



REPUBLIC OF ZIMBABWE

**ZIMBABWE NATIONAL  
HIV AND AIDS STRATEGIC PLAN  
[ZNASP II]  
2011-2015**



October 2011

**ZIMBABWE  
NATIONAL HIV AND AIDS STRATEGIC PLAN  
[ZNASP II]  
2011-2015**

**Delivering our commitment to:  
Zero new HIV infections,  
Zero discrimination,  
Zero AIDS-related deaths.**



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## Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
ATP	AIDS and TB Programme
BCC	Behaviour Change Communication
BTSZ	Blood Transfusion Services Zimbabwe
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CHBC	Community Home Based Care
CHS	Casual Heterosexual Sex
CSO	Central Statistical Office
CSS	Community Systems Strengthening
DAAC	District AIDS Action Committee
DAC	District AIDS Coordinator
DVA	Domestic Violence Act
EDLIZ	Essential Drug List of Zimbabwe
EDR-TB	Extensively Dug Resistant Tuberculosis
EID	Early Infant Diagnosis
EPP	Estimation and Projection Package
ESP	Expanded Support Programme
FBO	Faith Based Organisation
FP	Family Planning
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOZ	Government of Zimbabwe
GUD	Genital Ulcer Disease
HIV	Human Immunodeficiency Virus
HIVDR	HIV Drug Resistance
HMIS	Health Management Information Systems
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HTC	HIV Testing and Counselling
ICT	Information Communication Technology
IDU	Injecting Drug Users
IEC	Information, Education and Communication
IMAI	Integrated Management of Adolescent and Adult Illness
IMPACB	Integrated Management of Pregnancy and Child Birth
IPT	Isoniazid Preventive Therapy
KYE	Know Your Epidemic
KYR	Know Your Response
LMIS	Logistics Management Information Systems
M&E	Monitoring and Evaluation
MARP	Most At Risk Population
MC	Male Circumcision
MCAZ	Medicines Control Authority of Zimbabwe
MCP	Multiple and Concurrent Partners
MDG	Millennium Development Goals
MDR-TB	Multi-Drug Resistance Tuberculosis
MER	More Efficacious Regimens
MIPA	Meaningful Involvement of People Living with HIV
MOHCH	Ministry of Health and Child Welfare
MOT	Modes of Transmission

MSM	Men who have Sex with Men
MTR	Mid-Term Review
NAC	National AIDS Council
NACP	National AIDS Control Programme
NATF	National AIDS Trust Fund
NAP	National Action Plan
NASA	National AIDS Spending Assessment
NBCP	National Behaviour Change Programme
NBCS	National Behaviour Change Strategy 2006-2010
NBSZ	National Blood Service Zimbabwe
NGO	Non-Governmental Organization
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PAAC	Provincial AIDS Action Committee
PCC	Primary Care Counsellor
PEP	Post Exposure Prophylaxis
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living With HIV
PMTCT	Prevention of Mother to Child Transmission
POS	Programme of Support
PPT	Periodic Presumptive Treatment
PSI	Population Services International
RUTF	Ready to use Therapeutic Foods
SBCC	Social and Behaviour Change Communication
SCMLT	State Certified Medical Laboratory Technician
SOPS	Standard Operating Procedures
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TOT	Training of Trainers
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNJT	United Nations Joint Team
VCT	Voluntary Counselling and Testing
VIDCO	Village Development Committee
WAAC	Ward AIDS Action Committee
WADCO	Ward Development Committee
WB	World Bank
WHO	World Health Organisation
ZAN	Zimbabwe AIDS Network
ZBCA	Zimbabwe Business Council on HIV AND AIDS
ZDHS	Zimbabwe Demographic and Health Survey
ZINQAP	Zimbabwe National Quality Assurance Programme
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZNFPC	Zimbabwe National Family Planning Council
ZNNP+	Zimbabwe National Network for People Living with HIV

## Foreword

Global rates of new HIV infections have steadily declined over the past years, with the annual rate falling by nearly 25% between 2001 and 2009. Southern Africa remains the epicentre of the global HIV epidemic. I am heartened by the fact that Zimbabwe is among the first countries in the region to have recorded such a decline. HIV prevalence declined from 20.1% (2005) to 14.26% in 2009. The annual HIV incidence has also declined from a peak of 1.14% in 2006 to 0.85 in 2009. My government, through the National AIDS Council (NAC) in collaboration with local and international partners is providing effective leadership for the national multi-sectoral HIV and AIDS response despite significant funding, human resource, and material challenges. Through the decentralized NAC structures, we are able to ensure that services reach all people. Our vigorous national behaviour change campaign and the employment of several prevention strategies must be hailed. However, let me hasten to say that if we have to achieve an AIDS free generation, we should aim to reduce the annual HIV incidence by more than fifty per cent by 2015.

The implementation of our response between 2006 and 2010 was informed and guided by the Zimbabwe National HIV and AIDS Strategic Framework. A review of this framework shows new emerging issues that we must address now. We are further committed to fulfil our international and regional obligations including Millennium Development Goals, the United Nations Declaration of Commitment commonly known as the UNGASS Declaration and the 2011 Political Declaration on HIV and AIDS, the Global Plan towards elimination of new HIV infections in children and keeping mothers alive, Maseru and Brazzaville Declarations, and the Maputo Plan of Action. As we endeavour to achieve Universal Access to HIV prevention, treatment, care and support, we must ensure availability, accessibility and affordability of HIV and AIDS services to all our people. In this regard we must strengthen our health and community systems to ensure sustained and equitable services delivery

As we embark on another five-year journey, guided by the new Zimbabwe National HIV and AIDS Strategic Plan II 2011-2015, it is necessary to focus on specific measurable and achievable set of results. This demands concerted efforts and strong commitment at policy and operational levels to ensure that everyone plays a complementary role in the fight against HIV and AIDS.

Over the years, we adopted a multi-sectoral approach in our fight against HIV and AIDS. We will continue with this approach in order to ensure that all sectors play their role based on their mandate and comparative advantage. In this regard, we remain guided by the National AIDS Council in the implementation of the Zimbabwe National HIV and AIDS Plan II 2011-2015, within the context of the 'Three Ones' principle. This principle implies that we shall have one National multi-sectoral HIV and AIDS strategic plan, one coordinating authority, and one national monitoring and evaluation system. I call upon all our stakeholders and partners to align their plans with the national strategic plan.

Zimbabwe is grateful to the support and contribution of international partners, non-governmental organisations, faith based organisations, community based organisations, community leaders and the communities themselves in the fight against HIV and AIDS. It is my sincere hope that the spirit of cooperation and partnerships, the spirit of oneness that exists, will see us through as we implement this plan to achieve 'zero new HIV infections; zero discrimination; and zero AIDS-related deaths' by 2015.

**R. G. Mugabe**

His Excellency The President of the Republic of Zimbabwe

## **Acknowledgement**

The Government of Zimbabwe wishes to thank all the people and organisations that contributed to the development of this new Zimbabwe National HIV and AIDS Strategic Plan 2010-2015 (ZNASP II). In particular, we extended our appreciation to the oversight Committee that included representatives from the development partners, civil society organisations and people living with HIV and AIDS. The Committee was responsible for overseeing the strategic plan development process.

The Government also notes with appreciation the efforts and commitment of the various thematic technical working groups that made invaluable technical inputs during the process of developing the strategic plan. Without their efforts and technical inputs we would not have the strategic plan by now.

We wish also to sincerely thank all the development partners who provided funding and technical assistance to support the development of the Strategic Plan.

Finally the Government wishes to extend its appreciation to all the consultants involved in putting together the draft and the staff of the various organisations and government ministries, especially the staff of the National AIDS Council for providing logistical and technical assistance during the preparation of the strategic plan.

The current strategic plan is a reflection of what can be done if we work together focused on a common goal of achieving zero new infections, zero discrimination and zero AIDS related deaths.

## **Chairperson**

National AIDS Council – Board.



## Structure of the Zimbabwe National HIV and AIDS Strategic Plan (II) - 2011-2015

The Zimbabwe National HIV and AIDS Strategic Plan 2011 to 2015 is organized in the following five sections.

**Executive Summary**    **Executive Summary:** The executive summary provides an overview of the strategic plan. It articulates key policy issues, strategic orientation, outlines the impact, outcome and output results and targets of the national response and finally presents a summary of the prioritised interventions and strategies.

**Section 1:**    **Introduction:** This section provides the background information and the country context of the national HIV and AIDS response, the purpose of the strategic plan and the process that was followed in developing the plan.

**Section 2:**    **Situation analysis:** The section provides an analysis of the epidemiology of HIV in Zimbabwe and the national multi-sectoral response. The analysis of the national response documents the achievements and opportunities, and the challenges encountered during the implementation of the outgoing ZNASP (I) 2006-2010.

**Section 3:**    **Strategic orientation of the strategic plan:** The section highlights key policy and programme considerations and the guiding principles for the national response. The section further establishes the linkages between the strategic plan and other national, regional and international policy frameworks and commitments.

**Section 4**    **ZNASP – Strategic results, interventions and strategies:** The section constitutes the heart of the strategic plan. It provides detailed information on the prioritised interventions, strategies, impact and outcome level results. The section is presented in thematic areas of prevention, treatment, care and support, and systems strengthening – that include coordination and management systems, M&E, health and community systems strengthening.

**Section 5**    **Annexes:** This section contains the annexes of the strategic plan.

## Executive Summary

The Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) is a five-year 2011 to 2015, multi-sectoral framework developed to inform and guide the national response towards achieving zero new infections, zero discrimination and zero AIDS related deaths by 2015. The development of the plan is premised on human rights based planning approach that is complemented by evidence and results based management approaches. The strategic plan has mainstreamed gender dimensions in the response strategies, anticipated results and indicators that will be used to measure performance. The plan provides meaningful opportunities for man and diverse stakeholders' participation in the implementation of the national response. The strategic plan succeeds the outgoing ZNASP (I) - 2006-2010.

To achieve the anticipated results the implementation of the national response will require a revolutionary rather than an evolutionary strategy – that meaning doing better and more of the right things at the right time in the right scale and intensity. For the five years (2011-2015) period covered by the ZNASP II, Zimbabwe has identified the following two national priorities in the fight against HIV and AIDS.

- i. **Prevention of new adult and children HIV infections:** Zimbabwe aims to reduce the annual infections by 50% by 2015. Zimbabwe has consistently recorded a decline in HIV incidence from 1.14% in 2006 to 0.85% in 2009.
- ii. **Reduction of Mortality amongst PLHIV:** Available evidence indicates that Zimbabwe reduced annual deaths from 123,000 in 2006 to 71,299 in 2010. This was due to the provision of ART, management of TB/HIV co-infection and improved nutrition among others. Sustained provision of ART will not only help reduce death rates but also contribute to HIV prevention efforts

These priorities will be achieved through the implementation of prioritised interventions that contribute to specific impact, outcome and output results. The ZNASP II has articulated four impact and twenty-four outcome level results. A results framework is attached as annex 2. The following are the three impact level results

- Impact 1:** HIV incidence reduced by 50% from 0.85% (48, 168) for adults (2009) to 0.435% (24,084) by 2015
- Impact -2** HIV and AIDS related mortality reduced by 38% from 71299 (2010) for adults and 13,393 for children (2009) to 44,205 for adults and 8,304 for children by 2015
- Impact - 3** National HIV and AIDS response is effectively coordinated and managed: the NCPI rating is improved from 6.2 in 2010 to 9.0 in 2015

ZNASP II will support efforts that will consolidate mainstreaming of human rights and gender responsive approaches in HIV and AIDS planning and service delivery mechanisms. Strategies will target most at risk and key populations. To ensure better outcome results effort will be made to integrate services. Health and community will be strengthened to support efficient and effective services delivery.

Reduction of new HIV infections in adults and children will be achieved through revolutionising prevention interventions. In the case for Zimbabwe, reduction of sexual and vertical transmission of HIV has been prioritised. Innovative approaches will combine biomedical prevention programmes with

behaviour change. A key entry point in making prevention work is revolutionising the way individuals see and think about prevention and their personal risk perception of HIV infection.

In addressing sexual transmission of HIV, ZNASP has prioritised interventions around social and behaviour change; increased condom promotion and distribution, coupled with intensified awareness on correct and consistent; voluntary male circumcision; HIV, testing and counselling; prevention and control of sexually transmitted infections. The strategies will also address issues of multiple and concurrent partnerships, inter-generational sex, HIV prevention among discordant couples, and accelerating voluntary male (15 years and above) circumcision.

Zimbabwe has committed itself to elimination of new HIV infections in children and keeping their mothers and families alive. Zimbabwe aims at eliminating mother to child transmission of HIV by 2015. This will be achieved through the implementation of the PMTCT prongs. PMTCT services will be scaled up, including provision of ART to pregnant mothers to prevent mother to child transmission, accelerating paediatric HIV testing, provision of ART/CTX prophylaxis and ART to HIV pregnant mothers for their health. Similarly primary prevention interventions will be scaled up and integrated in other relevant health care services. Male involvement in PMTCT will be strengthened.

Interventions will be intensified to improve blood safety and prevent HIV transmission through blood transfusion. All donated blood will be screened for HIV in accordance with national guidelines. Campaigns for blood donation will target low risk population groups. Laboratory capacity for blood screening will be strengthened and laboratory services decentralised.

