 60% of PLHIV aged 15+ years are females. The target sample size distributions among PLHIV in their respective clusters are shown in Table 2.

Table 2. **Target sample size distribution among PLHIV**

Cluster	Province	Sample distribution				Total
		Key population (25%)	Youths (10%)	Other PLHIV (65%)		
				Women (60%)	Men (40%)	
1	Bulawayo	38	15	59	39	151
2	Harare	29	12	46	30	117
3	Manicaland	27	11	42	28	107
4	Mashonaland Central	26	11	41	27	105
5	Mashonaland East	35	14	54	36	139
6	Mashonaland West	30	12	47	32	121
7	Masvingo	31	13	49	33	126
8	Matabeleland North	43	17	68	45	174
9	Matabeleland South	51	20	80	53	204
10	Midlands	36	14	55	37	142
TOTAL		**346**	**139**	**541**	**360**	**1386**

The final sample for the study was 1,400 PLHIV. A detailed overview of the sample composition is provided in the Findings section 3.1.

2.2 Research Instrument

The PLHIV Stigma Index 2.0 questionnaire was the research instrument used to collect quantitative data for the study. Respondents were asked about their experiences of HIV-related stigma and discrimination within the last 12 months, and in some instances longer than the last 12 months. Data was collected on stigma and discrimination experienced by PLHIV in four areas:

I. The experience of HIV-related stigma:

- aExternal stigma that manifests through community, family structures, workplaces, and institutions
- bInternalized stigma (individual feelings that often lead to negative actions)

II. The impact of HIV-related stigma on:

- Disclosure of HIV status
- Treatment and care services for the PLHIV
- Missed opportunities arising from fears of HIV-related stigma
- General health care services

III. The experience of human rights:

- Types of violation experienced
- Response actions from PLHIV (resilience)
- Actions taken by PLHIV to effect change

IV. The effects of HIV-related stigma on different groups and key populations. These groups are:

- Male and female sex workers
- People who use/inject drugs (PWUD/PWID)
- Gay/homosexual men and men who have sex with men (MSM)
- Lesbians/gays, women and women who have sex with women (WSW)
- Bisexual people
- Transgender people
- Imprisoned people

2.3 Procedure

The study protocol was reviewed and approved by the Medical Research Council of Zimbabwe (MRCZ) in August 2021 (MRCZ/A/2739). The study only commenced after clearance from MRCZ. Team members consented to participate in the study either as team leaders, interviewers, study administrators or coordinators (Annex 3-4). Interviewers obtained informed consent from participants before commencing interviews. The research team provided sufficient and detailed information in three languages (Annex 5-7) about the that the interviewers were drawn from a diverse pool of PLHIV, including young people, women, and key populations.

The questionnaire was translated into the two main local languages used in Zimbabwe (Shona and Ndebele). A team of language experts was engaged to ensure consistency, accuracy, and respect for cultural sensitivities. The PLHIV interviewers were also involved in translating the questionnaire into local languages. The first stage was to translate into the local languages and then reverse translate the questionnaire to English language to maintain the original meaning. The electronic version of the questionnaire was also available in the three languages.

Interviewers were trained according to recommendations in the "User Guide Index 2.0", to ensure the full ownership and participation of PLHIV. Prior to the interviews, a three-day training session was organized for interviewers on Stigma Index 2.0 methods, interviewing skills, research ethics, and using hand-held tablets for data collection.

The venue-based sampling (VBS) and limited chain referral approaches were utilized to identify and recruit study participants. Overall, 75% of participants were recruited using the VBS approach at health facilities, community venues, and hotspots. Networks and organizations representing different subgroup populations, namely ZNNP+, Gays and Lesbians Association of Zimbabwe (GALZ), Transsmart, Rainbow Coalition of Zimbabwe, Trans and Intersex Rise in Zimbabwe (TIRZ), Centre for Sexual Health and HIV AIDS Research Zimbabwe (CeSHHAR), Sexual Rights Centre, and other CBOs were approached to identify key populations for inclusion into the study.

The questionnaire was administered verbally to study participants as a structured interview, and the responses recorded electronically on tablet devices.

2.4 Data Analysis

Data were analysed by research partners at the University of Zimbabwe using Stata software to generate descriptive statistics. Standard data cleaning techniques were used, and datasets were submitted to the biostatistician and senior researchers for analysis and interpretation. The data were analysed by generating frequencies and cross-tabulations for comparison with the findings in the 2014 Zimbabwe PLHIV Stigma Index study.

3 Results

3.1 Respondent Characteristics

Socio-demographic characteristics

A total of 1,400 participants were interviewed in the study. Table 3 outlines the socio-demographic characteristics of the study sample (province, age, gender, partner status education, and employment status). The gender distribution of the sample was 52.9% female, 41.4% male, 2.4% transgender, and 1.2% did not identify as female, male, or transgender. Generally, there were fewer respondents in the younger age groups, while the 40-49 age group had the most respondents (27%), followed by those age 50+ years (25.2%) and 30-39 years (25%). The 18-19 age group had the smallest proportion of respondents at 2.9%.
The largest proportion of respondents were from Matabeleland South (14.4%) and the smallest from Mashonaland Central (7.5%).

The majority of the respondents (60%) reported that they had reached secondary school level of education. Over one-third of the respondents were not working at all (37%), with 21.9% doing part-time self-employed work, and 17% doing full-time self-employed work. There was a noted decline in unemployment from the 2014 study, in which 47.5% (n=889) were unemployed.

Over two-thirds of respondents were currently in an intimate relationship (70.4%, n=985).

Table 3. Respondents socio-demographic characteristics, n=1400

Category	n	%
Province		
Bulawayo	159	11.4
Harare	120	8.6
Manicaland	107	7.6
Mashonaland Central	105	7.5
Mashonaland East	139	9.9
Mashonaland West	123	8.8
Masvingo	127	9.1
Matabeleland North	175	12.5
Matabeleland South	202	14.4
Midlands	143	10.2
Age group		
18-19 years	40	2.9
20-24 years	140	10.0
25-29 years	137	9.8
30-39 years	350	25.0
40-49 years	380	27.1
50+ years	353	25.2

Category	n	%
Sex at birth		
Female	779	55.6
Male	621	44.4
Gender identity		
Female	741	52.9
Male	580	41.4
Transgender	33	2.4
Do not identify as female male, or transgender	15	1.2
Prefer not to answer	31	2.2
Currently in an intimate/sexual relationship		
Yes	985	70.4
No	415	29.6
Is your partner also living with HIV? (n=985)		
Yes	651	66.1
No	186	18.9
Not sure	148	15.0
Are you currently following any type of formal education?		
Yes	178	12.7
No	1222	87.3

Category	n	%
Education level completed		
No formal education	45	3.2
Primary School	353	25.2
Secondary school	849	60.6
Trade/vocational school	51	3.6
University/tertiary education	102	7.3
Current occupation		
In full time employment (as an employee)	171	12.2
In part-time employment (as an employee)	130	9.3
Working full-time but not as an employee (self-employed)	238	17.0
Doing casual or part-time work (self-employed)	306	21.9
Retired/on pension	37	2.6
Unemployed and not working at all	518	37.0

Household composition

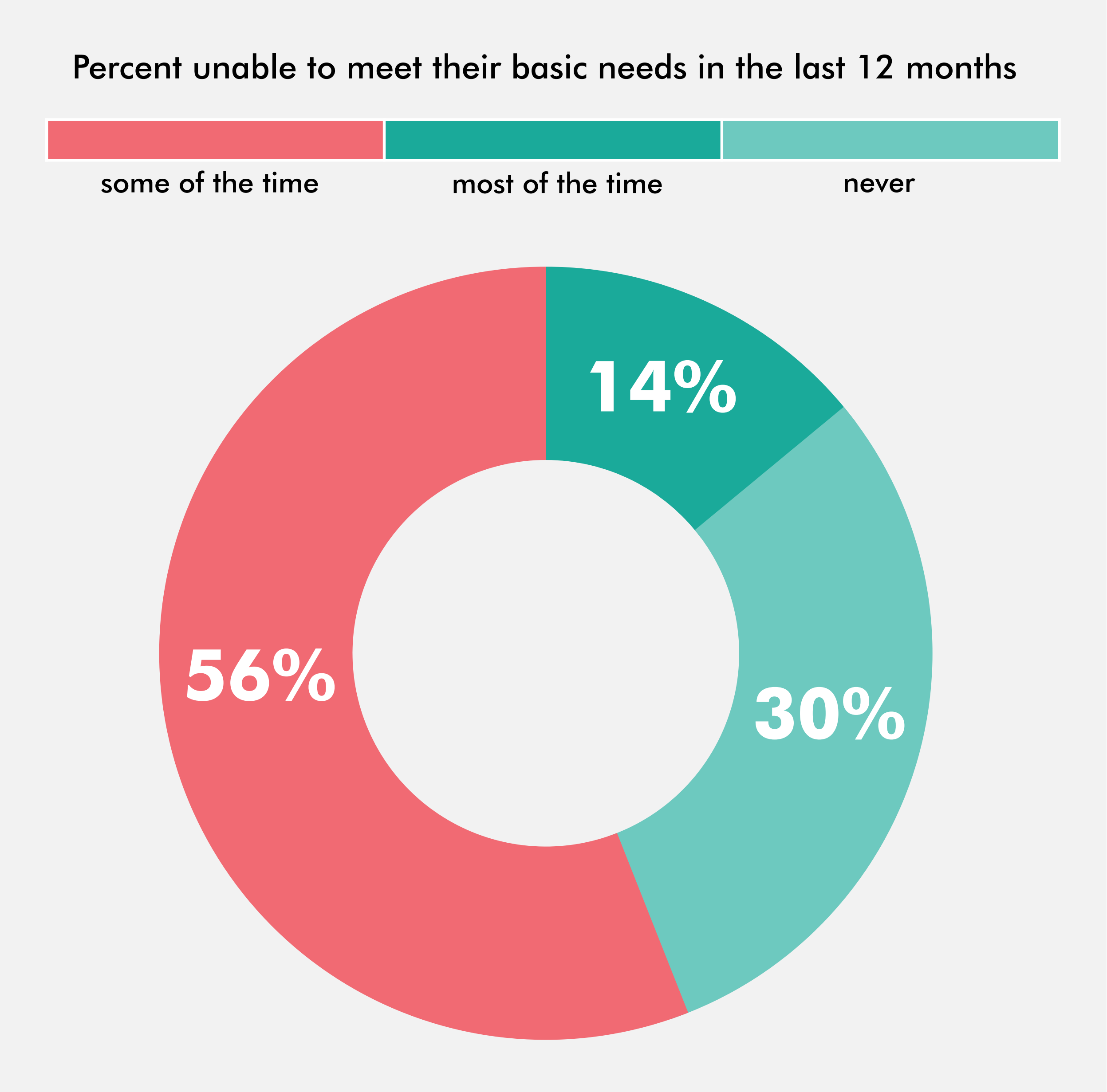
Table 4. Number of children in household, n=1400

How many children live in your household that you take care of?	n	%
0	268	19.1
1	196	14.0
2	281	20.1
3	262	18.7
4	166	11.9
5	115	8.2
6	63	4.5
7	21	1.5
8	16	1.1
9	4	0.3
10	4	0.3
11	1	0.1
12	1	0.1
Not known	2	0.1

Access to basic needs

When asked how often respondents had been unable to meet their basic needs in the past 12 months period prior the interviews, the majority of respondents (55.5%) indicated a partial failure, while 30.1% had never experienced any challenges. These trends are summarized in Figure 3.

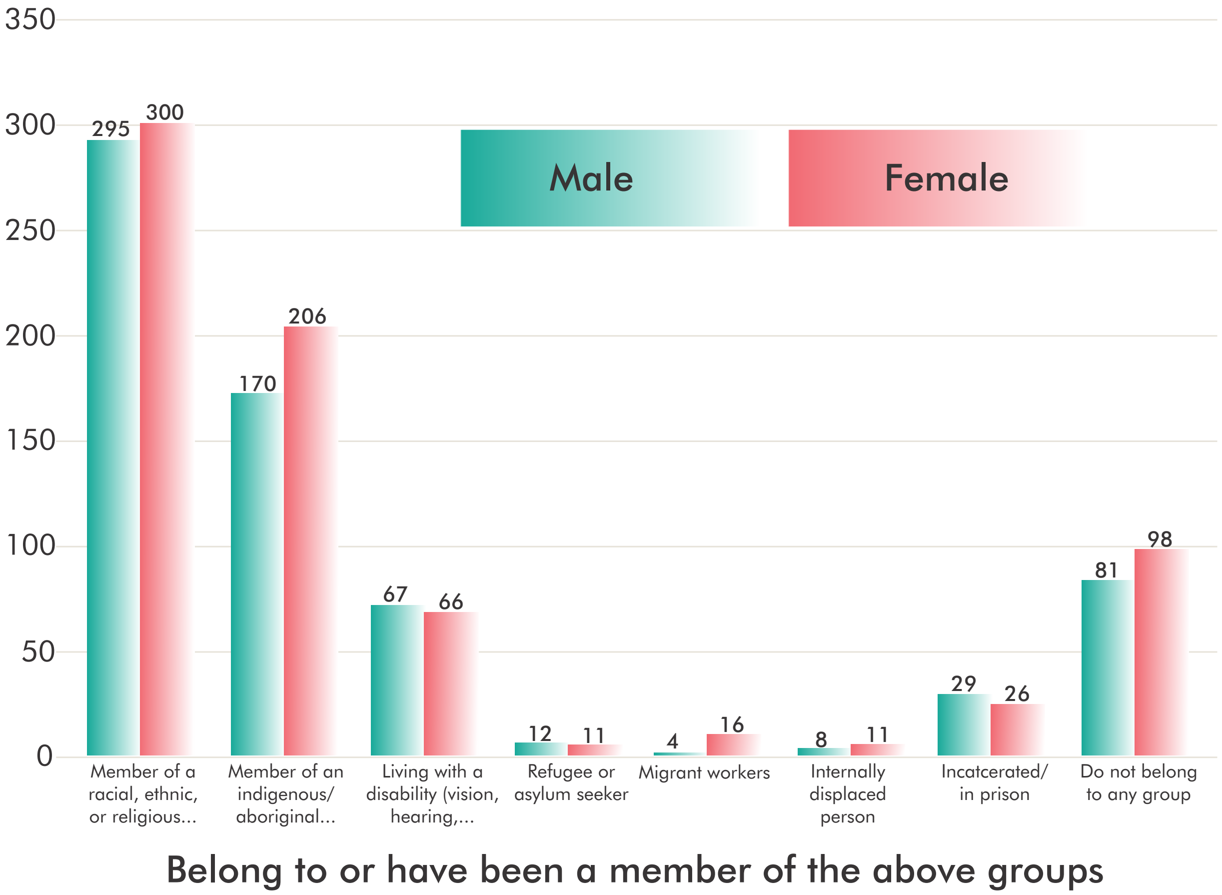
Figure 3. Inability to meet their basic needs in the last 12 months, n=1400



Membership of specific groups and support networks

Figure 4 shows the group membership of the study sample disaggregated by gender. Overall, 42.6% of participants (295 male, 300 female) mentioned that they were a member of a racial, ethnic, or religious minority. Overall, 26.9% (170 male, 206 female) were members of an indigenous group. Also, 9.5% of respondents had a disability, where the following disabilities were considered: vision, hearing, mobility, and intellectual/developmental of any kind other than HIV. A small proportion of the participants were incarcerated individuals at the time of the study or in the past (3.9%), refugee or asylum seekers, 1.6%, migrant workers, 1.4%, and internally displaced persons, 1.4%.

Figure 4. **Group membership, n=1400**



The majority of respondents (74%) belonged to a network or support group for PLHIV, with a negligible difference between male (72.3%) and female (75.9%) participants.

Table 5. Membership of a network or support group of PLHIV, n=1400

Are you a member of a network or support group of people living with HIV?	Male		Female		Total	
	n	%	n	%	n	%
Yes	449	72.3	591	75.9	1040	74.3
No	167	26.9	171	22.0	338	24.1
Prefer not to answer	167	0.8	17	2.2	22	1.6
Total	**621**	**100**	**779**	**100**	**1400**	**100**

3.2 Disclosure

Disclosure status

Participants were most likely to disclose their HIV status to people they are close to: other family members (73.2%), husband/wife/partner(s) (67%), children (59.1%), and friends (50.7%). The school environment accounted for the largest disclosure without consent and the involuntary disclosure was with mostly teachers/administrators (38.1%) and classmates (47.1%). Involuntary disclosure was also done with authorities (31.3%). The majority of key population subgroups had also disclosed to their family members (n=23 transgender, n=22 MSM, 70.9% sex workers, and 45.1% PWUD).

Table 6. **HIV status disclosure, n=1400**

Do the following people or groups of people know your HIV status?	Yes (%)	If "Yes", was your status ever disclosed to this person/group without your consent? (%)
Your husband/wife/partner(s)	67.0	24.0
Your children	59.1	20.8
Other family members	73.2	25.7
Your friends	50.7	24.2
Your neighbours	34.7	29.0
Your employer (s)	18.1	28.4
Your co-workers	22.6	25.3
Your teacher(s)/school administrator(s)	6.0	38.1
Your classmates	5.0	47.1
Local leaders	18.9	26.4
Authority figures (e.g. police, judges, law enforcement, etc.)	5.7	31.3

HIV status disclosure experience

Overall, participants had positive experiences when disclosing to people they are close to (83.9%) and found them supportive (79.6%). This was less the case with people they did not know well: 50.2% had a positive experience and 51.5% were supportive. A large majority (75.2%) said disclosing gets easier over time.

Table 7. Disclosure experience, n=1400

Please tell me if you "Agree", "Somewhat agree" or "Disagree" with each of the following statements about your experiences when disclosing your status	Agree (%)	Somewhat agree (%)	Disagree (%)
In general, disclosing your HIV status to people you are close to (e.g., partner, family, close friends) has been a positive experience.	71.5	12.4	13.9
In general, people you are close to were supportive when they first learned about your HIV status.	64.6	15.0	17.6
In general, disclosing your HIV status to people you don't know very well has been a positive experience.	32.0	18.2	40.4
In general, people you don't know very well were supportive when they first learned about your HIV status.	32.9	18.6	38.1
In general, disclosing your HIV status has become easier over time.	62.8	12.4	21.6

It was noted that 7.6% of participants were of the view that their HIV status reduced their ability to meet their personal needs. Among these were a slightly higher proportion of female participants (8.2%) than male participants (6.8%).

Table 8. Effect of HIV status on ability to meet personal needs, n=1400

In general, was the effect of your HIV status on your ability to meet your needs:	Male		Female		Total	
	n	%	n	%	n	%
Yes	370	59.6	441	56.6	811	57.9
No	184	29.6	236	30.3	420	30.0
Worse	42	6.8	64	8.2	106	7.6
N/A, because I was diagnosed with HIV within the last 12 months	25	4.0	38	4.9	63	4.5
Total	**621**	**100**	**779**	**100**	**1400**	**100**

3.3 Stigma and discrimination

Experiences of stigma and discrimination due to HIV status

The percentage of respondents who had been physically harassed or hurt or detained because of their HIV status or refused employment or lost a source of income or job because of HIV status in the last 12 months was 5.1%. However, the results showed that family members are still making discriminatory remarks or gossiping about the HIV status of the respondents (19.6%). In addition, 24.4% of respondents reported that they had been subjected to discriminatory remarks or gossiping about the HIV status by other people who were not their family members within the last 12 months. Almost 15% of respondents reported that they had been verbally harassed because of their HIV status in the past 12 months.

Table 9. PLHIV who self-reported experiencing the stigma and discrimination, n=1400

Discrimination experienced because of your HIV status	No (%)	Yes, within the last 12 months (%)	Yes, but not in the last 12 months (%)
Excluded from social gatherings or activities (e.g., weddings, funerals, parties, clubs) because of HIV status?	86.2	4.4	7.8
Excluded from religious activities or places of worship because of HIV status?	89.6	2.6	5.3
Excluded from family activities because of HIV status?	86.8	4.8	6.9
Have you ever been aware of family members making discriminatory remarks or gossiping about you because of your HIV status?	67.9	19.6	11.0
Have you ever been aware of other people (other than family members) making discriminatory remarks or gossiping about you because of your HIV status?	63.4	24.4	10.6
Has someone ever verbally harassed you (e.g., yelled, scolded, or was otherwise verbally abusive) because of your HIV status?	76.4	14.9	7.4
Has someone ever blackmailed you because of your HIV status?	87.4	5.6	5.6
Has someone every physically harassed or hurt you (e.g., pushed, hit, or was otherwise physically abusive) because of your HIV status?	89.1	4.0	5.2
Have you ever been refused employment or lost a source of income or job because of your HIV status?	82.8	5.1	5.1

Discrimination experienced because of your HIV status	No (%)	Yes, within the last 12 months (%)	Yes, but not in the last 12 months (%)
Has your job description or the nature of your job ever been changed, or have you ever been denied a promotion, because of your HIV status?	82.6	3.5	4.1
Has your wife/husband, partner(s) or child(ren) ever experienced discrimination because of your HIV status?	83.4	5.6	5.4

Internalized stigma

Respondents were asked whether their HIV status affected their ability to meet 10 internal personal needs, as summarized in Table 10. On average, 40.9% of respondents said their needs were not affected by their HIV status. HIV status most positively affected respondents in the areas of ability to find love (43.1%), self-confidence (42.9%), ability to have close and secure relationships (42.7%). Respondents were most negatively affected in the areas of desire to have children (18.2%), ability to cope with stress (15.5%), and ability to find love (15.1%).

Table 10. HIV status disclosure, n=1400

Whether your ability to meet the following needs over the past 12 months has been positively affected, not affected, or negatively affected by your HIV status.	Has been positively affected by my HIV status (%)	Has not been affected by my HIV status (%)	Has been negatively affected by my HIV status (%)	N/A (%)
My self-confidence	42.9	39.7	14.4	3.0
My self-respect	40.9	43.1	12.9	3.2
My ability to respect others	42.2	44.7	9.9	3.2
My ability to cope with stress	41.5	39.5	15.5	3.5
My ability to have close and secure relationships with others	42.7	40.6	13.9	2.8
My ability to find love	43.1	38.6	15.1	3.2
My desire to have children	35.8	36.0	18.2	10.0
My ability to achieve personal and/or professional goals	39.7	43.4	12.9	3.9
My ability to contribute to my community	41.7	41.1	12.8	4.4
My ability to practice a religion/faith as I want to	42.1	42.3	10.9	4.7

Feelings of guilt and shame

Guilt and shame manifested mostly in having difficulties with telling people about one's HIV positive status. This was experienced by a slightly higher proportion of male respondents (53.8%) than female respondents (50.8%). The other main challenges included hiding one's HIV status (43.3%) and being ashamed of being HIV positive (21.1%)

Table 11. Feeling of shame and guilt due to HIV status, n=1400

Please tell me if, in general, you agree with the following statements.	Male		Female		Total	
	n	%	n	%	n	%
It is difficult to tell people that I am HIV positive	334	53.8	396	50.8	730	52.1
Being HIV positive makes me feel dirty	92	14.8	131	16.8	223	15.9
I feel guilty that I am HIV positive	115	18.5	166	21.3	281	20.1
I am ashamed that I am HIV positive	121	19.5	174	22.3	295	21.1
I sometimes feel worthless because I am HIV positive	118	19.0	164	21.1	282	20.1
I hide my HIV status from others	266	42.8	340	43.7	606	43.3

Note: Only people who replied "Agree" are shown in the table.

In the last 12 months period, feelings of guilt and shame because of one's HIV status led to 13.1% of respondents not being able to attend social gatherings, 13.1% unable to have sex, and 10.1% of respondents isolating themselves from family and friends.

Table 12. Behaviours practiced in the last 12 months, n=1400

In the past 12 months have you ever done any of the following things because of your HIV status?	Male		Female		Total	
	n	%	n	%	n	%
I have chosen not to attend social gatherings	72	11.6	112	14.4	184	13.1
I avoided going to a clinic or hospital when I needed to	47	7.6	65	8.3	112	8.0
I have chosen not to apply for a job(s)	33	5.3	56	7.2	89	6.4
I have chosen not to seek social support	40	6.4	73	9.4	113	8.1
I have isolated myself from family and/or friends	61	9.8	80	10.3	141	10.1
I decided not to have sex	65	10.5	118	15.2	183	13.1

3.4 Interactions with healthcare services

HIV testing

The majority of respondents (82.1%) chose to be tested for HIV.

Table 13. Choice to be tested, n=1400

Was it your choice to be tested for HIV?	Male		Female		Total	
	n	%	n	%	n	%
Yes, it was my choice	503	81.0	647	83.1	1150	82.1
Yes, but I was pressured by others	43	6.9	40	5.1	83	5.9
No, I was tested without my knowledge and only found out after the test had been done	29	4.7	32	4.1	61	4.4
No, I was forced to take an HIV test without my consent	10	1.6	17	2.2	27	1.9
No, I was born with HIV or acquired HIV in infancy/childhood and was not aware I had been tested	36	5.8	43	5.5	79	5.96
TOTAL	**621**	**100**	**779**	**100**	**1400**	**100**

The biggest motivation to get tested was that the person felt sick and suspected it was HIV-related. Around 6.3% were HIV tested without their consent.

Table 14. **Main reason for taking HIV test, n=1233**

What was the MAIN reason you were tested for HIV?	Male		Female		Total	
	n	%	n	%	n	%
A provider recommended it, or as part of other health care	101	18.5	120	17.5	221	17.9
I believed I was at risk for HIV	136	24.9	199	29.0	335	27.2
I felt sick and I/someone close to me thought it might be HIV-related	205	37.6	235	34.2	440	35.7
As part of or because of a community-based program	28	5.1	31	4.5	59	4.8
It was mandatory	4	0.7	10	1.5	14	1.1
I just wanted to know	59	10.8	78	11.4	137	11.1
Other	13	2.4	14	2.0	27	2.2
TOTAL	**546**	**100**	**687**	**100**	**1233**	**100**

Almost two-thirds of respondents (63.5%) waited six months or less between the time they first thought they should get an HIV test and to the time they actually took a test.

Table 15. **Time taken to get an HIV test, n=1233**

About how long was the time between when you first thought you should get an HIV test and the time you first took an HIV test?	Male		Female		Total	
	n	%	n	%	n	%
6 months or less	332	60.8	451	65.7	783	63.5
More than 6 months to 2 years	116	21.3	122	17.8	238	19.3
More than 2 years	34	6.2	51	7.4	85	6.9
I don't know/can't remember	64	11.7	63	9.2	127	10.3
TOTAL	**546**	**100**	**687**	**100**	**1233**	**100**

A significant portion of respondents (39.2%) hesitated to get tested for fear of how other people in their community would respond if they tested positive.

Table 16. Fears about how other people would respond if one tested positive for HIV, n=1233

Did fears about how other people (e.g., your family, friends, employer, or community) would respond if you tested positive make you hesitate to get tested for HIV?	Male		Female		Total	
	n	%	n	%	n	%
Yes	191	35.0	300	43.7	491	39.2
No	355	65.0	387	56.3	742	60.2
TOTAL	**546**	**100**	**687**	**100**	**1233**	**100**

HIV treatment and viral load

An overwhelming majority of respondents (98%) reported that they had either received treatment in the past or were currently on treatment regimens.

Table 17. Current or previous HIV treatment, n=1400

Are you currently or have you ever been on HIV treatment?	Male		Female		Total	
	n	%	n	%	n	%
Yes	608	97.9	764	98.1	1372	98.0
No	13	2.1	15	1.9	28	2.0
TOTAL	**621**	**100**	**779**	**100**	**1400**	**100**

When asked if it was their choice to start taking ART, 88.7% of respondents reported that they had been told about the benefits and chose to start as soon as ART was offered.

Table 18. Choice to start ART, n=1372

Was it your choice to start taking HIV (antiretroviral) treatment or were you pressured or forced by anyone to start HIV treatment?	Male		Female		Total	
	n	%	n	%	n	%
I was told the benefits and chose to start as soon as it was offered to me	549	90.3	668	87.4	1217	88.7
When treatment was offered to me, I took the decision to wait and started at a later	29	4.8	45	5.9	74	5.4
I felt pressured or forced to start by health care staff	10	1.6	25	3.4	35	2.6
Other reasons	20	3.3	26	3.4	46	3.4
TOTAL	**608**	**100**	**764**	**100**	**1372**	**100**

Therefore, most respondents started taking ART immediately (56.9%) or between one day and one month of diagnosis (19.4%).

Table 19. Length of time between diagnosis and starting of ART, n=1372

After being diagnosed with HIV, how long was it before you began taking HIV (antiretroviral) treatment?	Male		Female		Total	
	n	%	n	%	n	%
Immediately – or the same day I was diagnosed	349	57.4	431	56.4	780	56.9
>1 day to 1 month (30 days) after being diagnosed	119	19.6	147	19.2	266	19.4
>1 month to 6 months after being diagnosed	69	11.4	82	10.7	151	11.0
>6 months to 2 years after being diagnosed	25	4.1	35	4.6	60	4.4
>2 years after being diagnosed	16	2.6	25	3.3	41	3.0
I can't remember	30	4.9	44	5.8	47	5.4
TOTAL	**608**	**100**	**764**	**100**	**1372**	**100**

For respondents who reported that they hesitated, delayed, or prevented initiation to care or treatment for HIV, 41.3% said it was because they were not ready to deal with the HIV positive status, 32.9% were worried that their partner, family or friends would find out about their HIV status, and 36.9% were worried that other people other than family or friends would find out about their HIV status.