Prevention interventions will be intensified to prevent infections through accidental contacts with contaminated blood especially at the work place. Exposure to HIV infection is likely to occur at the work place such as health facilities or during service provision in the case of police, or through sexual abuse including rape and child defilement. Post exposure prophylaxis (PEP) will be provided to prevent HIV infection if accidental contact with contaminated blood occurs. Interventions on HIV prevention at the work place will be intensified to prevention potential occupational exposure. For non-occupational exposure (rape, sexual abuse, domestic violence etc.) to HIV infection requiring PEP, communities will and sensitised. Referral system will be strengthened to ensure that people in need of PEP are appropriately referred to a qualified service provider

In the case of treatment, care and support, Zimbabwe is committed to the provision of ART for all PLHIV who meet the national eligibility criteria. With adoption of the CD4 350 criteria more people will be eligible for ART. The HIV testing and counselling has been identified as a strategic entry point for both ART and HIV prevention services. This strategy is intended to improve the quality of life of PLHIV in the first instance and secondly contribute to the prevention of new HIV infections. The provider initiated testing and counselling (PITC) services will be strengthened and scaled up. For malnourished PLHIV therapeutic and supplementary feeding will be provided to boost the immune system and encourage PLHIV to adhere to ART treatment protocol.

Pharmacovigilance systems of ART, anti-TB and opportunistic drugs in adults and children including those under PMTCT will be reviewed and strengthened in order to ensure early detection of adverse effects.

Community home based care (CHBC) services will be strengthened and aligned to emerging needs of PLHIV. Palliative care and psychosocial support are among the key services that will be provided under CHBC. Coverage will be expanded from 48% in 2010 to 85% by 2015.

Procurement and supply chain management systems for drugs and other consumables will be strengthened as part of the broader health systems strengthening, services and service delivery systems integration. Health care service providers will be trained in quality assurance of ART services. In the case of PLHIV enrolled on ART, or related treatment services treatment adherence awareness will be intensified. Provision of water and electricity supply at health facilities identified, as ART sites will be improved including installation of backup systems.

Zimbabwe has approximately 1.6 million orphans and vulnerable children (OVC). Only 20.9% of those in need had received the minimum package of services December 2010. During the implementation of ZNASP II identification, assessment and registration of OVC and in particular those in need of care and support will be expedited. Capacity for social and legal protection of vulnerable children will be developed and strategic partnerships established between service providers and in particular with civil society organisations. Community-based OVC support services will be identified and supported, and good practices documented and disseminated. Coordination of OVC service providers will be improved to ensure equitable distribution of services, synergy, and efficient use of resources and elimination of duplication of efforts.

It is anticipated that improved and strengthened coordination and management of the national response will in turn improve the efficiency and effectiveness of services delivery. The focus for coordination will be to ensure services availability and efficient service delivery mechanisms, and increased coverage and uptake of services. To achieve this an enabling policy and legal environment will be strengthened. Policy and legislation reviews will be conducted to establish and address barriers. Implementation of policies that address stigma and discrimination will be enforced. Where appropriate services, and services delivery mechanisms will be integrated. Health and community systems will be strengthened based on individual systems specific building blocks.

The ZNASP has articulated strategies that will promote and support HIV, gender and human rights mainstreaming in the workplace and in the development projects. Technical assistance and policy guidance will be provided to sectors establishing HIV and AIDS work place programmes and mainstreaming HIV in development projects. The overall consideration in HIV mainstreaming is how sectors will address the impacts of HIV and prevent sector's development work from influencing the spread of epidemic.

The National M&E system will be strengthened and decentralised to provide the evidence necessary to support "evidence and results based" management of the response. In particular, it is anticipated that the M&E system will provide all the indicator values and baselines of the ZNASP.

Domestic and international resource mobilisation will be accelerated and consolidated. The ZNASP II will facilitate the development and implementation of an investment framework to ensure sustainable financing of the national response. Efficiency and effective use of existing resources will be improved including considerations on cost reduction and services integration.

## Section-1: Introduction

### 1.1 Background information

The Zimbabwe National HIV and AIDS Strategic Plan is a five-year 2011 to 2015, multi-sectoral framework developed to inform and guide the national response towards achieving zero new infections of HIV, zero discrimination and zero AIDS related deaths by 2015. The strategic plan succeeds the outgoing ZNASP (I) - 2006-2010.

In developing the strategic plan Zimbabwe has adopted human rights, evidence and results based planning and management approaches. Gender dimensions have been mainstreamed in the results and strategies of the plan. The development process builds on the achievements and lessons learnt during the implementation of the outgoing strategic plan 2006-2010.

The strategic plan has identified national priorities and strategies that have the potential to contribute to the anticipated impact and outcome results. Its multi-sectoral and decentralised design provides meaningful opportunities for diverse stakeholders' participation based on their mandate, technical capacity and comparative advantage.

### 1.2 Country context

Zimbabwe is land locked with a surface area of approximately 400,000 square kilometres. It is bordered to the east by Mozambique, to the south by South Africa, Botswana in the west and Zambia on the north and northwest. Zimbabwe is divided into 10 administrative provinces of Harare, Bulawayo, Mashonaland West, Mashonaland East, Mashonaland Central, Matabeleland North, Matabeleland South, Masvingo, Midlands and Manicaland. The provinces are further subdivided into 62 administrative districts. For purposes of the national HIV and AIDS response the country has been divided into 85 operational districts.

The population of Zimbabwe is estimated to be 11,631,657 (CSO, 2000; Macro International<sup>1</sup>, 2007). The annual population growth rate is estimated at 2.6%. The literacy level for male and female is estimated at 92% (Index Mundi 2011<sup>2</sup>). Life expectancy is estimated at 47.0 years at birth<sup>3</sup>.

Zimbabwe is primarily an agriculture-based economy. Mining and tourism are the other major contributors to the national economy. Between, 2000 to 2009 the economic crisis impacted negatively on health (including HIV and AIDS) and social services delivery. Notwithstanding all these hardships Zimbabwe's, HIV prevalence continued to decline. The implementation of this strategic plan is intended sustain the decline path and consolidate existing gains.

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<sup>1</sup> CSO [Zimbabwe] and Macro International Inc. (2007). *Zimbabwe Demographic and Health Survey 2005* Calverton, Maryland: CSO and Macro International Inc.

<sup>2</sup> Index Mundi (2011 11 July 2011) Zimbabwe life expectancy at birth  
[http://www.indexmundi.com/zimbabwe/demographics\\_profile.html](http://www.indexmundi.com/zimbabwe/demographics_profile.html) accessed 11 July 2011

<sup>3</sup> UNDP (2010): Human Development Report – Real Wealth of Nations: pathways to human development

### **1.3 Purpose of the ZNASP**

The ZNASP has been developed to:

- i. Provide a strategic framework that will guide and inform the planning, coordination, implementation, monitoring and evaluation of the national multi-sectoral and decentralised HIV and AIDS response with the aim of achieving zero new infections, zero discrimination and zero AIDS related deaths.
- ii. Articulate national priorities, results and targets that all stakeholders and partners will contribute to.
- iii. Provide the basis for consolidating strategic partnerships and alliances especially with civil society organisations, public and private sector, and development partners.
- iv. Establish the basis for Zimbabwe to consolidate its efforts in developing sustainable financing mechanisms for HIV and AIDS response.

### **1.4 The Process of developing the strategic plan**

The process of developing the ZNASP has been participatory involving a wide range of stakeholders from public sector institutions, private sector, and civil society organisations (NGOs, FBOs, and CBOs) to organisations of PLHIV, and communities themselves. It started with conducting a Know Your Epidemic/ Know Your Response analysis. This was complemented by a number of other technical studies that generated the evidence that was necessary to inform the planning and development of ZNASP II.

Technical working group and other consultative meetings were organised that increased stakeholders participation in the process of developing ZNASP II. Participation in such meetings ranged from provision of documents for review, reviewing draft documents, and validating the draft reports. The process was participatory and took between September 2010 and May 2011.

## Section-2: ZNASP II – Strategic orientation

### 2.1 The strategic orientation of ZNASP II

As the epidemic unfolds, new social, economic, political, knowledge and technological challenges emerge. These challenges transcend institutional and sometimes national boundaries and hence demand periodical review and strengthening of operational strategies for the national multi-sectoral response. The challenges demand a paradigm shift from doing business as usual to a human rights based approach, a focus on results, innovative response strategies, gender mainstreaming, use of best practices and sustainable financing of the response.

Zimbabwe has adopted human rights; evidence and results based approach in its planning and implementation of the national response. The approach is necessary to ensure that Zimbabwe achieves its aspirations of Zimbabwe of zero new infections, zero discrimination, and zero AIDS related deaths by 2015. The approach demands a revolutionary rather than an evolutionary strategy that shakes up the current thinking and opens room to innovatively address the critical issues first. The revolutionary approach places emphasis on respect for human rights, strengthening the capacity of duty bearers to fulfil their obligations and the right holders to claim their rights

The ZNASP II will support national efforts to consolidate and strengthen political leadership and stakeholders participation in the response especially by civil society, PLHIV, key populations and communities. ZNASP strategies are aimed at making services available and accessible to all people regardless of their social or economic status. The ZNASP aims at accelerating scaling up of targeted services, intensifying implementation, and expanding coverage. It is only by doing so, can Zimbabwe achieve zero new infections, zero discrimination and zero AIDS related deaths. Gender issues will be mainstreamed in all aspects of the response from planning, budgeting, to monitoring and evaluation to address the gender bias of the epidemic.

In order to improve on efficiency and effectiveness, **services integration** will be prioritised, strategic partnerships and alliances will be established, health, and community and social systems will be strengthened to ensure timely service delivery.

Prevention of new infections will remain a national priority. It is evident that investing adequately in prevention will have significant benefits downstream with treatment, care and support.

### 2.2 Priorities for the national response

The epidemiological analysis of HIV in Zimbabwe and the analysis of the national response have provided the evidence used to identify and articulate the following national priorities.

- i. **Prevention of new adult and children HIV infections:** Zimbabwe aims to reduce the annual infections by 50% by 2015. Zimbabwe has consistently recorded a decline in HIV incidence from 1.14% in 2006 to 0.85% in 2009.
- ii. **Reduction of Mortality amongst PLHIV:** Available evidence indicates that Zimbabwe reduced annual deaths from 123,000 in 2006 to 71,299 in 2010. This was partly due to the provision of ART, management of TB/HIV co-infection and improved nutrition. The overall strategy is to improve the quality of life. Sustained provision of ART will not only help reduce death rates but also contribute to HIV prevention efforts

## 2.3 Impact level results for the national response

The following are the strategic impact level results that are anticipated to be achieved through an efficient and effective implementation of the ZNASP II.

**Impact Result 1:** HIV incidence reduced by 50% from 0.85% (48, 168 in 2009) to 0.425% (24,084) by 2015

By 2009, approximately 48,168 people were infected annually with 132 new infections occurring every day. Projections indicate that new adult infections will increase to 54,000 by 2015, unless effective prevention interventions are implemented in the right scale and intensity. Majority of new adult infections comes from low risk heterosexual sex accounting for 55.9% and followed by casual heterosexual sex (24.0%), and sex workers and their clients (14.05%)

Zimbabwe is committed to virtual elimination of mother to child transmission of HIV by 2015. The Global target for virtual elimination is less than 5% of mother to child transmission. By 2010, it was estimated that approximately 14,152 new infections occurred among children annually. The Target for the ZNASP is to reduce new infections among children to less than 5% by 2015.

The priority interventions that will contribute to 50% reduction of new infections by 2015 are reduction of sexual transmission, prevention of HIV transmission through blood transfusion and through accidental contacts with contaminated blood. The ZNASP II supports a combination prevention strategy that will include social and behaviour change communication, voluntary male circumcision, condoms promotion and distribution, consistent and correct use, PMTCT, control and management of sexually transmitted infections.

**Impact Result 2:** HIV and AIDS related mortality reduced by 38% from 71299 (2010) for adults and 13,393 for children (2009) to 44,205 for adults and 8,304 for children by 2015

Sustained provision of comprehensive and quality antiretroviral therapy (ART) is aimed at reducing adult and child mortality. It will also contributing to the reduction of new HIV infections. By 2009 annual AIDS related deaths stood at 70,543 for adults and 13,393 for children. By December 2010, ART coverage for children and adults was at 31.5% (28,149) and 59% (298,092) respectively.

The strategic plan will accelerate the provision of ART to close the gap. It is projected that ART coverage will be increased from 31.5% in children and 59% in adults in 2010 to 85% in both populations by 2015. Zimbabwe aims at reducing annual death rates from 71,299 in 2010 to 51,808 by 2015.

**Impact Result 3:** **The efficiency and effectiveness of the national multi-sectoral response improved:** *The NCPI rating is improved from 6.2 in 2010 to 9.0 in 2015*

The respect and fulfilment of human rights such as the right to health, right to privacy, food and education and protection from all forms of discrimination, is the basis for an efficient and effective national response. Improving the efficiency and effectiveness will require strengthening of the social, policy and legal enabling environment, improving coordination and management systems, developing a an efficient and effective functional M&E system, and sustainable financing mechanism. Meaningful participation and involvement by all people is a pre-requisite for an effective and efficient services delivery system. The desired enabling environment is characterised by availability, accessibility and



acceptance of health and social services by beneficiaries. The fulfilment of human rights can only be achieved if there are adequate and relevant policies and legislation that enhance universal access to HIV and AIDS, and health services, gender equality and sensitivity of the response, reduction of stigma and discrimination in all settings, meaningful participation by all people and in particular PLHIV, a strong political leadership and commitment.