Table 20. Reasons participants hesitated, delayed, or were prevented from initiatingHIV treatment, n=1400

Did any of the following make you hesitate, delay, or prevent you from initiating care or treatment for HIV?	Male		Female		Total	
	n	%	n	%	n	%
I was worried that my partner, family or friends would find out my status	349	57.4	431	56.4	780	56.9
I was worried other people (not family or friends) would find out my status	119	19.6	147	19.2	266	19.4
I was not ready to deal with my HIV infection+	69	11.4	82	10.7	151	11.0
>6 months to 2 years after being diagnosed	25	4.1	35	4.6	60	4.4
>2 years after being diagnosed	16	2.6	25	3.3	41	3.0
I can't remember	30	4.9	44	5.8	47	5.4
TOTAL	**608**	**100**	**764**	**100**	**1372**	**100**

Note: Only people who replied "Yes" are shown in the table.

A significant proportion of respondents (11.4%) had interrupted their HIV treatment at some point.

Table 21. Interrupted treatment, n=1372

Have you ever interrupted or stopped your HIV (antiretroviral) treatment?	Male		Female		Total	
	n	%	n	%	n	%
Yes	68	11.2	89	11.7	157	11.4
No	528	86.8	568	86.1	1186	86.4
Don't know / can't remember	12	2.0	17	2.2	29	21.0
TOTAL	**608**	**100**	**764**	**100**	**1372**	**100**

The majority of respondents (82.1%) did not report missing ART due to fear of disclosure.

Table 22. Missing of ART due to fears that someone would learn about their HIV status, n=1372

In the past 12 months, did fears about someone learning your HIV status lead you to miss a dose of your HIV (antiretroviral) treatment?	Male		Female		Total	
	n	%	n	%	n	%
Yes	103	16.9	143	18.7	246	17.9
No	505	83.1	621	81.3	1126	82.1
TOTAL	**608**	**100**	**764**	**100**	**1372**	**100**

However, of those who did interrupt their treatment within the last months, 42% reported that the reason was fear that someone would find out about their HIV status. The second most common reason, not being ready to deal with their HIV infection, was more prevalent in female respondents (n=15, 16.9%) than male respondents (n=6, 8.8%).

Table 23. Missing HIV treatment due to stigma-related reasons, n=157

If you have ever stopped taking HIV (antiretroviral) treatment for any period of time in the last 12 months, was that for any of the following stigma-related reasons?	Male		Female		Total	
	n	%	n	%	n	%
I am worried that someone would find out my HIV status	32	47.1	34	38.2	66	42.0
I am not ready to deal with my HIV infection	6	8.8	15	16.9	21	13.4
I am worried the health care workers would treat me badly or disclose my HIV status without my consent	2	2.9	2	2.3	4	2.6
I was denied HIV treatment due to currently using drugs	2	2.9	0	0.0	2	1.3
N/A – I have not been taking HIV (antiretroviral) treatment in the last 12 months or I have not stopped taking HIV (antiretroviral) treatment in the last 12 months	4	5.9	14	15.7	18	11.5
Other reason(s)	22	32.4	24	27.0	46	29.3

Among respondents who had stopped HIV treatment or care at some point, the main reasons that made them hesitate, delay, or abstain from restarting care or treatment for HIV were fear that family or friends would learn about their status (48.4%), fear that other people would find out about their status (52.2%), and not being ready to deal with their HIV infection (42%).

Table 24. Restarting care following interruption, n=157

If you have ever stopped care or treatment for HIV, did any of the following make you hesitate, delay, or prevent you from restarting care or treatment for HIV?	Male		Female		Total	
	n	%	n	%	n	%
I was worried that my partner, family or friends would find out my status	32	47.1	44	49.4	76	48.4
I was worried other people (not family or friends) would find out my status	37	54.4	45	50.6	82	52.2
I was not ready to deal with my HIV infection	28	41.2	38	42.7	66	42.0
I was afraid health workers (doctors, nurses, staff) would treat me badly or disclose my status without my consent	15	22.1	21	23.6	36	22.9
I had a bad experience with a health worker previously	11	16.2	8	9.0	19	12.1

The most common non-stigma related reasons why respondents had stopped HIV treatment within the last 12 months was that medication was not available (19.5%).


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Table 25. Non-stigma related reasons for not taking treatment, n=185

What is the main non-stigma related reason you are not currently taking HIV (antiretroviral) treatment or ever stopped it?	Male		Female		Total	
	n	%	n	%	n	%
Medication is not available at the clinic (based on policy or stock outs)	15	18.5	21	20.2	36	19.5
Medication is not affordable to me	1	1.2	2	1.9	3	1.6
I am unable to collect medications at the clinic or pharmacy	8	9.9	6	5.8	14	7.6
I cannot tolerate medication side effects	5	6.2	9	8.7	14	7.6
I do not feel treatment is needed	4	4.9	8	7.7	12	6.5
N/A – I have stopped treatment, but not in the last 12 months	18	22.2	25	24.0	43	23.2
Other	30	37.0	33	31.7	63	34.1
TOTAL	**81**	**100**	**104**	**100**	**185**	**100**

A majority of respondents (54.6%) reported viral load suppression from their most recent test within the past 12 months.

Table 26. Viral load suppression, n=1372

Did your most recent viral load test in the last 12 months show you have an undetectable viral load?	Male		Female		Total	
	n	%	n	%	n	%
Yes	327	53.8	422	55.2	749	54.6
No – I have not had a viral load test in the last 12 months	85	14.0	90	11.8	175	12.8
No – I had a viral load test and am waiting for the results	101	16.6	143	18.7	244	17.8
No – The virus was detectable/I am not virally suppressed	69	11.4	83	10.9	152	11.1
No – I have never had a viral load test	18	3.0	11	1.4	29	2.1
I don't know what viral load or viral suppression are	8	1.3	15	2.0	23	1.7
TOTAL	**608**	**100**	**764**	**100**	**1372**	**100**

General health

The majority of respondents (75.8%) reported being in good health at the time of the study.

Table 27. Description of general health, n=1400

In general, how would you describe your health at the moment?	Male		Female		Total	
	n	%	n	%	n	%
Good	465	74.9	596	76.5	1061	75.8
Fair	150	24.2	178	22.9	328	23.4
Poor	6	1.0	5	0.6	11	0.8
TOTAL	**621**	**100**	**779**	**100**	**1400**	**100**

Respondents were further asked if they had ever been diagnosed with any other medical conditions in the last 12 months, of which the most common were opportunistic infections (33.1%), non-communicable diseases (18.9%), and mental health conditions (16.1%).

Table 28. **Diagnosis and treatment for other medical conditions, n=1357**

In the last 12 months, have you been diagnosed with any of the following?	Male		Female		Total	
	n	%	n	%	n	%
Tuberculosis (TB)	54	8.7	44	5.7	98	7.0
Viral hepatitis	8	1.3	7	0.9	15	1.1
Sexually transmitted infection(s)/"STD" (e.g., herpes, gonorrhoea, chlamydia, syphilis)	70	11.3	101	13.0	171	12.3
Mental health condition (e.g., anxiety, depression, insomnia, post-traumatic stress)	88	14.2	138	17.7	226	16.1
Non-communicable disease(s) (NCDs)	123	19.8	142	18.2	265	18.9
Opportunistic infection(s)	227	36.6	236	30.3	463	33.1
Alcohol/drug dependency syndrome(s)	69	11.1	50	6.4	119	8.5

In the past 12 months, have you been offered treatment for all of the conditions you have listed to be diagnosed with in Q36?	Male		Female		Total	
	n	%	n	%	n	%
Yes	250	40.3	297	38.1	547	39.1
No	145	23.4	187	24.0	332	23.7
N/A I have not been diagnosed with any of these conditions in the last 12 months	226	36.4	295	37.9	521	37.2
TOTAL	**621**	**100**	**779**	**100**	**1400**	**100**

Access to treatment for HIV Care

The majority of respondents (91%) reported that they received regular HIV treatment and care services in public health institutions. A small minority received treatment from private doctors (3.1%) and community-led care (2%).

Table 29. Access to HIV treatment and care services, n=1400

Where do you usually receive your regular HIV care and treatment?	Male		Female		Total	
	n	%	n	%	n	%
Government or public clinic or facility	563	90.7	713	91.5	1276	91.1
Private clinic, hospital or doctor	22	3.5	22	2.8	44	3.1
Non-governmental (NGO) clinic or facility	16	2.6	23	3.0	39	2.8
Community-led care (e.g., drop-in canters run by key population groups)	13	2.1	15	1.9	28	2.0
Multiple places	6	1.0	5	0.6	11	0.8
N/A – I am not currently receiving HIV care or treatment	1	0.2	1	0.1	2	0.1
TOTAL	**621**	**100**	**779**	**100**	**1400**	**100**

The majority of respondents (80.3%) reported that there was a community-led clinic available, but only 47.8% accessed their HIV care through these facilities.

Table 30. Access to community-led clinics, n=1398

Do you know if there is a clinic providing HIV-related services that is community-led, that you can access?	Male		Female		Total	
	n	%	n	%	n	%
Yes, there is, but I don't access my HIV care there	204	32.9	250	32.1	454	32.5
Yes, there is, and I access my HIV care there	286	46.1	382	49.1	668	47.8
No, there is not	34	5.5	26	3.3	60	4.3
I don't know	96	15.5	120	15.4	216	15.5
TOTAL	620	100	778	100	1398	100

Which of the following HIV-related services can you access in the community-led facility?	Male, n=490		Female, n=632		Total, n=1122	
	n	%	n	%	n	%
HIV information	170	34.7	208	32.9	378	33.7
Peer support (groups)	129	26.3	164	25.9	293	26.1
Adherence counselling	153	31.2	186	29.4	339	30.2
Prevention services and commodities	125	25.5	143	22.6	268	23.9
HIV treatment services	133	27.1	169	26.7	302	26.9
Case management	81	16.5	921	4.6	173	15.4
HIV care and testing services	133	27.1	158	25.0	291	25.9

The biggest HIV-related challenge to accessing health care services was being talked badly about or gossiped about because of one's HIV status (9.9%) and having one's HIV status disclosed without one's consent (7.7%).

Table 31. Challenges in accessing health care services due to HIV status, n=1398

In the past 12 months, when seeking HIV specific health care, have you experienced any of the following from health facility staff working in the place you receive your HIV care?	Male		Female		Total	
	n	%	n	%	n	%
Denial of health services because of your HIV status	5	0.8	14	1.8	19	1.4
Being advised not to have sex because of your HIV status	24	3.9	47	6.0	71	5.1
Being talked badly about or gossiped about because of your HIV status	53	8.6	85	10.9	138	9.9
Verbal abuse (yelling, scolding, name calling, or being otherwise verbally abused) because of your HIV status	0	0.0	1	0.1	1	0.1
Physical abuse (pushing, hitting, or being otherwise physically abused) because of your HIV status	15	2.4	22	2.8	37	2.7
Avoidance of physical contact with you/taking extra precautions (e.g., wearing double gloves) because of your HIV status	19	3.1	38	4.9	57	4.1
Telling other people about your HIV status without your consent	45	7.3	62	8.0	107	7.7

Generally, internalized stigma was high, and all the age groups experienced it. However, the most affected age group was the 18-19 years.


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Non-HIV related health care services

A majority of respondents (n=911, 65%) had sought health care services for non-HIV related health needs in the past 12 months. In terms of the most common negative experiences, 10.8% reported being talked about badly or gossiped about because of their HIV status by staff, 8.8% reported staff disclosed their status without their consent, and 4.8% reported being verbally abused by staff.

Table 32. Health care seeking for non-HIV related causes, n=1400

In the past 12 months, have you sought health care for non-HIV related health needs?	Male		Female		Total	
	n	%	n	%	n	%
Yes	393	63.3	518	66.5	911	65.1
No	228	36.7	261	33.5	489	34.9
TOTAL	**621**	**100**	**779**	**100**	**1400**	**100**

Table 33. Experiences with health facility staff when seeking non-HIV related health care, n=1400

In the past 12 months, when seeking care for non-HIV related health needs, have you experienced any of the following treatment by health facility staff?	Male		Female		Total	
	n	%	n	%	n	%
Denial of health services because of your HIV status	2	0.8	8	1.5	10	1.1
Denial of dental care because of your HIV status	2	0.8	8	1.5	10	1.1
Being advised not to have sex because of your HIV status	10	2.5	29	5.6	39	4.2
Being talked badly about or gossiped about because of your HIV status	43	10.9	55	10.6	98	10.8
Verbal abuse (yelling, scolding, name calling, or being otherwise verbally abused) because of your HIV status	18	4.6	35	6.8	53	4.8
Physical abuse (pushing, hitting, or being otherwise physically abused) because of your HIV status	9	2.3	15	2.9	24	2.6
Avoidance of physical contact with you/taking extra precautions (e.g., wearing double gloves) because of your HIV status	8	2.0	20	3.9	28	3.1
Telling other people about your HIV status without your consent	35	8.9	45	8.7	80	8.8

An appreciable number of respondents (n=475, 33.9%) reported that they did not disclose their HIV status when seeking general health care services.

Table 34. Disclosure of HIV status when seeking general (non-HIV) health care services, n=1400

When you go outside the HIV clinic for general (non-HIV related) health services, do you usually disclose that you are living with HIV?	Male		Female		Total	
	n	%	n	%	n	%
Yes	406	65.4	519	66.6	925	66.1
No	215	34.6	260	33.4	475	33.9
TOTAL	**621**	**100**	**779**	**100**	**1400**	**100**

The majority of respondents (88.2%) felt that their medical records were kept confidential at their health facilities.

Table 35. Keeping of medical records related to HIV status at health facilities, n=1400

Do you think your medical records relating to your HIV status are kept confidential?	Male		Female		Total	
	n	%	n	%	n	%
I am sure that my medical records will be kept confidential and will not be shared without my written informed consent	550	88.6	685	87.9	1235	88.2
I don't know if my medical records are kept confidential	51	8.2	75	9.6	12	69.0
It is clear to me that my medical records are not being kept confidential	20	3.2	19	2.4	39	2.8

Sexual and reproductive health care services

The most common negative experiences when receiving sexual and reproductive health care were being advised not to mother/father a child (1.5%) and being told that one needed to use a specific type of contraception to receive ART (1.6%). At 2.2%, women were nearly four times more likely than men to be told not to have a child. Respondents reported a range of ways in which health care workers pressured them as mothers due to their HIV status, including using a particular infant feeding method (3.2%), using a specific contraceptive method (3.1%), and taking ART during pregnancy (3%).