The key ZNASP II approach is to ensure adequate availability, accessibility and consumer acceptability of services. Services integration is seen as an important strategy for expanding services provision, improving efficiency and effectiveness and strengthening strategic partnerships and alliances

## 2.4 The guiding principles

The following principles will guide the national HIV and AIDS response.

- **Respect and fulfilment of basic human rights:** Respect and fulfilment of human rights is a pre-requisite for an efficient and effective HIV and AIDS response. Efforts will be made to ensure that duty bearers and other service providers respect and fulfil their obligations to provide quality and comprehensive services to all people. Rights holders (beneficiaries) will be empowered to access and utilise such services.
- **Equity:** Access to services is a basic human right. During the ZNASP II efforts will be made to ensure equitable distribution, availability and access to services by all people especially most at risk and other key populations.
- **Evidence-based planning and results-based management:** The planning and management of the national response will be informed by empirical qualitative and quantitative evidence, and implementation will focus on measurable impact, outcome and output results.
- **Integrated service delivery:** The ZNASP II will support services integration as a strategy to improve synergy between intervention, complementarity and optimised use of resources.
- **Meaningful involvement of people living with HIV (MIPA):** PLHIV involvement will improve services uptake and address the challenges of stigma and discrimination, among other barriers to services uptake. The involvement of PLHIV will also enhance efforts on positive health, dignity and prevention.
- **Good practices:** Stakeholders will be encouraged to replicate the practices that have proven effective.
- **The “Three Ones” Principle:** Zimbabwe will continue the application of the three ones principle of having one national coordinating authority, one national strategic plan and one monitoring and evaluation system.
- **Gender sensitivity and responsiveness:** ZNASP strategies address gender inequality of national response including services uptake.
- **Creating an enabling environment:** An enabling environment is premised on the existence of appropriate and effective policies, laws, operational guidelines and standards, and more importantly the respect and fulfilment of human rights. During the ZNASP II period policies and legislations will be reviewed and strengthened. Monitoring of stakeholders compliance with such policies and legislation will be intensified.

## 2.5 Alignment with other national and international strategic frameworks

HIV and AIDS remains the greatest sustainable human development challenge for Zimbabwe. Its impacts have increasingly become complex and affect all economic and social sectors. The impacts range from declining life expectancy, economic productivity, and investment in education, health,

agriculture and human capital development. The epidemic has compromised the knowledge pool and skills necessary to sustain livelihoods. HIV is threatening the traditional community coping mechanisms (safety nets), food security<sup>4</sup> and long-term social economic development by contributing to deepening poverty, reducing individuals' ability to save and invest financial resources. It is evident that the epidemic is spreading along the fault lines of economic development as evidenced by social and structural drivers of the epidemic – poverty, gender inequality, migration, and transactional sex.

These challenges can only be addressed adequately if the response is properly anchored in the broad national socioeconomic development framework. It is for this reason that the ZNASP II has articulated strategies that link the national response to other national policy and development frameworks. Effective implementation of ZNASP II, will also contribute to Zimbabwe fulfilling its regional and international commitments including MDGs, Universal Access health care, and HIV and AIDS services.

The linkages between the ZNASP with the National Health strategy is critical in ensuring a comprehensive approach HIV services integration. It is also anticipated that other non-health sectors will equally mainstream HIV and AIDS responses in their work place and development projects

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<sup>4</sup> SADC 2006: Reviewing the Epidemic in Botswana, Lesotho, Namibia and Swaziland

### Section-3: HIV Situation and National Response Analysis

#### 3.1 The Epidemiology of HIV and AIDS in Zimbabwe

Adult HIV prevalence has declined from 27.2% (1998) to 14.26% in 2010 (HIV estimates, 2009). By 2010 the total number of adults and children living with HIV in Zimbabwe was estimated at 1,168,263. Of this 414,338 were men and 608,700 women. By 2015, the total number of PLHIV is projected to increase to 1,187,087.

It is estimated that 47,309 new adult infections occurred in 2010 with a projected increase to 54,053 in 2015. Similarly 14,152 new infections in children were estimated to have occurred in 2010. However the number of children infected by HIV annually is expected to decrease to 11,162 by 2015. Approximately 17,000 new infections were estimated to have come from children in 2009, as a result of Mother-to-child transmission (MTCT). MTCT is the second major HIV transmission route in Zimbabwe. Available data from the 2010 Estimates using EPP/Spectrum suggest that there has been a decline in annual HIV incidence from 1.14 in 2006 to 0.85 in 2009.

Overall Zimbabwe is among several countries in Southern Africa with a HIV epidemic showing a consistent decline in prevalence over the last decade. The decline is attributed partially to successful implementation of prevention strategies (i.e. significant changes in sexual behavior) and high mortality due to low ART coverage. Between 1999 and 2006 less than 5% of PLHIV had access to ART.

#### Sources of HIV Infections

HIV transmission remains predominantly sexually driven. Sexual transmission accounts for over 80% of infections. Majority of new infections occur in the age group 20 - 29 years. New infections are expected to come from a variety of sources as shown in the table 1 below.

**Table 1:** Source of new HIV infection

	Source	% - Contribution
1.	Low risk heterosexual	57.6%
2.	Casual heterosexual	7.5%
3.	Partners of casual heterosexual	18.8%
4.	Clients of heterosexual	6.4%
5.	Men who have sex with men (MSM)	4.0%
6.	Male partners of MSM	2.7%
7.	Female partners of MSM	0.4%
8.	Sex workers	1.4%
9.	Injecting Drug Users (IDU)	1.1%
10.	Partners of IDU	0.1%
11.	Medical Injections	0.1%

(Source: Power point presentation by NAC, 2011)

Table 2, below indicates the extent of HIV infection and its impact on the various population groups with projections to 2015 based on the spectrum modeling.

**Table 2:** Extent of HIV infection and its impact on various populations and projections to 2015

Summary of HIV estimates up to 2015							
	2009	2010	2011	2012	2013	2014	2015
HIV Population- Adults and Children	1,189,279	1,168,263	1,159,097	1,157,098	1,161,885	1,171,879	1,187,087
HIV Population- Children 0-14	151,749	145,224	138,642	132,488	126,929	122,056	118,100
HIV population- 15 +	1,037,530	1,023,038	1,020,455	1,024,610	1,034,956	1,049,823	1,068,988
HIV population 15 + Segregated by Sex							
Males	419,738	414,338	414,561	418,046	424,377	432,856	443,443
Females	617,792	608,700	605,894	606,564	610,579	616,967	625,545
Number of new infections							
Children 0-14	14,976	14,152	13,271	12,561	11,991	11,505	11,162
Adults 15+	48,168	47,309	46,450	47,193	48,655	50,379	54,053
Total number New Infections	63,144	61,461	59,721	59,754	60,646	61,884	65,215
Annual deaths							
Children 0-14	13,393	11,981	10,837	9,687	8,596	7,580	6,674
Adult 15+	70,543	59,318	52,927	52,320	49,787	46,458	45,134
Total annual deaths	83,936	71,299	63,765	62,007	58,382	54,038	51,808

Source: Spectrum/EPP estimates for Zimbabwe, UNAIDS June 2010

In 2010, the estimated number of AIDS related deaths was 71,299. It is anticipated that the number will decline to about 51,808 deaths by 2015. Zimbabwe is committed to achieving “zero AIDS related deaths” by 2015

### 3.2 National Response Analysis

The outgoing ZNASP (2006-2010) articulated four thematic priority areas for the national response i.e. prevention of new infections, treatment and care, mitigation and support, coordination and management. Under each of these thematic areas service delivery areas were identified as shown in table 3 below.

**Table 3:** Components of ZNASP I (2006-2010)

Prevention	Treatment and care	Mitigation and support	Coordination and management
<ul style="list-style-type: none"> <li>• Prevention of mother to child transmission (PMTCT)</li> <li>• HIV counselling and Testing (HCT)</li> <li>• Condoms</li> <li>• Most at risk populations (MARPS)</li> <li>• Behaviour Change Communication (BCC)</li> <li>• Youth</li> <li>• Male Circumcision (MC)</li> <li>• Sexually transmitted infections (STI)</li> <li>• Blood safety</li> <li>• Workplace</li> <li>• Gender</li> <li>• Advocacy</li> </ul>	<ul style="list-style-type: none"> <li>• Antiretroviral therapy (ART)</li> <li>• Opportunistic Infections (OI)</li> <li>• Laboratory services</li> <li>• Home based care (HBC)</li> </ul>	<ul style="list-style-type: none"> <li>• Orphans and Vulnerable Children (OVC)</li> <li>• Meaningful involvement of PLHIV (MIPA)</li> <li>• Nutrition</li> <li>• Water and sanitation</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthening leadership role of NAC</li> <li>• Strengthening coordination role of NAC</li> <li>• Strengthening planning and management role of NAC</li> <li>• Strengthening M&amp;E capacity at national, provincial and district level</li> </ul>

The following is a synopsis of the achievement made during the implementation of the ZNASP 2006-2010

**Prevention of New HIV infections:**

- The Zimbabwe National Behaviour Change Programme was developed. The programme was rolled out from the pilot 26 districts to all 62 districts. An interim evaluation of the programme conducted in 2009<sup>5</sup> showed that
  - More people had comprehensive knowledge of HIV,
  - There was an increase in condom use at last sex with all non-regular partner,
  - There was an increase in the number of people ever tested for HIV,
  - More couples tested together,
  - HIV prevalence among young pregnant women in SBCC focus districts also show some decline,
  - The evaluation reported some improvements in community norms about partner concurrency between the baseline and interim survey.
- Annual HIV incidence declined from 1.14% in 2006 to 0.85% in 2009. HIV prevalence equally declined by almost 50% from 27.2% in 2008 to 14.26% in 2009.
- In 2009, 85% of pregnant women attending ANC services were tested for HIV, and 59% of HIV positive women were enrolled on ART. In 2008, 80% of infants born to HIV positive mothers were provided with ARV prophylaxis for PMTCT at birth<sup>6</sup>.
- Voluntary male circumcision was adopted as a key prevention strategy. By the end of September 2010, 11,102 men had been circumcised<sup>7</sup>. This programme is being scaled up.
- 150 million male condoms were distributed in 2010 and 15,426,325 female condoms between 2006 and 2009.

<sup>5</sup> UNFPA/NAC. 2009. National Behaviour Change Strategy Interim Surveys

<sup>6</sup> MOHCW data base

<sup>7</sup> MOHCW data base

- The annual total number of STIs treated declined by approximately 55% from just over 480,000 in 2006 to 268,000 in 2009<sup>8</sup>. The decline in STI cases was attributed to reduction in sexual risk behaviour, concerted STI programming, training in syndromic management of STIs, and the strategic deployment of trained staff in health facilities.
- Zimbabwe attained 100% blood safety as all donated blood is screened in accordance with national guidelines that are aligned to international guidelines.
- By 2010, about 85% of people had tested and received results. HIV testing and counselling sites offering “Provider Initiated Testing and Counselling” (PITC), increased from 35% in 2006 to 64% in 2010. Couple counselling also increased from 12% in 2007 to 25% in 2009<sup>9</sup>.

### **Treatment, Care and Support**

- By December 2010, 326,241 of the 593,168 were receiving ART treatment representing coverage of 54% based on CD350 criteria. Of these, 60% were females and 32,000 children. ART sites have increased from 32 in 2006 to 387 by June 2010.
- Increased coverage of ART contributed to a reduction of annual AIDS deaths from 123,000 in 2006 to 71,299 in 2010.
- Progress was made in strengthening the technological capacity of laboratories. By 2007 Zimbabwe procured and distributed 71 CD4 count, 69 haematology and 45 biochemistry machines in the public health facilities.
- In order to expand human resource capacity for diagnostic service provision, the MoHCW reintroduced the State Certified Medical Laboratory Technician (SCMLT) training programme in 2007. To date 186 SCMLTs have been trained and posted to districts. Training of microscopists has also been expanded and 320 people trained out of 520 target by 2010,
- 13% of districts were offering early infant diagnosis (EID). Viral load testing has also been launched.
- At the end of 2009, the ART Programme began to undertake HIV drug resistance (HIVDR) prevention surveys that focus on consecutively selected cohort of eligible patients starting ART in each of the selected representative sentinel sites. HIVDR outcomes are evaluated 12 months after ART begins<sup>10</sup>.
- The National Tuberculosis Programme Strategic Plan (2009-2013) and the guidelines for co-management of TB/HIV, including strategies for intensified case finding and infection control in healthcare settings have been developed. It is estimated that 80% of TB cases in Zimbabwe are co-infected with HIV<sup>11</sup>. HIV testing and counselling has been expanded for people with TB since 2007. Table 4 below shows progress in TB/HIV programming.