Table 36. Advice from health care professional on reproductive health, n=1400

In the last 12 months, has a health care professional done any of the following, solely because of your HIV status	Male		Female		Total	
	n	%	n	%	n	%
Advised you not to mother/father a child	4	0.6	17	2.2	21	1.5
Pressured or incentivized you to get sterilized	1	0.2	2	0.3	3	0.2
Sterilized you without your knowledge or consent	1	0.2	1	0.1	2	0.1
Denied your contraception/family planning services	3	0.5	1	0.1	4	0.3
Told you that you had to use (a specific method of) contraception in order to get your HIV (antiretroviral) treatment	11	1.8	12	1.5	23	1.6

Table 37. Treatment from health care workers due to HIV status, n=779

Has a health care professional done any of the following, solely because of your HIV status?	Yes, within the last 12 months (%)	Yes, but not within the last 12 months (%)	No (%)	N/A (%)	Prefer not to answer (%)
Advised you to terminate a pregnancy	0.6	1.2	82.2	13.4	2.7
Pressured you to use a specific type of contraceptive method	2.1	1.03	81.3	12.8	2.8
Pressured you to use a particular method of giving birth/delivery option	1.3	1.5	80.7	13.4	3.1
Pressured you to use a particular infant feeding practice	1.5	1.7	79.6	13.9	3.3
Pressured you to take HIV (antiretroviral) treatment during pregnancy	1.8	1.2	79.9	13.7	3.5

3.5 Human rights and effecting change

Human rights abuses

The majority of respondents (80-90%) reported that they did not experience the human rights abuses investigated by the survey. Hence, only 4% (n=57) of respondents reported an abuse of some kind. The most common form of human rights abuse reported was being forced to disclose one's HIV status in order to access health care services (1.1%), apply for a job (0.9%), or obtain a visa (0.8%).

Table 38. Rights abuses of PLHIV, n=1400

Have you experienced any of the following abuses of your rights?	Yes, within the last 12 months (%)	Yes, but not within the last 12 months (%)	No (%)	N/A (%)	Prefer not to answer (%)
I was arrested or taken to court on a charge related to my HIV status	0.2	1.0	88.4	8.9	1.4
I was detained or quarantined because of my HIV status	0.0	0.9	83.9	68.2	1.5
I was denied a visa or permission to enter another country because of my HIV status	0.2	1.0	86.2	10.6	2.0
I was denied residency or permission to stay in another country because of my HIV status	0.3	0.9	87.2	9.8	1.8
I was forced to get tested for HIV or disclose my status in order to:					
… obtain a visa or to apply for residency/citizenship in a country	0.8	1.1	83.9	12.6	1.6
… apply for a job or get a pension plan	0.9	1.3	84.2	11.7	1.9
… attend an educational institution or get a scholarship	0.4	0.9	83.1	13.1	2.6
… get health care services	1.1	1.4	89.2	6.7	1.5
… get medical insurance	0.5	1.1	87.6	9.2	1.6

The respondents who experienced rights abuses (4%) were asked if they did anything about the matter(s). It was noted that 14% (n=) did something, 63% (n=36) did not do anything, and 23% (n=13) stated “not applicable”. The major reasons cited by respondents why they did not do anything about the abuse of their rights were not knowing where to go (n=13), having insufficient financial resources (n=7), and being worried about where taking action would lead (n=5).


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Table 39. Reaction of PLHIV following abuse of rights

What did you try to do about the matter?	n	%
Filed a complaint	44	50.
Contacted a lawyer	0	0.0
Contacted a government official or politician	0	0.0
Spoke out publicly	2	25.0
Contacted a community organization/network of persons living with HIV for support	3	37.5
If yes, what was the result?	**n**	**%**
The matter has been dealt with	3	37.5
The matter is still in the process of being dealt with	3	37.5
Nothing happened/the matter was not dealt with	2	25.0
Total	8	100
If no, what was the main reason for not trying to do something about the matter?	**n**	**%**
I did not know where to go	13	36.1
I had insufficient financial resource	7	19.4
The process of addressing the problem	3	8.3
I felt intimidated or scared to take action	4	11.1
I was worried taking action might lead	5	13.9
I was advised against taking action by	2	5.6
I had no/little confidence that the outcome would be favourable	1	2.8
Other	1	2.8
TOTAL	**36**	**100**

Knowledge of laws protecting PLHIV from discrimination

Almost three-quarters of respondents (74%) indicated that they knew of existing laws in Zimbabwe which protect PLHIV from discrimination. However, 22% of respondents were not aware of such laws, with female respondents (25%) being slightly more affected than males (18%).

Table 40. Knowledge of anti-discrimination laws, n=1400

Do you know if there are any laws in your country to protect people living with HIV from discrimination?	Male		Female		Total	
	n	%	n	%	n	%
Yes, there are laws	480	77.3	557	71.5	1037	74.1
No, there are no laws	29	4.7	29	3.7	58	4.1
I don't know if there are laws	112	18.0	193	24.8	305	21.8

The most common ways that respondents educated others about the rights of PLHIV were challenging or educating someone who was engaging in discrimination against PLHIV (39.7%); providing emotional, financial or moral support to PLHIV dealing with stigma (37.4%); and participating in an organization or campaign to address stigma against PLHIV (36.4%).

Table 41. Educating others about rights of PLHIV, n=1400

Have you experienced any of the following abuses of your rights?	Yes, within the last 12 months (%)	Yes, but not within the last 12 months (%)	No (%)
Challenged or educated someone who was engaging in stigma or discrimination against you	35.9	13.9	50.2
Challenged or educated someone who was engaging in stigma or discrimination against other people living with HIV	39.7	14.9	45.4
Provided emotional, financial, or other support to help someone living with HIV deal with stigma and/or discrimination	37.4	13.0	49.6
Participated in an organization or educational campaign working to address stigma and discrimination against people living with HIV	36.4	12.4	51.3
Encouraged a community leader to take action about issues of stigma and discrimination against people living with HIV	25.9	10.6	63.5
Encouraged a government leader or a politician to take action about issues of stigma and discrimination against people living with HIV	16.5	9.4	74.1
Spoke to the media about issues of stigma and discrimination against people living with HIV	13.0	9.5	77.5

3.6 Other sources of discrimination

Gender identity

Participants who identified as transgender, non-binary, or who had a different gender than the sex assigned to them at birth were asked about stigma related to their gender identity. The 33 transgender participants were the only ones to respond to the question. The most common experiences of discrimination based on their gender identity were verbal harassment (n=13) and gossip and discriminatory remarks from family members (n=8).

Table 42. Discrimination due to gender identity, n = 33

Ever experienced the following:	Yes, within the last 12 months	Yes, but not within the last 12 months	No	Prefer not to answer
Have you ever felt excluded from family activities because of your gender identity?	7	11	14	1
Have you ever felt that family members have made discriminatory remarks or gossiped about you because of your gender identity?	8	11	14	0
Have you ever felt afraid to seek health services because of your gender identity?	7	12	14	0
Have you ever avoided seeking health services because you worried someone may learn of your gender identity?	6	11	16	0
Has someone ever verbally harassed you because of your gender identity?	13	9	11	0
Has someone ever blackmailed you because of your gender identity?	6	4	25	1
Has someone ever physically harassed or hurt you because of your gender identity?	7	8	17	1


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Table 43. People or groups who know about one's gender identity

In general, do the following people or groups of people know your gender identity?	Male		Female		Total	
	n	%	n	%	n	%
Other transgender people or people whose gender identity differs from the sex they were assigned at birth	20	90.9	10	90.9	30	90.9
Family or other friends	17	77.3	65	4.6	23	69.7
Other people in your community	12	54.6	43	6.4	16	48.5

A large proportion of PLHIV whose gender identity differed from the sex they were assigned at birth (69.7%) belonged to a network or support group.

Table 44. Belonging to a network or support group for people whose gender identity is different than their sex assigned at birth

Do you belong to a network or support group for people whose gender identity differs from the sex they were assigned at birth?	n	%
Yes	23	69.7
No	10	30.3
TOTAL	**33**	**100**

Gay men and MSM

Among male participants, 53 reported being gay/homosexual/MSM or bisexual. Among those who did not identify with these groups (538 participants), 17 reported that they had sex with another man at some point, whilst another 70 preferred not to answer.

Table 45. Identification as MSM, gay/homosexual, or bisexual, n=591

Do you currently or have you previously identified as a member of any of the following groups?	n	%
Men who have sex with men (MSM)	21	3.6
Gay/homosexual	11	1.9
Bisexual	21	3.6
None of the above	538	91.0
TOTAL	591	100

Table 46. Men who have had sex with other men, but do not identify as gay or bisexual, n=538

Have you ever had sex with another man?	n	%
Yes	17	3.2
No	451	83.8
Prefer not to answer	70	13.0
TOTAL	**538**	**100**

Among male participants who were gay/homosexual/MSM or had ever had sex with men (49 participants), the most common experiences of discrimination were verbal harassment (24.5%), being excluded from family activities (22.5%), and gossip and discriminatory comments from family members (22.5%).

Table 47. Discrimination experienced by men from being gay/homosexual/MSM, n=49

Experiences	Yes, within the last 12 months	Yes, but not within the last 12 months	No	Prefer not to answer
Have you ever felt excluded from family activities because you are gay/homosexual/MSM/have sex with men?	11	6	29	3
Have you ever felt that family members have made discriminatory remarks or gossiped about you because you are gay/homosexual/MSM or have sex with men?	11	8	27	3
Have you ever felt afraid to seek health services because you worried someone may learn you are gay/homosexual/MSM/have sex with men?	6	25	33	3
Have you ever avoided seeking health services because you worried someone may learn you are gay/homosexual/MSM/have sex with men?	7	8	31	3
Has someone ever verbally harassed you because you are gay/homosexual/MSM/have sex with men?	12	7	27	3
Has someone ever blackmailed you because you are gay/homosexual/MSM/have sex with men?	8	6	32	3

Experiences	Yes, within the last 12 months	Yes, but <u>not</u> within the last 12 months	No	Prefer not to answer
Has someone ever physically harassed or hurt you because you are gay/homosexual/MSM/have sex with men?	7	5	34	3

Almost half of those who identified as gay/homosexual/MSM reported that their sexuality was known to others who are gay (49.98%) and family and friends (44.9%).

Table 48. People or groups who know that one is gay/ homosexual/MSM, n=60

In general, do the following people or groups of people know that you are gay/homosexual/MSM or have sex with men?	n	%
Others who are gay/homosexual/MSMs/have sex with men	24	49.9
Family or other friends	822	44.9
Other people in your community	42	18.6

A total of 23 males reported that they belonged to a network or support group for gay/homosexual/MSM.

Table 49. Belonging to a network or support group for men who are gay/homosexual/MSM, n=49

Do you belong to a network or support group for people who are gay/homosexual/MSM/have sex with men?	n	%
Yes	23	46.9
No	26	53.1
TOTAL	**49**	**100**

Among female participants, 48 (6.3% of females) reported that they were lesbian/gay/WSW or bisexual. Among those who did not identify with these groups, 12 reported that they had sex with another woman at some point, whilst 83 preferred not to answer.

Table 50. Identification as women who are lesbian/gay/WSW or bisexual, n=763

Do you currently or have you previously identified as a member of any of the following groups?	n	%
Women who have sex with women (WSW)	6	0.8
Lesbian/gay	9	1.2
Bisexual	33	4.3
None of the above	715	93.7
TOTAL	**763**	**100**

Table 51. Female participants who had ever had sex with another women but do not identify as lesbian/gay or bisexual, n=715

Have you ever had sex with another woman?	n	%
Yes	12	1.7
No	620	86.7
Prefer not to answer	83	11.6
Total	**715**	**100**

Among female participants who were lesbian/gay/WSW or ever had sex with women, the most common experiences of discrimination were being excluded from family gatherings (13.8%), verbal harassment (13.8%), and physical harassment (13.8%).

Table 52. Discrimination of women based on being lesbian/gay/having sex with women, n=29

Experiences	Yes, within the last 12 months	Yes, but not within the last 12 months	No	Prefer not to answer
Have you ever felt excluded from family activities because you are lesbian/gay/have sex with women?	4	5	19	1
Have you ever felt that family members have made discriminatory remarks or gossiped about you because you are lesbian/gay/have sex with women?	3	7	17	2
Have you ever felt afraid to seek health services because you worried someone may learn you are lesbian/gay/have sex with women?	2	3	22	2
Have you ever avoided seeking health services because you worried someone may learn you are lesbian/gay/have sex with women?	1	4	23	1
Has someone ever verbally harassed you because you are lesbian/gay/have sex with women?	4	5	19	1
Has someone ever blackmailed you because you are lesbian/gay/have sex with women?	2	4	22	1
Has someone ever physically harassed or hurt you because you are lesbian/gay/have sex with women?	4	3	21	1

In terms of groups who knew that the participants were lesbian/WSW, approximately one-third of participants reported in the affirmative for each group (other gay women, family or friends, and others in the community).

Table 53. People or groups knowing that one is lesbian/gay/WSW, n=19

In general, do the following people or groups of people know that you are lesbian/gay/have sex with women?	n	%
Others who are lesbian/gay/have sex with women	6	33.3
Family or other friends	7	38.9
Other people in your community	6	33.3

It was noted that 13 of the 29 lesbian/WSW participants reported that they belonged to a network or support group for women who are lesbian/gay/WSW.

Table 54. Belonging to support group for women who are lesbian/gay/WSW, n=29

Do you belong to a network or support group for people who are lesbian/gay/WSW?	n	%
Yes	13	44.8
No	165	5.2
Total	**29**	**100**

Bisexual people

Among respondents who identified as bisexual or had sex with both men and women (n=46), the most common experiences of discrimination were being excluded from family activities (10), gossip and discriminatory remarks from family members (19.6%), and verbal harassment (17.4%).

Table 55. **Discrimination experienced for being bisexual, n=46**

Experiences	Yes, within the last 12 months	Yes, but not within the last 12 months	No	Prefer not to answer
Have you ever felt excluded from family activities because you are bisexual/have sex with men and women?	10	9	25	2
Have you ever felt that family members have made discriminatory remarks or gossiped about you because you are bisexual/have sex with men and women?	9	7	27	3
Have you ever felt afraid to seek health services because you worried someone may learn you are bisexual/have sex with men and women?	7	5	31	3
Have you ever avoided seeking health services because you worried someone may learn you are bisexual/have sex with men and women?	6	4	33	3
Has someone ever verbally harassed you because you are bisexual/have sex with men and women?	8	17	21	0
Has someone ever blackmailed you because you are bisexual/have sex with men and women?	6	17	23	0
Has someone ever physically harassed or hurt you because you are bisexual/have sex with men and women?	6	16	24	0

Men were more likely than women to have their bisexuality known by others.

Table 56. People or groups who know that one is bisexual, n=46

In general, do the following people or groups of people know that you are bisexual/have sex with men and women?	Male		Female		Total	
	n	%	n	%	n	%
Others who are bisexual/have sex with men and women	17	77.3	11	45.8	28	60.9
Family or other friends	17	77.3	93	7.5	26	26.5
Other people in your community	11	50.0	52	0.8	16	34.9

Among respondents who identified themselves as bisexual, 34.8% reported that they belonged to a network or support group for people who are bisexual/have sex with men and women. Males (50%) were twice as likely as females (21%) to be members of such groups.

Table 57. Networks and support groups for people who are bisexual, n=46

Do you belong to a network or support group for people who are bisexual/have sex with men and women?	Male		Female		Total	
	n	%	n	%	n	%
Yes	11	50.0	52	0.8	16	34.8
No	11	50.0	19	79.2	30	65.2
TOTAL	**22**	**100**	**24**	**100**	**46**	**100**

Sex workers

As shown in Table 58, just above a quarter of the respondents (25.6%) reported having received sex in exchange for money or goods, with the highest proportion (41.1%) being in the 30-39 years age group. Meanwhile, 4.5% preferred not to answer. Among respondents who had or had possibly exchanged sex for money or goods (421 participants), 61.3% (80 males, 178 females) identified as a sex worker. Hence, in the total study sample, 18.4% of participants identified as sex workers.

Table 58. Engaged in sex in exchange for money or goods, n=1400

Have you ever had sex in exchange for money or goods?	Male		Female		Total	
	n	%	n	%	n	%
Yes	144	23.2	214	27.5	358	25.6
No	455	73.3	524	67.3	979	69.9
Prefer not to answer	22	3.5	41	5.3	63	4.5
TOTAL	**621**	**100**	**779**	**100**	**1400**	**100**

Table 59. Identification as a sex worker, n=421

Do you identify as a sex worker?	Male		Female		Total	
	n	%	n	%	n	%
Yes	80	48.2	178	69.8	258	61.3
No	69	41.6	44	17.3	113	26.8
Prefer not to answer	17	10.2	33	12.9	50	11.9
TOTAL	**166**	**100**	**255**	**100**	**421**	**100**

**Only those who responded "yes" or "prefer not to answer" to the question, "Have you ever had sex in exchange for money or goods?" were asked if they identified as a sex worker.*

Among respondents who identified as sex workers or who had sold sex at some point, the most common forms of discrimination were verbal harassment (25.7%), gossip and discriminatory remarks from family members (21.6%), and physical harassment (17.4%).

Table 60. **Discrimination experienced from being a sex worker, n=362**

Experiences	Yes, within the last 12 months	Yes, but not within the last 12 months	No	Prefer not to answer
Have you ever felt excluded from family activities because you are/were a sex worker or sell/sold sex?	13.8	8.8	76.2	1.1
Have you ever felt that family members have made discriminatory remarks or gossiped about you because you are/were a sex worker or sell/sold sex?	21.6	8.3	69.1	1.1
Have you ever felt afraid to seek health services because you worried someone may learn you are/were a sex worker or sell/sold sex?	10.2	5.5	82.9	1.4
Have you ever avoided seeking health services because you worried someone may learn you are/were a sex worker or sell/sold sex?	8.8	5.3	84.3	1.7
Has someone ever verbally harassed you because you are/were a sex worker or sell/sold sex?	25.7	6.6	66.6	1.1
Has someone ever blackmailed you because you are/were a sex worker or sell/sold sex?	12.98	4.4	80.7	1.9
Has someone ever physically harassed or hurt you are/were a sex worker or sell/sold sex?	17.4	6.4	74.9	1.4

Women who did sex work (216 participants) were more likely than men to be open about their sex work with other sex workers, family and friends, and other people in their community.

Table 61. People or groups who know that one is a sex worker, n=362

In general, do the following people or groups of people know that you are (or were) a sex worker or sell (or sold) sex?	Male, n=146		Female, n=216		Total	
	n	%	n	%	n	%
Other sex workers/peers in the sex work community	84	57.5	178	82.4	262	72.4
Family or other friends	66	45.2	152	70.4	218	60.2
Other people in your community	60	41.1	155	71.8	215	59.4

The largest proportion of sex workers (61.6%) belonged to a support group of sex workers. However, among male sex workers alone, the proportion was markedly lower (45.9%).

Table 62. Networks and support groups for people who are sex workers, n=362

Do you belong to a network or support group for people who are sex workers?	Male		Female		Total	
	n	%	n	%	n	%
Yes	67	45.9	156	72.2	223	61.6
No	79	54.1	60	27.8	139	38.4
TOTAL	**146**	**100**	**216**	**100**	**362**	**100**

PWUD/PWID

A total of 83 participants (41 male, 42 female) reported that they had injected or habitually used drugs such as heroin, cocaine, or methamphetamines. However,50 participants preferred not to answer. A follow-up question was asked to on whether they identified as drug users and 3 identified as people who use or inject drugs (PWUD/PWID), 4 answered "No", while 43 preferred not to answer. This is shown in

Table 63. Injecting or habitual drug users, n=1400

Have you ever injected or habitually used drugs such as heroin, cocaine, or methamphetamines?	Male		Female		Total	
	n	%	n	%	n	%
Yes	41	6.6	42	5.4	83	5.9
No	563	90.7	704	90.4	1267	90.5
Prefer not to answer	17	2.7	33	4.2	50	3.6
TOTAL	621	100	779	100	1400	100

Table 64. Identification as a person who uses drugs, n=50

Do you identify as a person who uses (or used) drugs?	Male		Female		Total	
	n	%	n	%	n	%
Yes	1	5.9	2	6.1	3	6.0
No	2	11.8	2	6.1	4	8.0
Prefer not to answer	14	82.4	29	87.9	43	86.0
TOTAL	**17**	**100**	**33**	**100**	**50**	**100**

Among respondents who identified as PWUD/PWID or had ever used drugs, the most common experiences of discrimination were gossip and discriminatory remarks from family members (20.3%), verbal harassment (18.8%), and physical harassment (15.04%).
Table 65 includes those who identified as PWUD / PWID and those who preferred not to answer.

Table 65. Discrimination due to usage of drugs, n=133

Experiences	Yes, within the last 12 months	Yes, but not within the last 12 months	No	Prefer not to answer
Have you ever felt excluded from family activities because you use (or used) drugs?	13.5	18.8	57.9	9.8
Have you ever felt that family members have made discriminatory remarks or gossiped about you because you use (or used) drugs?	20.3	19.6	50.4	9.8
Have you ever felt afraid to seek health services because you worried someone may learn you use (or used) drugs?	9.8	12.0	68.4	9.8
Have you ever avoided seeking health services because you worried someone may learn you use (or used) drugs?	38.3	11.3	70.7	9.8
Has someone ever verbally harassed you because you use (or used) drugs?	18.8	12.03	60.2	9.02
Has someone ever blackmailed you because you use (or used) drugs?	12.8	9.02	68.4	9.8
Has someone ever physically harassed or hurt you because you use (or used) drugs?	15.04	11.3	63.9	9.8

Among respondents who used drugs, 54.9% reported that their drug usage was known to others who used drugs, known to family or friends (45.1%), and known to others in their community (39.9%). This is shown in Table 66.

Table 66. People or groups who know that one is a drug user, n=133

In general, do the following people or groups of people know that you use (or used) drugs?	Male		Female		Total	
	n	%	n	%	n	%
Other people who use drugs	35	60.3	38	50.7	73	54.9
Family or other friends	32	55.2	28	37.3	60	45.1
Other people in your community	29	50.0	24	32.0	53	39.9
TOTAL	**58**	**100**	**75**	**100**	**133**	**100**

Nearly a quarter of people who use or have used drugs (24.8%) belong to a network or support group for people who use drugs.

Table 67. Belonging to a network or support group for people who use drugs, n=133

Do you belong to a network or support group for people who use drugs?	Male		Female		Total	
	n	%	n	%	n	%
Yes	14	24.1	19	25.3	33	24.8
No	44	75.9	56	74.7	100	75.2
TOTAL	**58**	**100**	**75**	**100**	**133**	**100**

4 Discussion

The 2021 Zimbabwe PLHIV Stigma Index 2.0 study aimed to broaden the understanding of the extent and forms of stigma and discrimination faced by PLHIV in Zimbabwe. The results from this exercise clearly demonstrated that PLHIV in Zimbabwe still face stigma and discrimination because of their HIV status in different facets of their lives.

4.1 Stigma and discrimination

Reduced experiences of stigma

The results of the study show that 69.7% of PLHIV experienced at least one form of stigma and discrimination due to their HIV status, echoing the levels of stigma that were previously reported in the 2014 PLHIV Stigma Index, where 65.5% of respondents had experienced at least one form of stigma and discrimination. Though marginal, tThis noted increase , highlights that despite increased awareness in the general population about the rights of PLHIV, stigma and discrimination are still rampant in Zimbabwe.

The most prevalent form of discrimination across groups and contexts by a large margin is consistent discriminatory remarks and gossip from other people (24.4% of the general sample). However, there have been improvements in other areas. For instance, the study showed that 20% of respondents had experienced discrimination in the form of gossiping about their HIV status by family members, and this is a reduction from the 51.4% reported in the 2014 study. Additionally, there was a reduction in the proportion of respondents reporting being verbally harassed (15%), compared to the previous study (31.2%). Reductions were also evident in other areas:

- exclusion from social gatherings (4.4% from 21% in 2014)
- physical harassment (4% from 19% in 2014)
- partner discrimination (5.6% from 15% in 2014)

Such improvements could be attributed to changing perceptions towards PLHIV in Zimbabwe. Results from this study highlight the need to raise awareness on the effects of stigma and discrimination against PLHIV in general and key populations in particular. This is especially urgent in a setting such as Zimbabwe where there are widespread negative perceptions about sex workers (Qiao et al., 2019; Tsang et al., 2019), men who have sex with men (Moyo et al., 2021), and incarcerated persons (Pillay et al., 2021).

Disclosure challenges

In general, PLHIV had more positive experiences with disclosing to family members than to others. This might be due to a reluctance to disclose to others at all because of internalized stigma (see discussion below). PLHIV may not be telling others outside of

friends and family for fear of their response, or just not finding it necessary to disclose to others, in which case the low reporting of positive disclosure experiences may not reflect a problem.
The highest incidence of disclosure without consent occurred with classmates (47.1%) and teachers (38%), authority figures (31%), neighbours (29%), employer (28%), local leaders (26%), other family members (26%), co-workers (25%), husband / wife / partner (24%) friends (24%), children 21%,. This could imply that the school environment is stigmatizing students who are living with HIV and that interventions should prioritise the school environment. This aligns with the findings on internalized stigma, which highlight the vulnerability of young PLHIV. However, it should be noted that classmates were one of the groups with the lowest proportion of disclosure (5%), especially compared to the group with the highest proportion of disclosures, husband/wife/partner(s) (67%).

Young people most affected by internalized stigma

Nearly half of the respondents reported that they were affected by some form of internalized stigma. Of particular concern was the fact that the adolescent group (18-19 years) was the most affected (57.5%). This is particularly troubling as adolescents face multitude additional challenges associated with their developmental stage, as well as access to HIV services. Internalized stigma had the biggest impact on the desire of participants to have children (18%). Therefore, this calls for more self-esteem related efforts to be targeted toward this vulnerable population, as highlighted by a number of scholars in the recent past (Falcão et al., 2021).

Overall, feelings of guilt and shame manifested most as a struggle to tell others about one's HIV status, with over half of respondents (52.1%, men and women equally) reporting that they struggle to disclose. Consequently, 43% of respondents said that they hide their status from others.

PLHIV in Zimbabwe are resilient

Despite the negative experiences reported that PLHIV face, the level of resilience, in terms of meeting their internal needs, was high. This is evidenced by the fact that more than 40% of respondents reported being positively affected by their HIV status in areas such as self-confidence, self-respect, ability to respect others, coping with stressful situations, ability to secure relationships, and ability to contribute meaningfully to their communities.

Experiences of Women Living with HIV

Experiences of stigma and discrimination due to HIV status, and internalized stigma were reported in similar degrees and proportions by male and female participants. The most noticiable gendered differences emerged around health care, including HIV treatment and reproductive health. For instance, women were more than twice as likely as men to start ART because they felt pressured or forced by health care workers at 3.4%. More women (44% compared to 35% of men) also reported that fear of being judged by others prevented them from getting tested in the first place.

In terms of reproductive health, at 5.6% women were twice as likely as men to be advised not to have sex because of their HIV status. At 2.2%, women were four times more likely than men to be told not to have a child. Around 3% of women also reported that when

they were pregnant, they felt pressured by health care professionals to use a specific contraceptive method, give birth a certain way, and use a specific method of infant feeding, and to take ART during pregnancy.
In general women disclosed their HIV status more than other sub-populations, to other family members (75%), husband / partner (65%), children (61%), friends (51%), co-workers (24%), local leaders (19%), neighbours (36%), teachers (6%), classmates (5%), authority figures (4%).

4.2 Interactions with health care services

PLHIV prioritize their health

In line with the above trends, the fear of stigma affected the decision to get tested in the first place, with 39.2% of respondents reporting that fear of others knowing their HIV status made them hesitate to get tested. In spite of this stigma, when it comes to their health, respondents revealed that they prioritize getting treatment and care. The majority of respondents (88.7%) chose to start ART when they learned of the benefits and 76.3% started within a month of diagnosis. It is encouraging to note that almost all respondents were either on current treatment or had accessed treatment in the past (98%) and had access to HIV treatment (91%). Overall, 75.8% of respondents reported being in good general health.

Although most respondents (86.4%) reported that they had not stopped ART treatment and more than half of respondents were virally suppressed at the time of study, 11.4% reported that they had stopped ART at some point and 12.8% reported that they had not had a viral suppression test in the last year. This suggests that health care providers should prioritize ART support and monitoring services for PLHIV patients.

Gossip leads PLHIV to discontinue ART

However, 17.9% of respondents revealed that when they had stopped ART treatment in the past year, it was for stigma-related reasons. Again, being gossiped about (9.9%) and having heard other people talk about their HIV status without their consent (7.7%), were the most common forms of discrimination experienced at health facilities. Similar numbers of participants reported these negative experiences from staff when seeking general health care services. Hence, there is a continued need to ensure that all health workers are trained and reminded to uphold the principles of confidentiality where PLHIV patient matters are concerned.