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<sup>8</sup> Ministry of Health and Child Welfare: The Zimbabwe Health Sector HIV Prevention Strategic Framework 2007-2010

<sup>9</sup> UNFPA/NAC. 2009. National Behaviour Change Strategy Interim Survey

<sup>10</sup> Report on the National HIV Drug Resistance Prevention and Assessment Strategy 2006-2008, MOHCW

<sup>11</sup> National TB Control Programme Database, MOHCW, 2009

**Table 4:** Progress in prevention, care and management of TB/HIV co-infection

Indicators	2007	2008	2009
% /# of TB cases tested for HIV	26 (10,762)	45(18,310)	83 (38,424)
% /# of HIV positive TB cases	69 (7,426)	76 (18,310)	77 (29,586)
%/# of HIV positive TB cases put on CPT	78 (5,824)	79 (12,402)	80 (23,669)
%/# of HIV positive TB cases put on ART	23 (1,727)	25 (4,630)	29 (8,509)

### **Impact Mitigation and Support**

- The number of people receiving CHBC increased from 489,000 in 2008 to 697,000 at the end of 2009.
- The Government has<sup>12</sup> supported therapeutic and supplementary feeding of children and adults living with HIV who suffer from severe and moderate acute malnutrition respectively.
- Of the 1.6 million OVC in Zimbabwe, 62% were due to HIV and AIDS<sup>13</sup>. 410,000 (25%) OVC had received support through the Programme of Support (PoS).

### **Management, Coordination and M&E of the National HIV Response**

- NAC has decentralized coordinating structures (AIDS Action Committees) at provincial, district, ward and village levels. – PAACS, DAACS, and WAACs. Additional structures such as *Ward Health Teams, development structures such as VIDCO, WADCO and DDCOs and Child Protection Committees* have been established to facilitate coordination and implementation of specific interventions including community advocacy on HIV and AIDS, TB and Malaria.
- Multi-sectoral coordination has been consolidated through umbrella coordinating structures such as ZBCA, ZAN, ZNNP+, CCM, and UNJT.
- Community and health systems continue to be strengthened to improve service delivery.

### **Monitoring and Evaluation**

- A national database for the HIV and AIDS response has been established.
- Training has been conducted for M&E officers from both public and civil society organisations.
- A national M&E plan was developed to monitor and report on the implementation of ZNASP I. The plan has been updated for purposes of monitoring and reporting on ZNASP II.
- Zimbabwe has consistently reported on its regional and international obligations on HIV and AIDS including UNGASS, MDGs, Maseru Declaration, universal access and Convention on the Rights of the Child (CRC) among others

### **Financing of the National Response to HIV and AIDS**

- Funds collected through the national AIDS levy increased from US\$ 5million in 2006 to US\$ 19 million in 2010. Approximately 50% of the levy funds are used to procure ART.
- Funding from bilateral and multilateral partners as well as international foundations increased to US\$25 million in 2008 and US\$38 million in 2009 towards HIV and AIDS programs<sup>14</sup>.

<sup>12</sup> MOHCW (2010) Guidelines on Dietary Management for PLHIV (2010) and MOHCW Policy Statement on Infant Feeding and HIV as well as Infant Feeding Guidelines for Health Workers were developed in 1999.

<sup>13</sup> ZDHS 2006-2010 and EPP/Spectrum estimates (June 2010)

<sup>14</sup> Reporting on 2009 funding matrix by Bilateral, Multilaterals and International Foundations for Zimbabwe UNGASS 2010 Report

- Zimbabwe received funding from the GFATM through Round 5 Grant- US\$60 million; and Round 8 - US\$46 million by December 2010
- The Expanded Support Program (ESP) received US\$ 42 million between 2007 and 2009 from Canadian International Development Agency (CIDA), Department for International Development (DFID), Norwegian Aid, Irish Aid and Swedish International Development Agency (SIDA).
- The OVC strategic plan was supported through the Programme of Support (PoS) with US\$84 million for 3-years by several donors to finance OVC education, healthcare, birth registration and access to HIV and AIDS prevention, treatment, and care and support services<sup>15</sup>.

### **3.3 Gaps and Challenges Analysis**

The strategic gaps and challenges encountered during the implementation of the ZNASP (I) 2006-2010 are incorporated in section 4 below under specific service delivery areas / programmes. Strategies to address these gaps and challenges have also been articulated in the respective sub sections in section four (4).

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<sup>15</sup> Programme of Support to the National Action Plan for Orphans and Vulnerable Children in Zimbabwe Annual Report, June 2009.



## Section 4: ZNASP Strategic interventions, Strategies and Results

### 4.1 Overview

The following section presents the prioritised interventions, strategies and results for the national response. The implementation of these interventions and strategies are expected to contribute to the achievement of the outcome and impact results. The impact and outcome results are presented in the strategic plan while the output results are contained in the National Operational Plan (NOP). The ZNASP II results framework (annex 2) presents the results chain and illustrates the linkages between the results. The selection of the interventions and strategies is premised on the need to focus on high impact interventions with evidence-based efficacy. Table 5 below presents the scope of the national response as articulated and prioritised in the ZNASP II for the period 2011 to 2015.

**Table 5:** Prioritised interventions for ZNASP II: 2011-2015

Prevention	Treatment, care and support	Coordination and management and Systems Strengthening
<ul style="list-style-type: none"> <li>• Social and behaviour change communication<sup>16</sup></li> <li>• Condoms – promotion and distribution</li> <li>• Male circumcision</li> <li>• PMTCT</li> <li>• HIV testing and counselling (to enhance prevention and treatment)</li> <li>• Treatment and control of sexually transmitted infections</li> <li>• Blood safety</li> <li>• Provision of Post Exposure Prophylaxis</li> </ul>	<ul style="list-style-type: none"> <li>• Antiretroviral Therapy (ART)</li> <li>• Nutrition</li> <li>• Community Home Based Care (CHBC)</li> <li>• Support for orphans and vulnerable children (OVC)</li> </ul>	<ul style="list-style-type: none"> <li>• Enabling Policy and Legal Environment</li> <li>• Coordination and Management of the National response</li> <li>• Mainstreaming / Integration of HIV and AIDS</li> <li>• Systems Strengthening</li> <li>• Strategic information Management</li> <li>• Sustainable financing and Resource Mobilisation</li> </ul>

### 4.2 Prevention

Prevention of new HIV infections remains the national priority in the fight against HIV and AIDS. Zimbabwe has adopted the “combination prevention strategy” for the implementation of the prioritised strategies and interventions. The strategies aims at reducing or preventing infection if exposure has occurred, reducing the probability of infection if transmission has occurred and finally influence behaviour change where social or cultural norms, values and practices remain barriers to adopting effective prevention behaviours. By 2015, Zimbabwe is aiming to achieve the following impact level prevention result

<sup>16</sup> To reduce risky behaviours, encourage safer behaviours and promote uptake of services and adherence to treatment?

**Table 6:** Prevention impact result

Impact 1:	HIV incidence reduce by 50% from 0.85% (48, 168) for adults (2009) to 0.435% (24,084) for adults by 2015
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To achieve these outcome result Zimbabwe has prioritised high impact interventions, including social and behaviour change communication, condom promotion and distribution, voluntary male circumcision, PMTCT, HIV testing and counselling, prevention and control of sexually transmitted infections, blood safety and Post Exposure Prophylaxis. Through these interventions the level of knowledge and perception of personal risk will be improved, leading to adoption of safe practices and increased uptake of prevention services.

Prevention interventions will be more targeted focusing on most at risk and key population groups, sources of new HIV infections and geographical areas with high HIV prevalence. Implementation will be intensified and sustained and coverage increased. Prevention strategies will be continuously reviewed to allow programming to incorporate emerging prevention technologies, new knowledge and best practices.

#### 4.2.1 Social and behaviour change communication

##### Overview

Social and behaviour change communication (SBCC) is key to adopting HIV prevention strategies. SBCC interventions will be intensified in the community, work place and in schools. During the ZNASP II, the priority will be to improve the level of comprehensive knowledge of HIV and AIDS as a strategy of helping people to assess and appreciate their personal risk and vulnerability to HIV infection. Second, advocacy work will be carried to address and influence changes in social and cultural behaviours that perpetuate the spread of HIV and are barriers to services uptake such stigma<sup>17</sup> and discrimination. It is evident that stigma remain the greatest challenge for people to disclose their HIV status and in services uptake. The combination of improved comprehensive knowledge, improved risk perception and people knowing their HIV status will enable people to make informed decisions and choices on their sexuality.

The coverage of the Social and Behaviour Change Communication Programmes will be expanded and implementation intensified targeting individuals and groups of people such as most at risk and key populations such as people in stable relationships, inmates, sex workers, uniformed personnel, young people (15-29 years), discordant couples and mobile populations among others.

Special attention will be paid to address factors that make women and girls more vulnerable such as gender inequality, negative socio-cultural norms, inter-generational sex, gender based violence, which manifested itself in physical, sexual and psychological forms. Awareness of these issues will be created among the general population given societal tolerance of practices that fuel the epidemic such as multiple and concurrent partnerships, alcohol abuse, inter-generational and transactional sex.

As social and behaviour change communication cuts across a wide range of other HIV and AIDS interventions, coordination and harmonisation of prevention interventions will be critical. A comprehensive National HIV Prevention Strategy will be developed to guide the prevention response.

<sup>17</sup> Note: Stigma strategies are covered under “enabling policy environment section”

## Gaps and Challenges

- Inadequate implementation of interventions targeting key or most at risk populations
- Although Zimbabwe has a national BCCC strategy and programme, implementation remains fragmented with inadequate coverage and intensity.
- Insufficient coverage, intensity and duration of interventions targeting young people and in particular those out of school.
- Stigma and discrimination not adequately addressed in the National Behaviour and Communication Programme (NBCP).
- Poor and low quality of life skills based HIV education provided.
- Inadequate coverage of people through workplace based HIV and AIDS education.

## Priority strategies

- Intensifying of the National BCCC strategy and programme implementation targeting most at risk and key populations
- Provision of quality of life skills based HIV education will be accelerated
- Integration of Social and Behaviour Change Communication interventions in the work place, schools and community development programmes
- Improvements in the standard, quality and comprehensiveness of prevention interventions by developing and disseminating a National HIV Prevention Strategy
- Strengthening of skills for the implementation of prevention interventions premised on the combination prevention strategy
- Improvement in access to HIV prevention information by all people.

**Table 7:** Social and behaviour change outcome results

OC-1	<b><i>More people have a better personal HIV risk perception:</i></b> Men and women aged 15 and above whose personal HIV risk perception improved by 50% by 2013 and 80% by 2015
OC-2:	Men and women 15-49 years who had 2 or more sexual partners in the last 12 months reduced from 14.1% for men and 1.3% for women in 2006 to 10.9% for men and 1.0% for women by 2013 to 9.9% for men and 1.0% for women by 2015

### 4.2.2 Condoms – Promotion and distribution

#### Overview

Correct and consistent use of condoms has been the most effective HIV prevention strategy. Recent studies show that when used correctly and consistently condoms effectiveness can be as high as 95%<sup>18,19</sup>. Available evidence also indicates that female condoms may offer similar levels of protection against HIV<sup>20</sup>. In Zimbabwe condoms are distributed for free by the Government and through social marketing.

The uptake of the male condom improved significantly between 2006 and 2010. In 2010, approximately 150 million male and 15 million female condoms were distributed. In most cases, condom use is

<sup>18</sup> Padian, S Nancy S. et al (2008): Lancet Biomedical interventions to prevent HIV infection: evidence, challenges, and way forward, Lancet (On line August 6, 2008),

<sup>19</sup> Pinkerton SD et al. (1997): Effectiveness of Condoms in Preventing HIV Transmission, Social Science Med 1997,

<sup>20</sup> World Health Organisation (2008): Priority Interventions: HIV and AIDS prevention, treatment and care in the health sector

dependent on the willingness of men to use them. Although general acceptance of female condoms remains low, usage has increased overtime. However monitoring consistent and correct use of condoms has remained a daunting challenge. Current information on condom use is based on self-reporting, whose reliability is compromised by the bias and inconsistency in the data.

During the implementation of ZNASP II, the following priority populations will be targeted:

- Sexually active young people and adults
- Couples in discordant relationships,
- PLHIV enrolled in the Pre-ART and ART programme,
- Men and women testing positive in HTC sites,
- Key populations (Sex workers, MSM) and their clients
- Men under going male circumcision

ZNASP II will seek to expand access to both male and female condoms, promote correct and consistent use of condoms among the above population groups. While some condoms will be made freely available others will be socially marketed.

Efforts will be made to integrate condoms education, awareness and distribution in other services such as male circumcision, adolescent sexual reproductive health including family planning, and control of STIs. Advocacy and education will be intensified to address social norms that create barriers to communication on sex and negotiating safer sex in particular within marriages and young people in-schools. In order to ensure comprehensive outreach multi-media channels will be used. Communication and negotiation skills among discordant couples, and among young people will be strengthened in order to promote safe sex practise. Advocacy work will be carried out with PLHIV to promote and support positive health, dignity, and prevention in the context of condom use.

To prevent condom stock outs, condom procurement and supply management system will be reviewed and strengthened. Capacity will be developed especially in condom quantification, quality control, and monitoring. Adequate and appropriate storage facilities at district level with additional outlets at community level will be established.

### **Gaps and Challenges**

- Condoms are not readily available and easily accessible to all people especially key populations through user-friendly outlets.
- While condom education has been widely conducted, many people still lack adequate knowledge on correct use of condoms.
- Female condoms uptake has remained low compared to the male condoms.
- Condom use in discordant couples remains low.
- Myths, misconceptions and negative perception by consumers of public sector distributed condoms persist.