4.3 Human rights and effecting change

Rights abuses declined

The PLHIV reported lower levels of human rights abuses (4.1%) compared to 2014 (21%)

and this could be a good indication that human rights advocates are sharing effective messages in stigma reduction among the general population.

Knowledge of laws protecting PLHIV from discrimination

Although there was a general awareness of laws meant to protect PLHIV from discrimination in Zimbabwe, there was a worryingly large number of respondents who were not aware of such laws (21.8%) or said there were no such laws (4.1%). Such gaps in knowledge could potentially have serious ramifications as they increase the vulnerability of PLHIV and also impede access to recourse in the case of human rights violations. Therefore, it is imperative for the government and other key stakeholders to hold awareness campaigns and educate vulnerable populations on the existing laws that are meant to reduce stigma and discrimination against PLHIV.

4.4 Key populations

Transgender, MSM, and bisexual people face the most stigma

The highest rates of group-related stigma were noted around gender identity (40% reported verbal harassment) and MSM (24% reported verbal harassment). Lesbians and WSW reported the least amount of stigma (a maximum of 13.8% reported exclusion from family gatherings). Amongst other key populations (bisexual, PWUD, and sex workers), 20-25% reported some sort of stigma, typically verbal harassment and gossip. Bisexual participants were the least likely to have family members know about their sexuality (26.5%), suggesting that this is the sexual identity group with the most internalized stigma.

PWUD/PWID risks with support

Nearly half of both MSM and WSW belonged to support groups for their identity groups – the highest of the key populations. PWUD had the lowest group membership with only 25.3% female respondents and 24.1% male respondents being part of support groups. These percentages are not encouraging considering the negative effects of drug use and the ensuing pandemic in Zimbabwe.

Also of concern is the fact that of the 73 people who admitted to using drugs, less than 50% had family members who were aware, meaning these people might not be receiving assistance in the form of rehabilitation. PWUD felt stigmatized by family members who gossiped about their usage of drugs, not their HIV status.

Female sex workers are more open about their identity

There was an increase in the number of people who identified as sex workers from 2.2% noted to 61.3% in 2014. Female sex workers reported were more likely to have their identity known by others by an average 30 percentage points across all groups. For instance, 71.8% of female sex workers said people in their communities were aware of their identity compared to 41.1% of male respondents. This suggests that male sex workers may face greater stigma in society more broadly, which, combined with concerns about fear of disclosure and missed ART at health facilities, means that they may be at greater risk for missing essential treatment.

4.5 Study Limitations

The study had design and sampling limitations that should be acknowledged when interpreting these findings. Some groups, such as PWUD/PWID, were underrepresented in the sample due to non-availability and this limits the generalizability of findings. There was no size estimate for the PWUD/PWID at country level, making it difficult to find and engage them for the study. Another challenge was that one participant could be a member of multiple identity groups, and this affected the appearance of the sample distribution. There is also a possibility that some individuals may not have identified themselves as transgender or PWUD due to concerns about social stigma, privacy, and fear.

Also, the study did not include PLHIV with mental health problems or asked about the mental health of respondents. This is another critical stigma category that may have enhanced feelings of stigma and discrimination.

5 Recommendations

The 2021 PLHIV Stigma Index 2.0 study has highlighted that experiences of stigma and discrimination can vary based on the social context, socio-demographic characteristics of PLHIV, and one's belonging to other identity groups. Therefore, in order to fully address HIV-related stigma for PLHIV in Zimbabwe, interventions need to be tailored to respond to the nuanced experiences of subgroups of PLHIV. As a result, the following recommendations are offered for different organizations to design effective interventions:

National AIDS Council: Disseminating information about HIV-related stigma and discrimination

- Use existing structures to widely disseminate the PLHIV Stigma Index 2.0 study results to all the participating districts, relevant stakeholders, and communities countrywide.
- Disseminate findings on the experience of stigma by PLHIV in all sectors of the Zimbabwean economy, including but not limited to government agencies, the private sector, educational sector, workplaces, health institutions, and the general population.
- Include HIV-related stigma and discrimination indicators in Zimbabwe's official HIV response monitoring and evaluation systems to track progress over time.
- Develop and roll out strategies and guidelines with a specific focus on key issues such as HIV status disclosure in all settings, such as the workplace, learning institutions, the community, prisons, and health care institutions.
- Establish and support community and PLHIV-led monitoring mechanisms HIV-related stigma and discrimination interventions.
- Collaborate with civil society organizations to run programmes on radio and television, for young PLHIV and key populations to discuss ways of mitigating stigma and discrimination.
- Continue to educate professionals within key sectors on anti-stigma and anti-discriminatory strategies, such as law enforcement agents, religious leaders, community gatekeepers, the media, and health care service providers.
- Encourage HIV-Stigma free workplace policies. This can be achieved through awareness-raising among private sector leadership, managers, supervisors, peer educators, and other significant cadres within the work setting. In addition, labour laws should protect against unethical practices (such as forced HIV testing prior to recruitment).

Civil society organizations: Addressing human rights abuses, empowering PLHIV, and supporting key populations

- Adopt a rights-based HIV programming approach at national and community level.
- Increase awareness, sensitization, capacity building, and empowerment of PLHIV to seek redress when their rights are infringed on.
- Increase HIV literacy among PLHIV and ensure that those who may be subjected to stigma and discriminatory practices are offered psychosocial care and support.
- Design client-centred and differentiated packages to tackle stigma at different levels, e.g., the community, family, church, workplaces, and schools.
- Set up and support community and PLHIV-led monitoring mechanisms meant to monitor and mitigate HIV-related stigma and discrimination, e.g., a call centre.
- Strengthen existing networks for key populations and create new networks where necessary.

Communities and families: Eliminating HIV-related discrimination among individuals

- Promote and encourage HIV status disclosure to intimate partners and within families to foster adherence and informed decision making.
- Since the majority of respondents reported that they faced discriminatory practices within their own families and the society at large, there is need to educate families and communities to reduce gossip, verbal abuse, exclusion from social gatherings, and physical abuse due to HIV status.
- Increase public awareness of PLHIV and address myths and misconceptions associated with HIV and AIDS at different levels of the community.
- Increase community sensitization and mobilization programmes to deliver key messages that discourage HIV-related stigma in the community.

Young people living with HIV: Reducing internalized stigma

- Link up young PLHIV with agencies like Zimbabwe Young positives and Zvandiri where they can find safe havens to share their concerns and be empowered through learning life skills.
- Increase focus on psychosocial needs of young PLHIV as they transition into adulthood to eliminate internalized stigma.

Ministry of Health and Child Care: Reducing stigma in health facilities

- Promote human rights, and people-centred and HIV-sensitive services within the public health delivery system.

Ministry of Primary and Secondary Education: Reducing HIV-related discrimination in schools

- Increase awareness among teachers due to their interactions with the young people at school.
- Create peer champions for schools to ensure that learners are not negatively affected by external stigma from teachers and other students.
- Strengthen school health programmes to include stigma.
- Use social media platforms for information dissemination for the young and school-going children
- Key population networks: Reducing non-HIV related stigma
- Increase commitment to combating stigma affecting key populations as they usually are faced with "double stigma". These key populations include MSM, WSW, bisexual people, transgender people, PWUD/PWID, and sex workers.
- Strengthen existing key populations services within the existing public health services and facilities in Zimbabwe.
- · Assist in the development of community monitoring systems that track stigma, discrimination, and human rights violations in these communities, and share the data in key population forums.

Further research

- Conduct further research of a qualitative design, which would help bring to the fore a deeper understanding of how stigma occurs in PLHIV in varying socio-cultural settings within Zimbabwe.
- Conduct further research focusing on implementation of cost-effective and culturally appropriate interventions to reduce stigma and discrimination for PLHIV in Zimbabwe.
- Undertake studies to understand the occurrence of stigma of PLHIV in specific institutions such as schools and universities, as well as workplaces.
- Conduct further studies on the stigma of vulnerable groups of PLHIV, such as migrant workers.

6 Conclusion

The 2021 Zimbabwe PLHIV Stigma Index 2.0 Study revealed that are still existing gaps around HIV-related stigma and discrimination. The study showed that there is a high prevalence of stigma and discrimination and that PLHIV are subjected to different forms of stigma and discriminatory practices. Notably, these practices stem from PLHIV status and their membership and association with other stigmatized identity groups. Specifically, the main stigma and discrimination practices include, being excluded from social gatherings, gossip, and verbal and physical abuse from family, friends, teachers, health care workers, and authority figures, among others. Furthermore, HIV-related stigma still exists at many levels including the family, public institutions, and the community at large. Nevertheless, study results also show that Zimbabwe has made major strides in ensuring that PLHIV have access to HIV treatment and care services, with close to 100% of respondents reporting that they had access to treatment. There is also evidence that the level of resilience among PLHIV is high. Resilience in the face of various shocks is important for PLHIV's physical and psychological well-being. Prospectively, HIV programming in Zimbabwe should prioritize creating an enabling environment to reduce stigma and discrimination against PLHIV to sustain and enhance health outcomes and quality of life for PLHIV.

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ANNEXURES

Annex 1: Zimbabwe HIV epidemic, 1988-2015

Panel 2. Annex 1: Zimbabwe HIV epidemic, 1988-2015

1988

As of 1988, 17.4% of the Zimbabwe's population had never heard of AIDS, with 14% of the population taking some action to avoid AIDS, 0.4% using condoms, and 17.2% not knowing how to avoid AIDS. At the time, the major sources of information about AIDs were health workers, newspapers, and radio. At this time, data on prevalence or incidence were not readily available, and HIV and AIDS were mostly associated with homosexual people. Stigma and discrimination were high, with 78% of people believing that people living with AIDS should be quarantined and only 7.6% believing that they should be allowed in public places (MoHCC, 1988).

1994

By 1994, there was a vast increase in HIV and AIDS awareness, with 98.7% of women and 99.6% of men having heard of the pandemic. There was a marked improvement in condom use, with 57.1% of women and 52.3% of men using condoms. HIV prevalence among pregnant women was estimated to be between 8 and 12% at the time. In terms of risk perception, 46.1% of women and 55.3% men believed they had no risk at all. In terms of behavioural change, 21.1% of women and 37.6% men had changed their sexual behaviour in light of the pandemic (MoHCC, 1994).

1999

By 1999, HIV prevalence in Zimbabwe indicated that one in four adults in Zimbabwe were infected with HIV and that the principal mode of transmission of HIV was heterosexual contact, followed by mother to child transmission. In terms of HIV prevention knowledge, only 3.5% women and 0.9% men did not know how to prevent HIV transmission. In terms of stigma and discrimination, 60% of married women and 81% married men had never discussed about HIV with their spouses. In terms of HIV testing, 11.8% of women and 9.2% of men had been tested for HIV. Among those not tested, 59.1% of women were willing to be tested, 22% were not and 63.4% did not know where to access testing services. In terms of condom use, 9.1% of women and 27.7% men used condom with any partner (MoHCC, 1999). By this time, HIV testing facilities were readily available. Also, there was provision of antiretroviral therapy in the country as well as prevention of mother to child transmission programmes that included provision of single dose nevirapine to pregnant mothers. The nevirapine was also locally produced.

2006

By 2006, the epidemic was regarded as a generalized epidemic, with high prevalence levels among the different population groups. HIV prevalence was 18.1%, with 14.5% being among men and 21.1% among women. In terms of HIV testing, 75.9% women and 63.4% men indicated that they had been tested. In terms of comprehensive knowledge of HIV, 43.7% of women and 45.6% of men had comprehensive knowledge. With regards to stigma and discrimination, 91% of the population would care for a family member living with HIV. However, 56.8% of the population would buy vegetables from someone living with HIV (MoHCC, 2006).

2011

HIV prevalence decreased to 15.2% in Zimbabwe in 2011, with 17.7% among women and 12.3% among men. In terms of comprehensive knowledge of HIV transmission, 53% of both men and women had comprehensive knowledge. In the area of stigma and discrimination, 94.7% of the population were willing to care for a family member with AIDS and 77.9% would buy vegetables from a PLHIV (MoHCC, 2011).

2015

In 2015, HIV dropped to 13.8% in Zimbabwe, with 16.7% being among women and 10.5% being among men. Among people living with HIV, 93% women and 83% men were tested and received their results. In terms of comprehensive knowledge of HIV, 55% of women and 56% of men had such knowledge. In terms of stigma and discrimination, 20% of men had discriminatory attitude and 21.8% women had discriminatory attitude.

Annex 2: ZNNP+ Programmes

Target, Accelerate, Sustain Quality Care (TASQC)

In October 2020, the PEPFAR funded Target, Accelerate, Sustain Quality Care (TASQC) for Epidemic Control Program was launched with support from USAID Zimbabwe.. The programme is led by OPHID with J F Kapnek and ZNNP+ as implementing partners. The goal of the programme is to contribute to the achievement and sustainability of HIV epidemic control in Zimbabwe through the provision of technical, financial, and material support towards the management, coordination, and provision of comprehensive clinical and community care services within the national HIV programme.

National AIDS Trust Fund

With financial and logistical support from the National AIDS Council (NAC), ZNNP+ is implementing interventions that align to the strategic pillars which are advocacy, communication and social mobilization, community systems strengthening and coordination of the PLHIV sector in Zimbabwe.

UNAIDS

UNAIDS is providing support to ZNNP+ to operate a call centre which serves the function of disseminating information to people living with HIV in Zimbabwe. This is a helpline through which people living with HIV can call for free and seek assistance. This platform provided support to people living with HIV during the COVID-19 containment measures period, where there was limited movement and access to health facilities. UNAIDS has also supported the Stigma Index Study which is conducted across all the country's 10 provinces.

Health Care Private Limited

The project is focusing on finding, linking, and retaining children aged 0-14 years who are not in care across two provinces and four districts, with two districts targeted per province. The project will run from 2022 to 2024, and will feed into the strategic pillars which are advocacy, communication and social mobilization, community systems strengthening, and knowledge management. Essentially, the project is expected to contribute towards the national EMTCT targets.