### **Priority strategies**

- Development and implementation of a condom distribution and communication strategy
- Promotion of male and female correct and consistent use of condom among key and most at risk populations.
- Increased community-based male and female condom distribution outlets. Such outlets should be located in user-friendly sites

- Promotion of consistent and correct use of condoms among sero-discordant couples
- Integration of condom education and distribution in other health and sexual reproductive services including family planning
- Establishment of condom distribution outlets and in particular friendly outlets for youth and key populations

**Table 8:** Condom use outcome results

OC-3	Female and Male aged 15–49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse increased from 50% in 2010, to 70% in 2013 and 80% by 2015
OC-4	Women and men in sero-discordant relationships who reported using condoms consistently in the last sexual intercourse increased to 50% by 2013 and to 80% by 2015.

### 4.2.3 Voluntary male circumcision

#### Overview

Medical science shows that male circumcision (MC) can reduce the probability of HIV infection in an HIV negative male by 60%<sup>21</sup>. In Zimbabwe voluntary male circumcision (MC) has been adopted as a key prevention strategy. A national MC policy was developed and disseminated in November 2009 and a pilot study conducted in five learning sites. Following the study a five-year 2010-2015 Voluntary Male Circumcision Strategy was developed. The strategy aims to reduce HIV incidence through MC by between 25% and 35%, by circumcising at least 80% of people aged 15 – 29 years by 2015. However, by the end of September 2010, only 11,102 men were reported having been circumcised.

During the implementation of the ZNASP II, MC will be rolled out countrywide. However MC targeted interventions will focus on geographical settings in areas where HIV prevalence in the general population exceeds 15%<sup>22</sup>. Although the initial priority is for men who are sexually active, neonatal circumcisions will be conducted simultaneously.

Rolling out voluntary male circumcision will involve multiple strategies ranging from community mobilisation to create demand for MC, strengthening health facilities to conduct MC procedures, provision of MC supplies and commodities, to integration of MC with condom use, HTC, STI, family planning and other sexual and reproductive health services. Doctors will be trained in MC procedures and task shifting will be accelerated. Through the period adequate supervision and mentoring on site will be provided. Health facilities will be assessed for preparedness to offer quality voluntary male circumcision. Standard information packages will be developed and distributed to communities to increase access to information on MC. Regular reviews on community perception and acceptability of MC will be conducted to determine community attitudes towards MC. The acceptability studies will inform the development of awareness and educational materials on male circumcision.

Collaborative efforts with traditional circumcisers will be developed and referral services strengthened. Efforts will be made to sensitise traditional circumcisers on the need to have male circumcisions in an acceptable, quality and safety assured environment.

<sup>21</sup> (Bongaarts et al. 1989; Moses et al, 1990; Auvert et al, 2005; Drain PK et al. 2006, Bailey RC et al., 2007; Gray et al., 2007).

<sup>22</sup> World Health Organisation (August 2008) Priorities Interventions – HIV prevention, treatment and care in the health sector,

## Gaps and Challenges

- Low uptake of male circumcision attributed to low levels of community mobilisation and education on male circumcision
- Inadequate capacity at health facilities to conduct counselling and testing and voluntary MC procedures.
- Roll out of MC in district and community level health facilities has been slow and inadequate.

## Priority strategies

### Priority Strategy

- Strengthening of health facilities and health systems in general to support provision of sustain MC services
- Intensifying education, awareness, and community mobilisation to generated demand for MC

**Table 9:** Male circumcision outcome result

OC-5	Men aged 15-49 who reported being circumcised increased from 10% in 2006 to 50% by 2013, and to 80% by 2015.
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## 4.2.4 Prevention of Mother to Child (MTCT) Transmission of HIV

### Overview

The World Health Organisation (WHO) estimates that the risk of mother to child transmission can be reduced to less than 2% through antiretroviral prophylaxis given to women during pregnancy and labour and to their HIV-exposed infants soon after birth. The global target for virtual elimination of mother to child transmission is less than 5% by 2015. The probability of infection can also be reduced by safe obstetrical interventions including elective caesarean delivery and safer infant feeding practices<sup>23</sup>.

In Zimbabwe by 2010, approximately 49% of pregnant women attended ANC annually. Evidence from the “Zimbabwe cascade model” noted that 83% of pregnant women were counselled and tested. Women who tested HIV positive (82%) only 59% were offered ART for PMTCT in 2009. Mother to child transmission (MTCT) was estimated at 30% based on EPP modelling. This data indicates that MTCT contributes a significant proportion of new HIV infections. Fifty eight per cent (58%) of children in need of ART received the prophylaxis. Zimbabwe target is to increase the number of infants born to HIV positive pregnant women receiving ART to 95% and above by 2015.

The PMTCT programme will focus on the four prongs.

PMTCT will focus on the following four prongs.

- Primary prevention of HIV infection among women of childbearing age,
- Preventing unintended pregnancies among women living with HIV,
- Prevention HIV transmission from women living with HIV to their infants

<sup>23</sup> WHO, UNICEF, IATT: Guidance on global scale-up of the prevention of mother to child transmission of HIV: towards universal access for women, infants and young children and eliminating HIV and AIDS among children- Inter-Agency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and their Children.

- iv. Providing appropriate treatment, care and support to mothers living with HIV, their children and families.

PMTCT programme will integrate other prevention interventions such as a social and behaviour change communications, HTC, condom use, voluntary male circumcision, treatment and control of STIs and family planning. Integration of family planning for PMTCT is intended to reduce unintended pregnancies. ART prophylaxis to prevent mother to child transmission will be provided for HIV positive women and their infants in accordance with the national guidelines. HIV positive mothers will also be offered ART for their own health. Safe obstetric practices will be strengthened across the health system. Communities and families will be mobilised to create demand for PMTCT.

A comprehensive standardised package of PMTCT services will be defined inclusive of and not limited to HTC; counselling and support on family planning, maternal care, nutrition, infant & young child feeding; ART for mothers for their own health, ART for HIV infants positive; cotrimoxazole for mothers and babies; and Early Infant Diagnosis (EID) of HIV.

Scaling up paediatric ART will involve strengthening capacity of services delivery, accelerating collection and delivery of Dried Blood Spot (DBS) specimens for HIV PCR DNA test and intensifying the follow up of babies born to HIV positive mothers.

To ensure no stock outs of PMTCT drugs and commodities the procurement and supply management systems will be strengthened as part of the health system strengthening. Referral system will be improved and linkages established with related services. PMTCT service providers will be trained in HIV testing and counselling for children, integrated management of adolescents and adult illness (IMAI), and integrated management of pregnancy and child birth (IMPAC).

### **Gaps and Challenges**

- Not all HIV positive pregnant women access and utilise PMTCT services. By 2009 59% of HIV positive pregnant women access PMTCT.
- Follow up of babies born of HIV mothers remain inadequate.
- Lack of availability to all women of a standardised comprehensive gender sensitive package in PMTCT services such as contraception and ART for mothers taking into consideration 2009 WHO guidelines.
- Low virologic testing coverage (13%) for exposed infants hence many HIV positive infants remain unidentified post-natal thereby missing out on critical interventions.
- ANC user fees at point of service have remained a barrier to access to and utilization of PMTCT services.
- HIV related stigma prevents the utilization of PMTCT services in Zimbabwe<sup>24</sup>.

### **Priority strategies**

- Intensifying community education and awareness of PMTCT and encourage accessing and utilisation of the services
- Advocate and facilitate integration of PMTCT into other relevant health services to accelerate availability, access and utilisation,
- Strengthen the supply and logistics management for ARV drugs to PMTCT

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<sup>24</sup> Sibanda, I (2010): Pregnant teens shun HIV treatment for fear of stigmatization.  
<http://ipsnews.net/news.asp?idnews=52243>

- Strengthen availability, accessibility the referral system from PMTCT to ART and other service
- Strengthen laboratory capacity (equipment and personnel) to support PMTC scale up
- Mobilise and support male involvement in PMTCT
- Strengthen Provider Initiated Testing and Counselling (PITC) for children at service delivery points (SDPs)

**Table 10:** PMTCT outcome result

OC-6	Infants born to HIV positive mothers who are infected reduced from 30% in 2010 to 10% in 2013 and to less than 5% by 2015
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#### 4.2.5 HIV testing and counselling (HTC)

##### Overview

HIV counselling and testing remains a critical service in the national response. Approximately 64% of health facilities were providing HTC at the end of June 2010 compared to 35% in 2006. This increase is attributed to the scaling up of provider initiated testing and counselling (PITC). It is anticipated that by 2015 all health facilities will be providing HTC. Approximately 1.6 million people knew their HIV status by 2010. By 2015, this number is estimated to increase to 2.2 million people. Scaling up of HTC will contribute significantly to more people knowing their HIV status and enabling them to seek treatment early enough.

The demand for HTC will increase as programmes such as MC, PMTCT, PEP, STI, blood safety and outreach to most at risk populations are rolled-out. This demand can only be met through improved and intensified coverage coupled with an effective strategy of recruitment, training and retention of HIV counsellors and HIV testers. To achieve this goal ZNASP II will support health systems strengthening to increase the number of health facilities and sites providing HTC from 1218 (2010) to 1578 by 2015. The strategic plan will target priority populations including couples (formal and informal unions); partners of PLHIV on the national Pre-ART and ART programme; young people aged 15-29 years and key populations. While HTC services will be available country wide, priority will be the six provinces with a high HIV burden.

Innovative strategies will be explored including strengthening mobile HCT facilities, establishing youth friendly HTC sites that will also offer adolescent friendly sexual and reproductive health services. PLHIV will be trained and participate as peer counsellors and community mobilizers. Couple counselling, including regular counselling and testing for couples in discordant relationships will be consolidated. HTC will be carried out in conformity with relevant international human rights standards taking cognisance of the “three Cs” (Consent, Counselling and Confidentiality) code.

The logistics and supply chain management will be strengthened to ensure sustained supply of HIV test kits and consumables. The HTC policy will be reviewed periodically to take cognisance of emerging issues. Efforts will be put in place to strengthen linkages and referral systems that utilise or support HTC services such as MC, Family Planning (FP), SBCC, PMTCT, TB/HIV, CHBC, school health services, nutrition, monitoring and evaluation systems for HTC services.

##### Gaps and Challenges

- Inadequate integration of HTC services with other services.
- Referral systems remain weak for HTC services.



- Inadequate capacity and skills for counselling children.
- Inadequate capacity and skills for counselling couples in discordant relationships.
- Inadequate primary counsellors offering pre and post-test counselling or performing rapid tests.
- The policy on testing of minors needs to be reviewed to align itself with emerging global and regional trends.

### Priority strategies

- Integration of HTC with other health, social and HIV and AIDS related service.
- Strengthening health systems to support the referral system and procurement and supply management system for HTC kits and consumables.
- Intensifying training of HIV lay counsellors and testers.
- Review policy guidelines on counselling and testing and in particular in the case of minors.
- Improvement of availability of HTC services through expansion of HTC sites
- Capacity development of health workers in HTC skills
- Increased community mobilisation to generate demand for HTC.

**Table 11:** HTC outcome result

OC-7	Women and men aged 15-49 who received an HIV test in the last 12 months and know their status increased from 6.6% for women and 6.7% for men in 2006 to 20% in 2013 and 35% for both by 2015
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### 4.2.6 Prevention and control of sexually transmitted infections (STIs)

#### Overview

In a sexually active population, STI remains a serious public health concern. The presence STIs such as syphilis, chancroid, ulcers or genital herpes simplex virus infection greatly increases the risk of acquiring or transmitting HIV. According to UNAIDS, the presence of an untreated STIs can enhance both the acquisition and transmission of HIV by a factor of up to 10<sup>25</sup>. The World Health Organisation (WHO) suggests that<sup>26</sup> STI treatment is an important HIV prevention strategy in a general population. Almost all the measures for preventing sexual transmission of HIV and STIs are the same, as are the target audiences for interventions<sup>27</sup>. Despite this evidence, efforts to control the spread of STIs have lost momentum in the past decade as the focus has shifted to HIV therapies.<sup>28</sup>

The review of the STI programme in 2007 showed that all the 10 provinces conduct health education and behaviour change interventions. The STI management guidelines were revised in 2007 and flowcharts printed and distributed. The training curricula was reviewed and expanded to include other HIV prevention strategies. Despite the highlighted interventions, evidence shows that at the individual level, STI and HIV are co-factors for HIV acquisition and transmission especially for specific STIs that cause genital ulcer disease. The 2009 ANC sentinel surveillance report showed that women with current or past genital ulcer disease (GUD) had a higher HIV prevalence nearly three times more than

<sup>25</sup> UNAIDS (1998): Public Health approach to STI control- UNAIDS update

<sup>26</sup> World Health Organisation (2007): Global Strategy for the Prevention of and Control of Sexually Transmitted Infections 2006 -2015,

<sup>27</sup> World Health Organisation (2007): Global Strategy for the Prevention of and Control of Sexually Transmitted Infections 2006 -2015,

<sup>28</sup> World Health Organisation (2007): Global Strategy for the Prevention of and Control of Sexually Transmitted Infections: 2006 -2015,

those without a history of GUD. Among young ANCs attendees age 15-24 those with GUD had a HIV prevalence of 31%.

In Zimbabwe the strategy in dealing with STIs is to interrupt transmission, reduce infections and the duration of infection, and prevent the development of complications in STI clients through early diagnosis and syndromic management. The ZNASP has articulated primary prevention of STIs that include health education, condom use and abstinence from sex if a partner is infected with an STI.