Annex 3: Interviewer confidentiality agreement

I.., an interviewer administering the People Living with HIV Stigma Index 2.0 study in... *[INSERT the name of the country in which the study is being conducted]*, agree to the following:

a. I will take all possible steps to protect the confidentiality of the information I receive during the interviews I conduct. This means that I will not disclose any personally identifying information to anyone, unless:
   i. explicitly instructed to do so by the participant in the study; or
   ii. compelled to disclose specific information under a court order of a competent court.

b. I will not record any personally identifying information on the questionnaire.

c. I will keep the "key" (contact list and questionnaire code) in a secure location (e.g. under lock and key), and stored separately from the questionnaires.

d. Any information stored electronically will be on a password-protected system where I have sole access to or in a password-protected file.

e. Following the data entry and verification process, and upon instruction from the project leader with the.. *[INSERT name of the organization managing the study]*, I will destroy all completed questionnaires and the "key". I will retain a contact list for the purpose of sharing results of the study with participants expressing interest in receiving such information.

INTERVIEWER	Signature

Name (printed)	Date	Place (city, country)

PROJECT LEADER OR WITNESS	Signature

Name (printed)	Date	Place (city, country)

Annex 4: Team leader confidentiality agreement

I,…………………………………………………………………., a team leader responsible for overseeing and supporting the delivery of the People Living with HIV Stigma Index 2.0 study in
……………………………………………………………*[INSERT the name of the country in which the study is being conducted],* agree to the following:

a. I will take all possible steps to protect the confidentiality of the information that is under my care. This means that I will not disclose any personally identifying information to anyone, either verbally or in writing, unless:
   i. explicitly instructed to do so by a participant in the study; or
   ii. compelled to disclose specific information under a court order of a competent court.

b. I will take all possible steps to protect the confidentiality of employee/volunteer information in accordance with local laws and regulations.

c. Any information stored electronically will be on a password-protected system or in a password-protected file, and I will ensure that only project employees/volunteers who need access to this information have the necessary password.

d. I will instruct interviewers administering the People Living with HIV Stigma Index 2.0 study to keep the "key" (contact list and questionnaire code) in a secure location (e.g. under lock and key), and stored separately from the questionnaires.

e. Following the data entry and verification process, I will destroy all completed questionnaires and the "key". I will instruct interviewers to do the same. I will retain a contact list for the purpose of sharing results of the study with participants expressing interest in receiving such information.

f. I will protect the identity of all people participating in the People Living with HIV Stigma Index 2.0 study. I will do nothing that discloses the identity of someone who is or has been associated with the project.

g. I am responsible for ensuring that appropriate ethical standards are maintained in this project. As part of the training that is provided to interviewers administering the People Living with HIV Stigma Index 2.0 study, I will instruct them not to record any personally identifying information on the questionnaire. I will remove (or make illegible) any personally identifying information that I observe when reviewing completed questionnaires (e.g. while doing quality checks).

TEAM LEADER
Signature

Name (printed)
Date
Place (city, country)

WITNESS
Signature

Name (printed)
Date
Place (city, country)

Annex 5: Ndebele consent form

UMHOKHELI OMKHULU: Dr J. January, University of Zimbabwe Department of Community Medicine
UCINGO: 0772 807 029
OSEKELA INHLOLISISO: The Joint United Nations Programme on HIV/AIDS (UNAIDS)

Ukuvumelana ngemuva kokuzwisisa (INFORMED CONSENT)
Okumele ukwazi mayelana ngalinhlolisiso:

- Sikunikeza ifomu yesivumelwano ukuze ubale mayelana ngenhloso, ingozi kanye loncedo oluvela kulinhlolisiso.
- Ulelungelo lokwala ukungena kulinhlolisiso, kumbe ukuvuma ukungena kodwa ube usuguqula umqondo ngokuhamba kwesikhathi.
- Lokho okukhethayo akusoze kuphazamise uncedo olutholayo ekilinika yakho.
- Siyacela ukuthi uhluze ifumo yokuvuma le ngonanzelelo. Buza imibuzo ongabe ulayo ungakathathi isinqumo.
- Ukungena kwakho kuloluhlelo ukwenza ngentando yakho.

INJONGO YALINHLOLISISO NGEYANI?

Ngiphethe iphepha lemibuzo mayelana ngempilo yalabo abaphila legciwane leHIV, ikakhulu ukukhethwa lokubandlululwa kwabo. Sengikunikeze ikhasi elichaza inhloso yogwalo lwemibuzo, kanye lokuthi imbiko ezatholakala lapha izaba yingxenye yenhlolisiso enkulu eqhutshwa elizweni edinga ukwazi impilo yalabo abaphila legciwane leHIV. Ikhasi leli lichaza njalo indaba ozazibuzwa, ukuthi imbiko le igcinwa njani ngendlela efihlekileyo kanye lengozi ezingaba khona nxa umuntu engangena ehlelweni lolu.

INDLELA OKUQHUTSHWA NGAYO LINHLOLISISO (PROCEDURES AND DURATION)

Kulokhu kuxwayisisa sizakhetha ihlekana labantu abaphila lomkhuhlane wengculazi. Sikhangelele ukuxoxisana Labantu abangafika inkulungwane elizweni jikelele. Imibono yalabo abakhethiweyo ukungena kuloluxwayisiso lokhu sizayithola ngokubabuza imibuzo emayelelana lendlela abazizwa bephatheka ngayo evelela ekuthini baphila lomkhuhlane lo. Sixoxisana lawe njengomunye ngomunye wabantu abaphila lomkhuhlane wengculazi. Kulilungelo lakho ukuba uvume kumbe wale ukungena kukuxwayisisa lokhu. Uzabuzwa imbuzo mayelana ngokuhlukuluzeka lokungaphathwa kahle kuvelela ekuphileni kwakho lalumkhuhlane. Ulakho ukungaphenduli imibuzo engasoze ikuphathe kahle. Imibuzo le ilakho ukuthatha ihola elilodwa kusiya kwamabili. Nxa ungakhetha ukuphendula imibuzo kanye lokuphatheka kulinhlolisiso, ngizakubuza imibuzo mayelana ngempilo yakho njengomuntu ophila legciwane leHIV, ikakhulu ukukhethwa lokubandlululwa. Ngikhangelele ukuthi ingxoxo le ithathe isikhathi esiphakathi kwamahola amabili kusiya kwamathathu.

INGOZI LALOKHO OKUNGAPHATHI KAHLE (RISKS AND DISCOMFORTS)

Iphepha lemibuzo libuza imibuzo ngawe, elakho ukwenza ungahlaliseki kwesinye isikhathi, njalo ilakho ukuvusa indaba ezingaba nzima ukukhuluma ngazo. Singakaqhubi lingxoxo, ngithanda ukuba leqiniso lokuthi ungene ehlelweni lolu ngentando yakho njalo uyitholile imbiko yonke efunekayo ukuze uthathe inyathelo mayelana ngokuphatheka kwakho kulinhlolisiso. Ukhululekile ukuthintana lomkhokheli waloluhlelo nxa kukhona ofuna ukukubuza mayelana ngoluhlu lwemibuzo kumbe inhlolisiso le.

OKUNGAKUNCEDA (POTENTIAL BENEFITS)

Silethemba lokuthi ingxoxo yemibuzo le izabe ikhwabitheka kuwe njengoba ilakho ukuphatha ezinye indaba obungazange ucabange ngazo okujulileyo. Silethemba njalo lokuthi uzafunda okunengi kulingxoxo kanye lezinye ingxoxo ezingalandela. Nxa ufuna, ukuphatheka kwakho kungenza ukuba ngikunikeze uluhlu lwalabo abangakunika uncedoesigabeni sakho olubalisela ukwelatshwa, inhlalakahle kanye loncedo lwezomthetho.

INDLEKO LENHLAWULO (COSTS AND REIMBURSEMENTS)

Akula ndleko ozakuba lazo nxa ungaphatheka kulinhlolisiso. Uzahlawulwa imali eyi $5 eyesikhathi osisebenzisileyo ukuphendula limibuzo.

UKUTHEMBEKA /IMFIHLO (CONFIDENTIALITY)

Konke ozasitshela khona kuzagcinwa kuyimfihlo. Akekho ongaphandle kwale inhlolisiso ozakuba kwazi ngempumela yayo. Konke okubhalwayo kuzagcinelwa endaweni ekhiywayo kumbe ukugcinwa kuma Computer. Ibizo lakho kumbe amanye amazwi angakuveza kakusoze kusetshenziswe kumaphephandaba kumbe kuma rephoti kusuka kule inhlolisiso. Imbiko ezatholakala kulingxoxo izagcinwa ngemfihlo enkulu. Ukuze kube lemfihlakalo, angisoze ngibhale igama lakho ekhasini lemibuzo kumbe kuyonale ifomu, njalo angisoze ngibhale imbiko engenza abantu babe kwazi ukuthi ungubani.

Nxa ufuna ukuba kwazi amanyathelo esiwathathayo ukuze sigcine imbiko njengemfihlakalo, ukhululekile ukungibuza.

INGOZI ENGABANGELWA YINHLOLISISO LE (IN THE EVENT OF INJURY)

Nxa kungenzeka ukuthi ulimale ngenxa yokuphatheka kulinhlolisiso, uzanikezwa uncedo khonapho khonapho.

UKUNGABANJWA NGAMANDLA/VOLUNTARY PARTICIPATION

Ngingakakubuzi ukuthi uyafuna kumbe hatshi ukuphatheka ehlelweni lolu, ngifuna ube kwazi okulandelayo: Ukuphatheka kwakho kulinhlolisiso ukwenza ngentando yakho. Yikufuna kwakho ukuphatheka kumbe ukwekela. Ukhululekile ukungaphenduli imibuzo ekuleli khasi lemibuzo. Ulakho ukwekela ukuqhubekela phambili ngengxoxo iloba yisiphi isikhathi. Ulemvumo yokutshiya ukuphatheka kuokhu kuxwayisisa loba ngasikhathi bani akulakujeziswa ozakwenziwa.

IMVUMO YOKUBUZWA (OFFER TO ANSWER QUESTIONS)

Sengibalile kumbe ngibalelwe mayelana ngokuxwayisisa lokhu. Ngiyazwisisa ngobuhle lobubi bokuxwayisisa lokhu. Ngiyazwisisa ukuthi ukungena kukuxwayisisa lokhu ngiyazikhethela. Ngiyazikhethela ukungena. Ngiyazi ukuthi ngilemvumo yokuma kumbe ukwala ukuphatheka kulokhu kuxwayisisa loba ngasiphi isikhathi njalo akulakujesiswa kumbe ukuthathela ilungelo lami. Ngiyazi ngizathola iphepha logwalo lolu.

Imvumo yakho oyenza ngomlomo yiyo efunekayo ukuthi siqhubekele phambili ngalingxoxo. Nxa usizwa ukhululekile ukwenza lokho, usungasayina igama lakho kumbe ukubhala amabala okuqala egama lakho phansi, okutshengisa imvumo yakho oyibhale phansi, yokwenza lingxoxo.

Ungalibali kodwa ukuthi imvumo yomlomo yiyo efunekayo kuphela. Akudingakali ukuthi usinikeze imvumo ebhalwe phansi, kodwa nxa ufuna ungakwenza lokho.

UKUBUZA ONGAZWISISANGA KHONA
Ungabuza lapho ongezwisisanga khona ungakasayini.

______________	______________
Ilanga	I siyinature yobuzwayo

____
Ibizolobuzwayo

______________	______________
Umfakazi	Ilanga

______________	______________	______________
Igama luvumayo	Ukusayina	Usuku

Isitshengiso sokuvuma nxa ngingenelisi ukuloba (thumbprint/mark if unable to sign)

______________ Usuku______________

Annex 6: Shona consen form

MUONGORORI MUKURU: Dr J. January, University of Zimbabwe Department of Community Medicine
NHARE: 0772 807 029
VATSIGIRI VEONGORORO: The Joint United Nations Programme on HIV/AIDS (UNAIDS)

MVUMO INE KUNZWISISA (INFORMED CONSENT)

Zvaunofanira kuziva mayererano neongororo iyi:

- Tinokupa fomu rekubvuma iri kuitira kuti ugoverenga nezvechinangwa, njodzi nezvinobatsira muongororo iyi.
- Une kodzero yekuramba kupinda kana kubvuma kupinda iye zvino, asi kumberi wozosandura pfungwa dzako.
- Sarudzo yako haisi kuzokanganisa rubatsiro rwaunopiwa kukirinika iri munharaunda mako.
- Ongorora fomu iri zvakasimba. Bvunza mibvunzo usati watora danho rauri kuda.
- Kupinda kwako muchirongwa ichi kurikuitwa nekuda kwako.

CHINANGWA CHEONGORORO IYI NDECHEI?

Ndirikuona nezvegwaro remibvunzo rinove mayererano nehupenyu hwevanorarama nehutachiwana hweHIV, zvikuru kunyenyeredzwa nekusarudzwa kwavanoitwa.
Ndakupa bepa rine mashoko anotsanangura chinangwa chegwaro remibvunzo iri pamwe nekuti mashoko achawanikwa apa, achashandiswa sei muongororo huru irikuitwa munyika muno mayererano nehupenyu hwevanhu vanorarama neHIV. Bepa iri rinotsanangura zvekare zvauchabvunzwa, kuchengetedzwa kuchaitwa mashoko acho pamwe nenjodzi dzinogona kuvapo kana ukapinda muongororo iyi.

NZIRA DZEKUFAMBISA ONGORORO IYI (PROCEDURES AND DURATION)

Ndichakubvunza mimwe mibvunzo pamusoro pehupenyu hwako, semunhu anorarama neHIV, zvikuru nyaya dzekunyenyeredzwa nekusarudzwa nevanhu. Ndinotarisira kuti hurukuro yedu yemibvunzo iyi ichatora nguva inobvira pama awa maviri kusvika matatu.
Ndisati ndakubvunza kuti unoda kupinda muongororo iyi kana kuti kwete, ndinoda kuti utange waziva zvinotevera. Mashoko achawanikwa pahurukuro iyi achachengetedzwa nekuvimbika kukuru. Mukuedza kuvimbika, handisi kuzonyora zita rako pafomu iri kana pagwaro remibvunzo, uye handisi kuzonyora mashoko anogona kuita kuti vanhu vazive kuti ndiwe ani. Kana uchida kuziva zvakawanda mayererano nematanho atiri kutora mukuchengetedza mashoko nekuvimbika kukuru, ndibvunze hako uye ndichakupindura zvizere.

NJODZI / KANA ZVINOUNZA KUSAGADZIKANA (RISKS AND DISCOMFORTS)

Gwaro remibvunzo rinobvunza mibvunzo inogona kuita kuti unzwe usisina kugadzikana dzimwe nguva, uye mimwe mibvunzo inogona kuunza nyaya dzinonetsa kutaura nezvadzo.

URIKUPINDA MUCHIRONGWA ICHI NEKUDA KWAKO (YOUR TAKING PART IS VOLUNTARY)

Tisati tatanga hurukuro yemibvunzo iyi, ndinoda kuva nechokwadi chekuti urikupinda muongororo iyi nekuda kwako, uye wawana mashoko ese awange uchida, mukutora danho rekupinda muchirongwa ichi.