Delivering these services health care workers will be trained to diagnose and treat STIs. STI services will be integrated with other HIV and AIDS, and health care services especially MC, FP and PMTCT. At the same time, health care facilities will be equipped with the necessary diagnostic tools and treatment drugs as well as condoms to effectively treat and manage patients with STIs. Communities will be mobilised and sensitised to adopt health-seeking behaviours for both STIs and HIV. Districts with high prevalence of STI will be prioritised.

Frequent stock outs of key STI drugs and lack of training of some health providers in STIs management remains the two critical gaps affecting effective control and treatment of STIs. During the period of ZNASP II, training in early diagnosis and syndromic management will be accelerated. Procurement and supply of STI drugs and consumables will be improved. STI surveillance systems will be put in place to inform patient management and care. Data collection and reporting on STIs will improved to keep track of implementation of the STI interventions.

### Gaps and Challenges

- Uptake of STI services remains low due to double stigma associated with STI and HIV.
- Frequent stock outs of STI drugs and consumables.
- Training of health workers in syndromic management remains low.
- Inadequate awareness and knowledge among the general population of STIs and their relationship with HIV.
- Inadequate partner contact tracing.

### Priority strategies

- Acceleration of STI education and awareness in the general population and in particular among the most at risk populations as mobile populations and people engaged in multiple and concurrent partnerships.
- Strengthening the procurement and supply of STI drugs, test kits and other consumables.
- Intensifying training of health workers in STI prevention and management.
- Facilitation of STI surveillance.
- Strengthening health and community systems to improve partner contact tracing.

**Table 12:** STIs outcome result

OC-8	Female and Male who reported having STI in the past 12 months reduced from 204,819 in 2010 by 20% (163,855 of 204 819) in 2013 and by 50% (81,928 of 163,855) in 2015
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## 4.2.7 Blood safety

### Overview

Blood safety is the most effective strategy for preventing HIV transmission. Zimbabwe has attained a 100% screening of blood for transfusion transmissible infections (TTIs), including STIs. Safe blood is supplied by the National Blood Services of Zimbabwe (NBSZ), an independent non-profit organization. The NBSZ is a WHO collaborating centre for blood safety in Southern Africa.

Demand for safe blood exceeds supply. Between 2000 and 2009, blood donation declined from 80,000 units in 2000 to 42,000 in 2009. The uptake of post donation counselling has also been low with only 15% of donors coming back to get their test results and post donation counselling services in 2008.

The current Blood Transfusion Policy seeks to instil efficiency in blood donor education, recruitment, selection and retention; blood collection, laboratory testing, storage and distribution. The policy puts emphasis on quality assurance in clinical transfusion practices and adherence to the code of ethics. In order to prevent new HIV infections occurring through blood transfusion, quality assurance and quality improvement systems and strategies will be strengthened. Laboratory technologies will be modernised and human resources capacities improved.

Zimbabwe will strengthen its blood donation programme to ensure that demand for safe blood is met. These will involve intensifying education and awareness targeting low risk groups, developing a donor retention strategy, and strengthening community outreach to collect blood, including procurement of vans and equipment to support on site HIV testing and counselling, and blood collection. Provincial blood collection centres will be set up, equipped and adequately manned. Laboratory and clinical staff will be trained in all aspects of blood collection, storage, testing and utilization.

### Gaps and Challenges

- Demand for safe blood exceeds supply.
- A declining donor base and the absence of a donor retention strategy.
- Inadequate community mobilisation and in particular low risk groups as voluntary blood donors.

### Priority Strategies

- Intensifying awareness and education on blood donation targeting in the first instance on low risk groups.
- Facilitating training of service providers on blood donation strategies, including HIV testing and counselling, storage and screening techniques
- Strengthening of laboratory technological and human resource capacity to sustain 100% screening of all donated blood.
- Establishment of district and provincial level blood donation programmes and storage facilities.
- Development of a national blood donor retention strategy

**Table 13:** Blood safety outcome result

OC-9	100% of donated blood screened in a quality assured manner for TTIs according to national guidelines and maintained at that level by 2015
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#### 4.2.8 Post exposure prophylaxis

##### Overview

Post exposure prophylaxis (PEP) will be provided to address occupational and non-occupational exposure to HIV infections. Occupational exposure is associated with incidents at the workplace while non-occupational exposure is more related to sexual abuse such as rape and defilement.

PEP services consist of counselling and risk assessment, HIV testing and counselling, provision of short term ARV based on the assessed risk and follow up post PEP service counselling. ART sites are equipped to provide PEP services. ZNASP II seeks to improve availability and access to PEP services countrywide.

As most of occupational exposure to blood borne pathogens occurs in health settings, health workers will be trained on universal precautions. In 2008, 66% of health workers who reported a work related injury received PEP, while 69% of them completed treatment. PEP training, awareness and education will also be offered to other service professions including police, firemen, construction workers, shop stewards and foremen. Communities will be mobilised, sensitised and encouraged to access and utilise PEP services especially survivors of sexual abuse (rape and defilement).

The national PEP guidelines (2007) will be reviewed periodically to ensure that they remain relevant and take cognisance of emerging issues, new knowledge and technologies. The uptake of PEP will also increase demand for ARV.

##### Gaps and Challenges

- Inadequate awareness of PEP services among most people and communities.
- Low uptake of PEP services due to lack of awareness and stigma associated with HIV, or rape
- PEP services are not available in all health facilities due lack of qualified personnel to offer PEP.

##### Priority Strategies

- Intensifying education and awareness of PEP in the general population and in particular among people who are at most risk of infection by virtue of their work.
- Accelerating roll out provision of PEP service to all health facilities and in particular those offering ART and PMTCT.
- Strengthening the capacity of service providers to provider PEP – including police and others
- Mobilise communities and create awareness of PEP services and how to access and utilise them
- Strengthening community-based HIV counsellors to provide pre-PEP counselling especially for rape and sexual abuse survivors.

**Table 14:** Post exposure prophylaxis outcome result

OC-10	<p><b>100% of</b> people in need of PEP in the last 12 months received PEP services as per national guidelines and maintained at that level by 2015.</p> <p><i>(Disaggregated by exposure: occupational, rape/sexual abuse, other non-occupational)</i></p>
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### 4.3 Treatment, Care and Support

Reduction of mortality and morbidity amongst PLHIV is the second national priority for the national HIV and AIDS response in the coming five years. This is in line with Zimbabwe's commitment to improve the quality of life through a comprehensive ART programme and in particular eliminate AIDS related deaths.

By December 2010, the combined ART coverage for children and adults was at 31.5% (28,149) and 59% (298,092) respectively. The coverage is projected to increase to 85% by 2015 for both adults and children. In 2009, AIDS related deaths stood at 71,299 for adults and 13,393 for children. Effective implementation of ZNASP II is intended to reduce the AIDS-related deaths by 38% to 44,205 for adults and 8,304 for children by 2015. Table 15 below shows ZNASP II treatment and care impact results with indicator, baseline value and target by 2015.

**Table 15:** Treatment, care and support impact results

Impact -2	HIV and AIDS related mortality for adults reduced by 38% from 71,299 (2010) for adults and 13,393 for children in 2009 to 44,205 for adults and 8,304 for children by 2015
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Increased demand for ART services is anticipated following the shift from CD4 200 to CD4 350 criteria coupled with the increased PMTCT and PEP uptakes. As coverage for ART increases, so are supportive services such as testing and counseling, adherence support, nutrition and palliative care. A comprehensive ART programme will also require an effective management of opportunistic infections (OI) typically associated with HIV such as TB, STIs and hepatitis B co-infection. TB remains the leading opportunistic infection with a co-infection rate of 80% by 2010.

#### 4.3.1 Antiretroviral Therapy (ART)

##### Overview

Zimbabwe is committed to ensuring that all people in need of ART have access to the service as part of the national strategy to improve the quality of life of PLHIV, and to enhance prevention efforts. By 2010, 326,241 PLHIV were enrolled on ART out of 593,168 in need. ART services were being offered in 387 sites around the country. During the same period, the percentage of adults and children with HIV known to be on treatment at 12 months after initiation of ART was estimated at 86.35% in 2010. The increase in the number accessing ART is partly due to the change of eligibility criteria from CD4 200 to CD4 350 following the World Health Organisation (WHO) recommendation. The demand for ART is likely to increase following the roll out of ART services, increased uptake in PMTCT and PEP. The WHO has also recommends that persons with Hepatitis B HIV co-infection be provided with ART.

The Pre-ART services include screening and treatment of opportunistic infections, provision of prophylaxis, monitoring of viral loads, nutritional support, treatment literacy in preparation for ART and the avoidance of re-infection, counselling and psychosocial support.

ART services will be rolled out to more health facilities. The capacity of such facilities will be improved including skills training, mentoring, task shifting, upgrading of laboratories to support HIV testing, and diagnosis of opportunistic infections. Physical facilities will be refurbished to ensure they meet the minimum national standards. ART services will also be integrated in other relevant health services.

The procurement and supply management systems will be strengthened to avoid facilities experiencing drug and commodities stock outs. At national and district level procurement personnel will be trained in drugs and commodity quantification, audits and consumption monitoring. Decentralized storage and distribution of HIV and AIDS at National Pharmaceuticals (NatPharm) Bulawayo Regional Store will be further strengthened. M&E support to the harmonized decentralized distribution for HIV and AIDS commodities at provincial Level will be conducted. Standard Operating Procedures (SoP) will be developed and staff trained on their application.

Laboratory capacity will be improved and facilities refurbished to acceptable standards. Additional haematology, biochemistry, CD4 and HIV viral load machines and reagents as well as consumables will be procured and distributed based on requirements and targets provided. In addition, freezers and air conditioners, water reservoirs and generators will be procured and distributed based on individual facility (ART site) needs.

Services providers will be trained in appropriate skills. Training will be incorporated in pre-service training curriculums and where appropriate integrated with other training programmes. A comprehensive mentorship programme will be developed where more experienced staff will be assigned to support less experienced staff as part of transferring skills.

A virtual network will be established to keep service providers updated with emerging new information and knowledge on ART, HIV and AIDS. Strategic partnerships will be established with civil society organisations to support community-based ART related interventions such as treatment adherence education and counselling.

Community mobilisation, education and awareness on ART, treatment adherence, nutrition and positive living are intensified and coverage expanded. Strategic partnerships with civil society organisation and mass media will be forged based on their comparative advantage. This strategy will aim at creating comprehensive awareness and knowledge of ART, and improving demand for ART services.

Tuberculosis remains a major cause of death amongst PLHIV. Efforts will be made to intensify the implementation of the “Three I’s” strategy that entails Intensified Case Finding (ICF), provision of Isoniazid Preventative Therapy (IPT) and TB Infection Control (IC). Monitoring of TB drug resistant [TB (MDR-TB and EDR-TB)] will be intensified following the emergence of Multi-drug resistant TB (MDR-TB) and Extensively Drug Resistant TB (XDR-TB) over the last few years. Specific attention will be paid to improving TB/HIV collaborative actions that will allow adequate and effective integration of services. Joint planning for HIV and TB will be held at national, provincial and district levels. These sessions will be complemented by periodical supervision for the HIV and TB programmes and mentoring of service providers. Zimbabwe is working towards the global target of reducing TB related death by 50% in 2015. By then 100% of all HIV positive TB patients will be tested for HIV, and enrolled on ART.

ART services quality assurance and improvement will be conducted under the supervision of the Clinical Mentorship and Quality Improvement (QI) Steering Committee.

Zimbabwe will address barriers to ART access including transport costs, long distance and long waiting time at ART treatment centres, inadequate human resources, and poor implementation of task shifting policy. In scaling availability of ART, new sites will be assessed and accredited using the national criteria to determine a site’s readiness for ART services for adults and children.

## Gaps and Challenges

- Uptake of ART remains low at 59% in 2010.
- Inadequate human resources, infrastructure and equipment to support ART services rollout.
- Financial resource constraints in rolling out the CD4 350 eligibility criteria.
- Weak ART services referral system.
- TB/HIV co-infection remains a critical challenge. 80% of TB patients are said to be co-infected with HIV.
- Inadequate implementation of the Isoniazid preventive therapy (IPT)
- Weak ART monitoring systems that are linked to other related services.
- Weak laboratory services for adults and children for both pre-ART and ART.
- Unreliable and sustained supply of electricity and clean water in several health facilities.
- Support and supervision systems for quality assurance are inadequate.

## Priority strategies

- Intensifying HTC services and in particular PITC in all health facilities.
- Roll out ART services to more health facilities that meet the accreditation criteria
- Capacity development of ART service providers.
- Improvement of referral systems from HTC sites to ART service centres.
- Strengthening of procurement and supply chain management of ARV and related commodities.
- Integration of ART services with other health care services.
- Strengthening coordination of national level efforts for TB/HIV collaborative activities.
- Strengthen treatment adherence and retention among adults and children on ART
- Strengthening quality assurance systems for ART services

**Table 16:** ART outcome results

OC-11	PLHIV with HIV still alive at 12 months after the initiation of ART increased from 86.35% in 2010 to 89% by 2013 and 90% by 2015
OC-12	PLHIV who are eligible and are receiving ART increased from 59% for adults and 31.5% for children in 2010 to 81% for adults and 63% for children in 2013 and by 85% for adults and 85% for children by 2015
OC-13	TB deaths in PLHIV reduced by 30% in 2013 and by 50% by 2015

### 4.3.2 Nutrition

#### Overview

It is widely accepted that nutritional health is essential for PLHIV to maximise the period of asymptomatic infection, to mount an effective immune response to fight opportunistic infections and to optimise benefits of ART. Several programmes have reported high mortality in the first 90 days of ART treatment correlated strongly with low body mass index (BMI<16). HIV exacerbates under nutrition through lack of food intake, increased energy needs, and reduced absorption of nutrients. This can hasten the progression of HIV and worsen its impact by weakening the immune system, increasing susceptibility to opportunistic infections and by reducing the effectiveness of treatment. The malnutrition–infection complex which is an outcome of HIV and AIDS is a significant factor among

adults, but more severe among children. Furthermore, poor nutrition in children is associated with risk of children's faltered growth, impaired mental development and even death.

Food and nutritional insecurity increases the mobility and migration patterns of individuals seeking for food. Mobility and migration place people in risky situations and behaviours such as involvement in transactional and commercial sex. Socially marginalised and economically disadvantaged women also, tend to stay in sexually abusive and violent relationships.

The ZNASP strategy is to ensure that households are empowered and capacitated to become self reliant on food, through sustainable food production systems that take into account factors such as climate, geography, socio-economic systems and national legal framework for food production and investment. Collaboration with Ministry of Agriculture and civil society organisations will be critical in securing household food security. To address severe malnutrition in PLHIV and in particular children provision of therapeutic foods will be considered.

Communities will be mobilised and educated on food and nutrition issues. Advocacy, educational and awareness materials will be developed, produced in languages most people can understand and disseminated countrywide. Service providers will be trained to provide nutritional counselling at household level.

### Gaps and Challenges

- Food and nutrition insecurity at household level due to environmental factors and low food production.
- Lack of a national strategy or policy addressing food and nutrition insecurity in vulnerable households with PLHIV.
- Lack of programmatic data on nutrition and other related interventions (e.g. food distribution) limit the ability to ensure quality and comprehensive nutrition programming, decision-making and advocacy.
- Unsustainable supply chain for nutritional commodities.

### Priority strategies

- Facilitate a national assessment of food and nutrition security in vulnerable households and communities.
- Development and implementation of a national household food and nutrition strategy.
- Strengthening coordination of national level efforts on nutrition for PLHIV.
- Strengthening health sector capacity to address nutrition challenges among severely and moderately affected adults and children living with HIV.
- Strengthening monitoring and evaluation systems for nutrition programming.
- Improvement of procurement and supply chain management systems for nutrition products.

**Table 17:** Nutrition outcome result

OC-14	Adults and children PLHIV who are malnourished reduced from 41,742 in 2010, by 25% (31,307) in 2013 and 50% (20,871) by 2015
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### 4.3.3 Community Home Based Care (CHBC)

#### Overview

Community and home-based care (CHBC) is an integral component of the continuum of care and support. Services provided in Zimbabwe include palliative care, nursing care, counselling and psychosocial support, spiritual support, nutrition and referral services. Provision of these services is premised on the partnership between government, civil society organizations, support groups of PLHIV and the communities themselves.

The nature of community CHBC service has evolved overtime given the impacts of ART on patients that were previously bed ridden and not longer in such status. As a result new services have emerged based on demand such as promoting treatment adherence, addressing issues of stigma and providing social protection, and strengthening capacity of households to initiate and implement sustainable livelihoods.

Support groups of PLHIV have shown to be effective in providing care and support services and in particular in addressing stigma and discrimination through promotion of positive living and human rights education and awareness. Within the context of positive living support groups have focused on addressing dietary and safe health practices that improve quality of life such as regular exercising, psychological wellbeing, effects of alcohol and smoking and nutrition. Therefore ZNASP seeks to increase the number of PLHIV receiving psychosocial support from 112, 244 in 2010 to 269,958 by 2015.

Financial and technical support will be provided to community-based organisation providing CHBC services, to enable them improve on quality and expand coverage. Training in home based care skills will be offered based on standardised modules or curricula. Community leaders will be mobilised and encouraged to provide leadership by participating in community based activities.

Community systems will be strengthened to support CHBC service delivery. Procurement and distribution of CHBC supplies to communities will be improved and service providers trained in its management. In improving efficiency and effectiveness of CHBC service delivery motorcycles will be considered and procured. A review of the CHBC monitoring tools will be conducted annually to ensure their continued relevance and practicality.

#### Gaps and challenges

- Limited skills and experience of CHBC service providers.
- Lack of standards and quality assurance for CHBC services
- Inconsistent supply of CHBC kits and other supplies.
- A weak referral system.
- A weak monitoring and evaluation of CHBC services.

#### Priority strategies

- Development of a CHBC capacity strengthening strategy.
- Strengthening of the referral system from and to CHBC
- Review and improvement of M&E tools for CHBC, and training of service providers on the use of the tools.

- Strengthening of the procurement, logistics and distribution systems for community home based care and support.

**Table 18:** CHBC outcome result

OC-15	PLHIV receiving CHBC services increased from 48% in 2010 to 60% in 2013 and 85% by 2015
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#### 4.3.4 Orphans and Vulnerable Children (OVC)

##### Overview

Vulnerable children have become the face of vulnerability due to HIV and AIDS. By December 2010, Zimbabwe had approximately 1.6 million orphans and vulnerable children. Of this only 410,000 were receiving care and support through the Programme of Support (PoS). Zimbabwe has developed a national plan of action to guide care and support services for OVC. The ZNASP II has aligned its OVC interventions to the OVC strategic plan. The services available to OVC range from social and legal protection, care and support, access to education, health, food and shelter.

During the implementation of the ZNASP II, OVC social protection systems and coping mechanisms will be strengthened. This will include among other things accelerated provision of life skills based HIV education for both in and out of school vulnerable children. Community, social and legal protection systems will be improved to protect OVC from social and sexual abuse, exploitation, from being neglected and or abandoned.

Finally community based interventions that support and or improve the wellbeing of OVC will be scaled up.

##### Gaps and challenges

- Not all OVC have been identified or assessed for support, hence not all OVC are receiving support.
- Financial constraints to meet the needs of all OVC.
- Inadequate M&E system to monitor the provision of basic services for OVC.
- Lack of capacity within the government departments to facilitate OVC services delivery.
- A weak coordination of OVC services at provincial, district and community levels
- Inconsistent quality of services for OVC

##### Priority strategies

- Facilitating the assessment and registration of OVC.
- Accelerating resource mobilisation to support OVC interventions.
- Strengthening of OVC M&E system.
- Capacity development of service providers through training, mentorship and provision of resources.
- Improvement of national legal and social protection of OVC
- Facilitating access to education for all OVC of school going age including Early Childhood Care and development (ECCD).
- Facilitating capacity development of civil society organisations to support OVC

**Table 19:** OVC outcome results

OC-16	OVC receiving minimum package of services is increased from 20.9% (410,000) in 2009 to 50% (800,000) by 2013 and to 80% (1,360,000) by 2015.
OC-17	The OVC policy and planning efforts index rating is improved to 5 and above by 2013, and 8 by 2015.

#### 4.4 Coordination and Management and Systems Strengthening

Zimbabwe has established functional coordination systems of the national multi-sectoral HIV and AIDS response at national, provincial, district and community levels. The functions, roles and responsibilities of these institutions have evolved over time given the changes brought about by services integration and mainstreaming efforts.

While coordination remains essential, it is no longer the primary priority of coordinating structures. The emerging focus is in ensuring efficiency and effectiveness, availability and accessibility of services. This calls for anchoring the coordination of the national response in the broader social, health and community systems.

Systems strengthening within the context of the national response service delivery will improve efficiency and effectiveness in service delivery; facilitate a process that will narrow the gap between supply and demand for services. Strong systems will also promote strategic partnerships and alliances and accountability. Stakeholders will be able to harmonise their services to avoid duplication, competition and beneficiary fatigue and align such services to national priorities.

Efficient and effective systems will contribute to the realisation of the following impact level result.

**Table 20:** Coordination and management impact result

Impact - 3	National HIV and AIDS response is effectively coordinated and managed: the NCPI rating is improved from 6.2 in 2010 to 9.0 in 2015
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##### 4.4.1 Enabling Policy and Legal Environment

###### Overview

An enabling policy, legal and social environment is a pre-requisite for successful implementation of the national response. It is also central to the promotion of human rights in the context of HIV and AIDS response. The existence of such an environment facilitates services uptake, reduction of stigma and discrimination, removal of social, legal and or policy barriers to services uptake and provides a unique opportunity to address gender inequalities, social and cultural norms and practices that prevent people from adopting prevention behaviours.

The Zimbabwe National HIV and AIDS policy was last reviewed in 1999. Since then Zimbabwe has opted to mainstream policy issues in the National HIV and AIDS Strategic Plan rather than developing a separate policy document. In 2011, Zimbabwe conducted a review of national policies to establish their continued relevance in an HIV and AIDS era. The study has recommended sectors to mainstream HIV and AIDS, and gender into their sectoral policies in-order to expand the scope of the national response.

In mainstreaming HIV in sector policies, sectors are expected to take into consideration emerging new strategic information and knowledge, global trends and practices in human rights and gender as they relate to HIV and AIDS response. The implementation of policies and enforcement of legislation by all duty-bearers and other stakeholders requires strong political leadership and commitment.

Stigma and discrimination remains a daunting challenge for PLHIV participation in the national response and access to services. Available evidence indicates that stigma is prevalent at a social, institutional and personal level. Its impact has compromised the development of an enabling environment. Available evidence shows that some of the factors driving and sustaining stigma include lack of knowledge and awareness, fear and cultural norms. Cultural norms and practices exacerbate stigma through fear of labelling if one is identified as a person living with HIV. Stigma is also prevalent among health care providers in health care settings. To address this capacity of PLHIV networks and support groups will be strengthened in leadership, governance, advocacy, and more importantly strategies will be put in place to enable PLHIV participate in national, provincial and district decision-making and policy structures.

Zimbabwe is committed to “zero discrimination” by 2015. Efforts will be made to increase accepting attitudes among the general population from a baseline of 17% for women and 11% for men in 2005-6 to 100% by 2015. Policies that address stigma and discrimination reduction will be developed and disseminated. Service providers will be trained in stigma reduction strategies and their implementation. A national wide advocacy campaign will be conducted targeting all social setting where stigma is prevalent. Meaningful involvement and participation by PLHIV is considered a pre-requisite in stigma reduction.

Zimbabwe is also committed to addressing the needs of key populations within the context of prevention, treatment, care and support. In the context of ZNASP II key populations are groups of people considered to be at most risk of HIV infection due to their behaviours, the nature of their duty and or their lifestyle practices. In many cases lack of empirical data on the extent of HIV prevalence or key population size estimation prevents effective planning and service delivery, and hence access to services is often compromised. Efforts will be made to address these challenges from a policy and service delivery perspectives.

### **Gaps and Challenges**

- Inadequate monitoring of the implementation of stigma and discrimination strategies by law enforcement officers and responsible health providers.
- Most sectoral policies have not been reviewed in light of the national response to HIV and AIDS. Consequently they have remained silent on critical issues or some of their elements remain barriers to service delivery.
- Lack of awareness among duty bearers of existing policies and legislation designed to support an enabling environment and reduction of stigma and discrimination in particular at community, workplace and other social environments.
- Stigma associated with HIV and AIDS has compromised services uptake, and the effectiveness of the enabling environment. Monitoring of human rights associated with stigmatisation is weak
- Inadequate and or lack of meaningful participation by PLHIV in national, provincial and district policy and planning structures. PLHIV involvement in the implementation of the response is constrained by lack of resources, stigma and sometimes discrimination from the processes.

## Priority strategies

- Review and strengthening of existing policies and legislation, guidelines and standards that impinge on effective and efficient implementation of the national response in terms of human rights of all people infected or affected by HIV.
- Strengthening of the implementation capacity, coupled with adequate skills for monitoring, reporting and follow up on any form of violations or non-compliance with existing policies and legislation.
- Mobilising and engaging political and community leaders to provide effective leadership to support the establishment and sustenance of an enabling policy, social and legal environment.
- Intensifying education and awareness of existing policies and legislation relevant to the national HIV and AIDS response.
- Promoting a national dialogue on HIV and the law with government, judiciary, legal representatives, civil society and PLHIV and key population networks to understand the impact/effect of inappropriate laws and practices on the access to prevention, testing care and support for PLHIV and most at risk of HIV populations.
- Strengthening the capacity of PLHIV networks to advocate, effectively engage in national decision making processes and governance of the national HIV and AIDS response.

**Table 21:** Enabling policy and legal environment outcome results

OC-18	The national composite policy index improved from 6.2 in 2010 to 9.0 by 2013 and maintained at that level by 2015.
OC-19	Women and men aged 15 – 49 expressing accepting attitudes towards people living with HIV increased from 17% for women and 11% for men in 2010, to 35% for women and 30% for men by 2013 to 75% for women and 60% for men by 2015

### 4.4.2 Coordination and management of the National response

#### Overview

The adoption of the multi-sectoral and decentralised approaches in the coordination and management of the national response have created more opportunities for many and diverse stakeholders involvement. With increased number of stakeholders, coordination has increasingly become complex, challenging and dynamic. The process demands innovation, clarity of roles and responsibilities linked to institutional mandates and comparative advantages. The national response coordination and management is premised on the three ones principle.