Fomu iri rinogona kuva nemazwi awusinganzwisise. Kumbira kuti ndimire kana pane zvaunenge usina kunzwisisa uye ndichakutsanangurira. Hausi kuzosarudza nhasi kuti unoda kupindura mibvunzo iyi kana kuti kwete. Usati waita sarudzo yako, unogona kutaura nemumwe munhu wawakasununguka kutaura naye mayerana negwaro remibvunzo iri kana ongororo iyi. Sununguka kutaura nemutungamiri wechirongwa ichi kana uyine mibvunzo kana zvimwe zvinokunetsa mayererano negwaro remibvunzo kana ongororo.

ZVINOBATSIRA (BENEFITS AND COMPENSATION)

Tinovimba kuti kupindura mibvunzo iri mugwaronhau kuchakunakidza sezvo kuchigona kuunza dzimwe nyaya dzawanga usina kufunga zvakadzama. Tinovimbawo zvekare kuti pane zvauchadzidza muhurukuro iyi pamwe nedzimwe dzinogona kuzoitwa.

Kana uchida, kupinda kwako muchirongwa ichi kuchaita kuti ndikupe mazita evanokwanisa kukupa zvirongwa zvakaita sekurapwa, rubatsiro mumagariro ako pamwe nerubatsiro mune zvemitemo munharaunda mako.

TSINDIDZO (CONFIDENTIALITY)

Zvose zvamuchatiudza zvichachengetedzwa pakavanzika. Hapana munhu ari kunze Kwetsvagiridzo ino. achaziva zvinenge zvabuda mubvunzurudzo dzenyu. Zvinyorwa zvose zvichaiswa munokiiwa kana kuchengetwa mumaComputer. Zita renyu kana mamwe mashoko angaita kuti muzivikanwe hazvizoshandiswi muzvinyorwa zvinoratidzwa ruzhinji (reports or publications) zvichabva mutsvagiridzo ino.

MARI DZINOBHADHARWA PAMWE NEMIRIPO (ADDITIONAL COSTS)

Hapana mari yaunoshandisa kuti upinde muongororo iyi. Ucharipwa mari inoita $5, yenguva yawashandisa kupindura mibvunzo.

NJODZI DZINOGONA KUKONZERWA NEONGORORO (IN THE EVENT OF INJURY)

Kana pakaita chiitiko chinokukuvadza nemhaka yekupinda kwako muongororo iyi, uchapiwa rubatsiro ipapo ipapo.

MVUMO

Kusayina kwamuchaita panzvimbo inotevera zvinoratidza kubvuma kuti maziviswa maererano neongororo iyi, hamuna kumanikidzwa kuva nechokuita nayo, uyezve kuti zvamaudzwa zvaita kuti mugone kunyatsonzwisisa zvamuri kukurudzirwa kuita uye muchitaura zvamunoziva. Zvamunenge mazivisa patsvakiridzo ino zvichabvumidza ini pamwe nevarairidzi vangu kuti tizvishandise muongororo ino bedzi.

Zita re Mupinduri (Nyorai Zvinooneka)	Zuva
Kusayina kwemupinduri	Zuva
Zita reMuongorori	Zuva
Kusayina kweMuongorori	Zuva

Chapupu	Kusayina	Zuva
Zita/Chigunwe (kune vasingagone kunyora)	Kusayina	Zuva
Zita remuongorori	Kusayina	Zuva

MUCHAPIHWA RIMWE GWARO RECHITENDERANO KUTI MUGARE NARO.
Kana muine imwe mibvunzo isina kupindurwa nemuongorori, kana mibvunzo yakanangana nekubatwa kwamaitwa mutsvakurudzo iyi, kana kodzero dzenyu, kana kusabatwa zvakanaka kwamunenge maitwa makasununguka kubata veMedical Research Council of Zimbabwe panhamba dzerunhare dzinoti: 04-791792 kana 04-791193 kana kuti 0772 433 166 or 0779 439 564. Nzvimbo iyi inowanikwa pakero rinoti, National Institute of Health Research, Corner Josiah Tongogara and Mazowe Avenue muHarare.

Annex 7: English informed consent form

PROTOCOL TITLE: **National PLHIV Stigma Index 2.0 Study by the Zimbabwe National Network of People Living With HIV (ZNNP+)**

PRINCIPAL INVESTIGATOR: Dr J. January, University of Zimbabwe Department of Community Medicine

CONTACT DEATAILS: 0772 807 029 /04795835

STUDY SPONSOR: The Joint United Nations Programme on HIV/AIDS (UNAIDS)

INFORMED CONSENT

What you should know about this research study:

- We give you this consent form so that you may read about the purpose, risks, and benefits of this research study.
- You have the right to refuse to take part or agree to take part now and change your mind later.
- Whatever you decide will not affect your regular care that you get at your local clinic.
- Please review this consent form carefully. Ask any questions before you make a decision.
- Your taking part is voluntary.

WHAT IS THE PURPOSE OF THE STUDY?

My name is ………………. and I am doing a study on the experiences of people living with HIV, particularly in relation to stigma and discrimination This study will include around a thousand participants living with HIV throughout the country and you have been selected as a possible participant in this study.

PROCEDURES AND DURATION

If you decide to participate in this study, I will ask you some questions about some of your experiences as a person living with HIV, in particular those related to stigma or discrimination. I expect that the interview will take between two and three hours.

Before asking you whether or not you would like to be a participant, I would like you to know that:

RISKS AND DISCOMFORTS

The questionnaire asks personal questions that may make you feel uncomfortable at times, and it may bring up topics that are difficult to talk about. You are free not to answer such questions. In the event that you are psychologically traumatized, we will refer you for counselling. Your participation in this study is entirely voluntary. It is your choice whether to participate or not.

You are free to not answer any of the questions in the questionnaire. You may stop participating in the interview at any given time.

YOUR TAKING PART IS VOLUNTARY

Before we begin the questionnaire, I would like to make sure that you are voluntarily willing to participate in this study and that you have obtained all the information that you need to make an informed choice about your participation.

This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. You do not have to decide today whether or not you will respond to this questionnaire. Before you make a decision, you can talk to anyone you feel comfortable with about the questionnaire and/or the study.

Please feel free to contact the project team leader if you have any questions or concerns about this questionnaire or the study.

BENEFITS AND/OR COMPENSATION

We cannot and do not guarantee or promise that you will receive any benefits from this study. However we hope that the process of going through the questionnaire is an interesting one for you as it might cover some issues that you may not have thought about in detail. We also hope that you will learn from the interview process and from any discussions which may arise from it. If you wish, your participation will include me providing you with a list of services that are available in our community, including health care, social support and legal services.

There are no costs to you for taking part in this research. You will be reimbursed $5 for your time you have spent answering these questions.

CONFIDENTIALITY

If you agree to participate in this study we will ensure that the interviews are conducted in a private place and all the information you provide will be kept in confidence. Any information that is obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your permission. Your name will not be recorded on the questionnaire and your identity will be kept confidential. Numbers will be used and we will ensure that the papers you sign will not be stored together with the questionnaires.

ADDITIONAL COSTS

There will not be any costs that will arise from participating in this study other than your time.

IN THE EVENT OF INJURY

Though unforeseen, in the event that you get injured whilst participating in this study, efforts will be made to ensure that you receive appropriate care and the costs will be borne by the study. In the event of injury you can contact Dr James January or any member of the research team.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the health facilities, its personnel, and associated hospitals. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty.

OFFER TO ANSWER QUESTIONS

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

Signature of Participant		Time
Name of Staff Obtaining Consent	Signature	Date
Name of Witness (if required)	Signature	Date

YOU WILL BE OFFERED A COPY OF THIS CONSENT FORM TO KEEP.

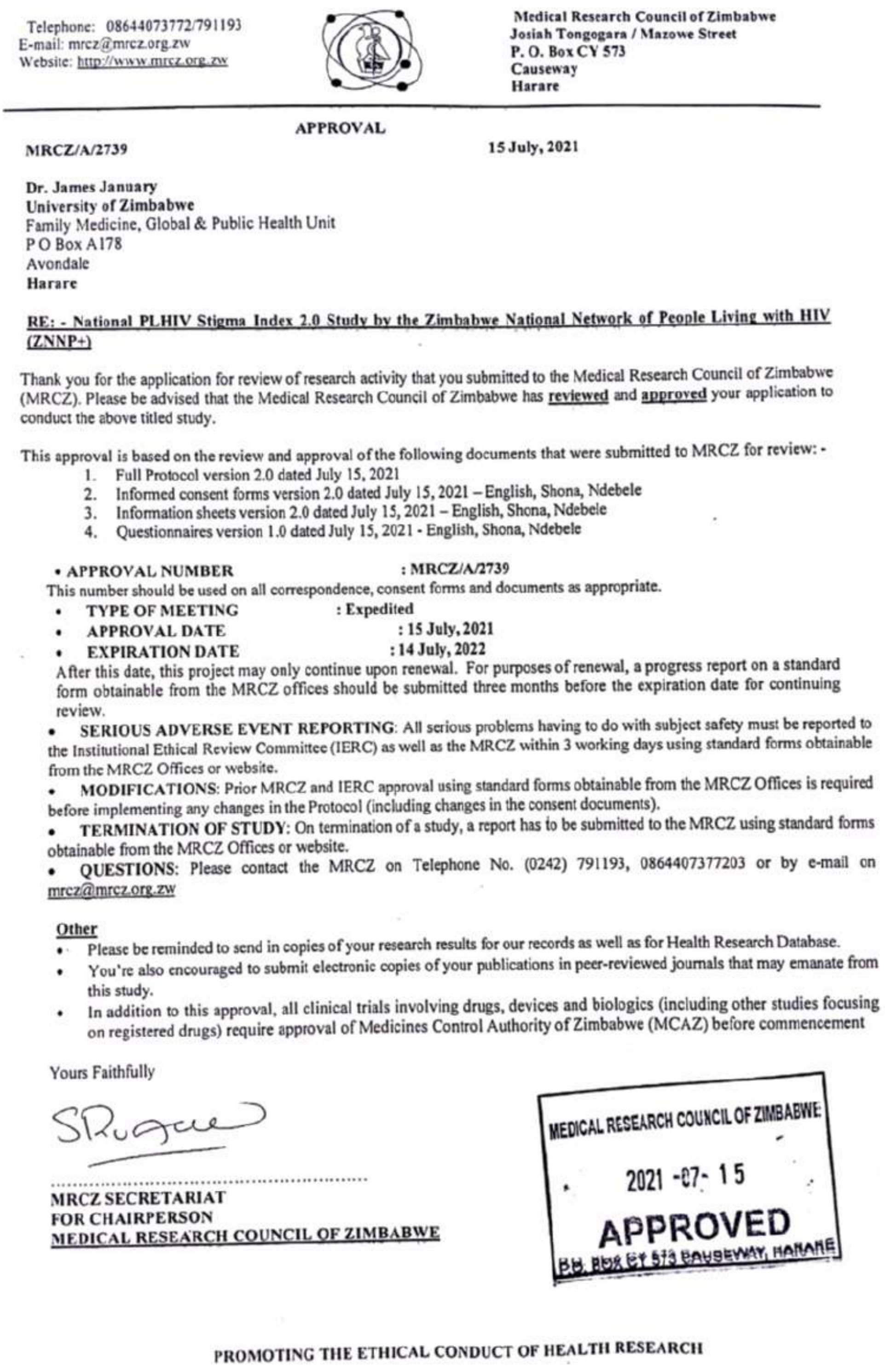
If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research participant or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the Medical Research Council of Zimbabwe (MRCZ) on telephone (04)791792 or (04) 791193 and cell phone lines 0784 956 128. The MRCZ Offices are located at the National Institute of Health Research premises at Corner Josiah Tongogara and Mazowe Avenue in Harare.

Statement	Please initial or thumbprint* each box
This information sheet has been read and explained in a language that I understand and I freely and voluntarily agree to participate in this study. I have been given an opportunity to ask questions about the study and I understand that all the information discussed will not be linked to my identity. I may withdraw my participation at any time and this will not have any negative effect on me.	
I understand that my consent is voluntary and that I am free to withdraw this consent at any time without giving any reason and without my legal rights being affected.	
I agree to take part in the above-named study.	

____
Signature of participant
(or thumbprint/mark if unable to sign)

____
Date

Annex 8: Medical Research Council of Zimbabwe approval letter



Telephone: 08644073772/791193
E-mail: mrcz@mrcz.org.zw
Website: http://www.mrcz.org.zw

Medical Research Council of Zimbabwe
Josiah Tongogara / Mazowe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

MRCZ/A/2739

15 July, 2021

Dr. James January
University of Zimbabwe
Family Medicine, Global & Public Health Unit
P O Box A178
Avondale
Harare

RE: - National PLHIV Stigma Index 2.0 Study by the Zimbabwe National Network of People Living with HIV (ZNNP+)

Thank you for the application for review of research activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review: -

1. Full Protocol version 2.0 dated July 15, 2021
2. Informed consent forms version 2.0 dated July 15, 2021 – English, Shona, Ndebele
3. Information sheets version 2.0 dated July 15, 2021 – English, Shona, Ndebele
4. Questionnaires version 1.0 dated July 15, 2021 - English, Shona, Ndebele

- **APPROVAL NUMBER** : **MRCZ/A/2739**

This number should be used on all correspondence, consent forms and documents as appropriate.

- **TYPE OF MEETING** : **Expedited**
- **APPROVAL DATE** : **15 July, 2021**
- **EXPIRATION DATE** : **14 July, 2022**

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ offices should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING**: All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.
- **MODIFICATIONS**: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.
- **QUESTIONS**: Please contact the MRCZ on Telephone No. (0242) 791193, 0864407377203 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.
- In addition to this approval, all clinical trials involving drugs, devices and biologics (including other studies focusing on registered drugs) require approval of Medicines Control Authority of Zimbabwe (MCAZ) before commencement

Yours Faithfully

……………………………………………………
MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

MEDICAL RESEARCH COUNCIL OF ZIMBABWE
2021 -07- 15
APPROVED
P.O. BOX CY 573 CAUSEWAY, HARARE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

ZNNP+

PRIMARY HEALTH CARE
A HEALTHY NATION
MINISTRY OF HEALTH AND CHILD CARE
ZIMBABWE

NATIONAL AIDS COUNCIL
ZIMBABWE

UNAIDS

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

USAID
FROM THE AMERICAN PEOPLE

OPHID
Organization for Public Health Interventions & Development

GNP+
GLOBAL NETWORK OF PEOPLE LIVING WITH HIV

THE PEOPLE LIVING WITH HIV STIGMA INDEX