During the implementation of ZNASP (I) 2006 to 2010, Zimbabwe established coordination and management structures at all levels of the response. The National AIDS Council is mandated by an Act of Parliament to coordinate and manage the national HIV and AIDS multi-sectoral response. The Ministry of Health and Child Welfare has the technical mandate of coordinating the health sector response. The decentralised coordinating structures include the PAACs, DAACs, and WAACs. Civil society organisations and private sector are coordinated through umbrella or networks such as Zimbabwe AIDS Network and Zimbabwe Business Council on HIV and AIDS among others.

Although coordination and management remains essential, during the period of ZNASP II, the focus will be improving efficiency and effectiveness of the national response, governance and leadership, social

and resources accountability, and more importantly ensuring that duty bearers and other service providers adhere to human rights such as the right to health, privacy, protection and the right to nutrition (food), while providing essential services, and that the rights holders (service beneficiaries) are able to access health and nutrition services without fear of being stigmatised or discriminated against.

An environment that supports efficiency in service delivery is characterised by well-articulated mandates, roles and responsibilities, a functional joint programme review mechanism, planning and development process, and a strong monitoring and evaluation system. The strategic roles of communities, civil society, PLHIV and the private sector are clearly defined and communicated. Decisions in such an environment are evidence-based and focus on specific results; they are gender sensitive and anchored in a human rights framework.

In an environment where resources for HIV and AIDS are declining, coordination of resource mobilisation, allocation and distribution is necessary to sustain availability of services. Systems for resource tracking from both the demand and supply side will be improved. NAC will spearhead the coordination, development and implementation of strategies for sustainable financing of the national response.

### Gaps and Challenges

- Limited resources (human, financial, technological) to support coordination and management of the response
- Lack of clarity of the mandate, roles and responsibilities of coordinating structures especially non-governmental structures. Some of the structures/forums are dysfunctional and duplicate coordination efforts.
- Lack of a coordinated HIV and AIDS financing mechanism by donors and other partners. This in some way has resulted in a funds driven rather than a needs driven response.
- Inadequate resource tracking from the supply and demand side – especially for funds not channelled through the government system.

### Priority strategies

- Improvement of the effectiveness and efficiency of the coordination system.
- Promotion of equitable distribution and delivery of services countrywide.
- Alignment of partners' coordination mechanisms with national systems and policy frameworks.
- Strengthening partnerships and strategic alliances between government and communities with development partners and civil society organisations

**Table 22:** Coordination and management outcome result

OC-20	The NCPI rating on efficiency and effectiveness of national response coordination improved from 6.2 in 2010 to 9.0 by 2013 and maintained at that level by 2015
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#### 4.4.3 Mainstreaming of HIV in the workplace and in development projects

HIV and AIDS epidemic is rapidly spreading along the fault lines of socioeconomic development. The impacts of HIV and AIDS transcend social and institutional boundaries, and are likely to halt national efforts to achieve long-term development goals including Millennium Development Goals. The response demands a national multi-sectoral and decentralised approach that provides meaningful

opportunities for public and private sectors, and civil society organisations to participate in the response based on their mandate and comparative advantage.

Mainstreaming of HIV, gender and human rights has been identified as the key strategy to support sectors in their response to the epidemic in two ways. First, by helping sectors address the threat posed by HIV and AIDS to the sector i.e. the impact on their human resources and economic productivity. Second, by facilitating sector efforts to ensure that sector practices and programmes do not fuel the spread of HIV. The mainstreaming process will also facilitate mainstreaming of human rights and gender dimensions in the response.

In the context of ZNASP II, efforts will be made to intensify education and awareness of human rights, such as the right to safe sex, social protection against sexual abuse, and access to services such as use of condoms, strengthen systems to protect women in particular and provide remedies especially for the most vulnerable women living in abusive relationships and who experience gender based violence, and those living in vulnerable (economically poor) households. Stakeholders will be supported to address cultural norms and practices that fuel the spread of HIV and AIDS.

ZNASP II will support development of HIV and AIDS workplace programmes and mainstreaming in development projects. Interventions will be human rights sensitive and gender responsive. Sectors will align their responses to their core mandates, operational policies and strategies. Consequently HIV and AIDS response dimensions will be integrated into all sector and corporate functions ranging from human resources, finance, policies, field operations, decision making, planning process to socioeconomic performance and environmental impact assessments.

To ensure efficient and effective mainstreaming of HIV, national guidelines for mainstreaming will be developed and capacity of stakeholders strengthened. Sectors will incorporate financial resources to support sectoral HIV mainstreaming in their regular budgets. Technical support will be provided to sectors to conduct sector specific HIV and AIDS impact assessments that will also include assessment HIV prevalence. Capacity development will be premised on a human rights based approach to ensure better outcomes downstream.

In the case for large development projects, HIV social assessment assessments will be incorporated into the standard environmental impact assessments. The impact assessments will also take into considerations gender and human rights dimensions.

Currently the level of private sector and civil society organisations involvement in mainstreaming remains low. This is attributed to inadequate human and financial resources, and lack of clear policy guidelines to inform their participation and involvement.

### **Public sector mainstreaming**

While it is necessary for all sectors to mainstream HIV and AIDS, it is strategic to prioritise mainstreaming sectors taking into account those sectors that will have the greatest impact on preventing new infections and or expanding opportunities for treatment, care and support. The Government of Zimbabwe has prioritised thirteen (13) ministries as priority public sectors for mainstreaming. All these sectors started HIV and AIDS mainstreaming during the implementation of ZNASP (I). They are at different levels of mainstreaming with MoHCW being the most advanced.

In 2006, the Public Service Commission approved the Public Service HIV and AIDS Strategic Plan 2006-2010 that has informed public sector HIV and AIDS mainstreaming plans. Sector involvement is

premised on its mandate and comparative advantaged. The potential for public sector mainstreaming response has been compromised by lack of adequate human and financial resources, a weak policy and legal mainstreaming environment, inadequate leadership, technical experience and skills for mainstreaming.

The following are the thirteen public sector ministries that have been prioritised for HIV and AIDS mainstreaming during the ZNASP II period.

**Table 23:** Prioritised public sector for HIV and AIDS mainstreaming

<b>Sector</b>	<b>Sector relevance to mainstreaming</b>	<b>Lead Ministry</b>
Agriculture	With countrywide network of extension workers, the ministry is able to reach many people with HIV and AIDS interventions, especially those related to nutrition and food security. Similarly empowering their staff and in particular extension staff can significantly contribute to prevention of new infections.	Ministry of Agriculture
Defence	Uniformed forces are highly mobile and considered among the key populations most at risk. Empowering them to adopt prevention behaviours has a direct prevention impact at communities level.	Ministry of Defence
Education	Through education and sports a large population of people especially young can be reached with HIV and AIDS prevention interventions. Such interventions will contribute to a reduction of new infections and help Zimbabwe move towards an AIDS free generation. Similarly through the ministry's cultural outreach – social-cultural norms, values and practices that are barriers to HIV prevention can be addressed.	Ministry of Education, Sports and Culture
Finance	The ministry can steer the course of poverty through initiating pro-poor policies aimed at poverty reduction that can benefit vulnerable populations including PLHIV and OVC. It can also influence other sector to mainstream HIV and AIDS through sector budgets.	Ministry of Finance
Gender	The epidemic has a gender bias, with women more affected than men; the Ministry can intensify advocacy work, education and awareness of gender related drivers. The ministry can effectively influence changes in policies and legislation to address gender issues.	Ministry of Gender and Women Empowerment
Health	Health sector is the largest supplier of HIV and AIDS services especially in the context of treatment, care and support, including child welfare issues. It is also responsible for managing the TB/HIV co-infection. TB is the most significant cause of death among people living with HIV and AIDS.	Ministry of Health and Child Welfare
Information / ICT	Information, awareness and education constitute the key to behaviour change. Use of Mass media has strong effect on advocacy work across the country. The Ministry can play an important role in disseminating HIV and AIDS information, and supporting advocacy work.	Ministry of Information, Media, Information and Publicity
Ministry of Labour and Social Services	The Ministry can be instrument in ensuring all public and private sector institutions develop and implement HIV and AIDS workplace programmes, while at the same time promoting social protection for vulnerable adults and children	
Rural and Urban Development	The Ministry can ensure that services reach out to all people in rural and urban areas by ensuring adequate systems and infrastructure. It can also enhance coordination of the response through local structures.	Ministry of Local Government, Rural and Urban Dev.
Small and Medium Enterprises	The sector employs more than 50% of the labour force in Zimbabwe and can effectively reach them through workplace programmes.	Ministry of Small and Medium Enterprises
Tourism	Tourism promotes people's mobility and informal interactions. Mobility is one of the factors that have been identified as an epidemic driver.	Ministry of Tourism



	Effective strategies will reduce the probability of exposure.	
Trade and Commerce	Trade and commerce promotes human interaction both nationally, cross border and internationally. Promoting HIV and AIDS responses within trade systems stimulates adoption of prevention behaviours.	Ministry of Industry and International Trade
Youth	Young people are considered the window of hope in the national response. They are also sexually active, and the risks and vulnerabilities for HIV infection are high. Developing effective response strategies are critical	Ministry of Youth, Development, and Employment Creation

### Gaps and Challenges

- Policy and technical guidelines are focused on public sector institutions. The role of private sector and civil society organisations is inadequately articulated.
- Inadequate capacity and experience in mainstreaming HIV, gender and human rights.
- Existing guidelines are more biased on mainstreaming HIV, with inadequate attention to gender and human rights
- Inadequate resource to support mainstreaming initiatives.
- Lack of clarity on what needs to be mainstreamed, where, how, when and by whom.

### Priority strategies

- Review and strengthening of mainstreaming policy and technical guidelines.
- Evaluation of the Public Sector Strategic Plan for Mainstreaming and develop a successor plan in line with ZNASP II
- Capacity development for mainstreaming. This will also incorporate training on impact assessments, budgeting and monitoring of mainstreaming outcomes.
- Review of policies and guidelines for HIV Workplace Programmes
- Strengthening of HIV Workplace programmes in all ministries
- Establishment of coordination units or appointment of focal persons to coordinate HIV and AIDS mainstreaming in the respective sectors

**Table 24:** HIV and AIDS Mainstreaming outcome result

OC-21	100% of prioritised public sectors (ministries) and 50% of key private sector companies have mainstreamed HIV, relevant HIV gender and human rights dimensions in their development work by 2013 and maintained above that level by 2015
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#### 4.4.4 Systems Strengthening

##### Overview

Successful implementation of the national response is to a large extent dependent on strong and functional systems. Zimbabwe has prioritised strengthening health and community systems. Systems strengthening has been defined as the efforts to improve the functioning of a system for better outcomes, increased access, coverage and quality of services, efficiency and effectiveness of services delivery.

For health systems strengthening, it will be modelled around the six blocks articulated by World Health Organisation (WHO). The blocks are services delivery; human resources; strategic information; products, commodities and technology; finance, and leadership and governance. In the case of

community systems strengthening, the process will be modelled around six blocks that include enabling environment, community networks and partnerships, resources and capacity development, community activities, organisational and leadership development, and finally M&E<sup>29</sup>. Collectively these blocks contribute to improved health and social outcomes, improved efficiency and effectiveness in services delivery, use of financial and human resources.

#### **4.4.4.1 Health Systems Strengthening**

An efficient and effective health system is a pre-requisite for the national HIV and AIDS multi-sectoral response. A functional system helps to scale up services, enhance the harmonisation and alignment of interventions, improves the synergy, integration and implementation intensity. The process results in improved services availability, access and utilisation. Strong health systems facilitate leveraging of resources, the use of strategic information in decision-making and planning, the application of appropriate technologies for better outcomes.

The current health system is weakened by a number of organizational challenges including vertical sub-systems that result in uneven quality of services, fragmentation and sometimes duplication of service. In some cases health facility-based systems are inadequate to meet the needs of communities and households around them. Issues of governance and leadership have compromised service delivery especially in the context of key populations. Collaboration between public and private sector health systems remains weak and largely uncoordinated.

The National Health Strategy, 2009-2013 aims at ensuring “equity and quality in health” for all people from a human rights perspective. Zimbabwe hopes to achieve this through a strengthened health system. The health system in Zimbabwe will be strengthened based on the six components identified by World Health Organisation as articulated in table 25 below.

ZNASP II will support the development of a comprehensive human development plan, given the importance of human resources in the health sector and HIV and AIDS service delivery. The plan will include retention strategies for experienced and qualified staff, institutionalisation of task shifting, mentorship, and recruitment process.

Procurement and supply chain management systems need special attention to ensure no stock out of important medicines and other commodities. Capacity in forecasting, quantification, consumption monitoring and ordering will be developed. Additional capacity for storage at district level will be considered based on need.

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<sup>29</sup> GFATM (May 2010): Community Systems Strengthening Framework

**Table 25:** Components for health systems strengthening

Component	Description	Challenges	Strategies to Address the identified Gaps and challenges
Health products, and technologies	The aim is to ensure that services are available, affordable and accessible to all people. This will require understanding of the health needs and status of the people that will translate into defining the health products, services and commodities necessary for improving the quality of life.	<ul style="list-style-type: none"> <li>• Inadequate scaling up / coverage of services,</li> <li>• User fees and transport remains key barriers to services uptake especially in rural areas</li> <li>• Stigma and discrimination prevents people accessing and utilising services freely</li> <li>• Weak quality assurance monitoring of services and service delivery mechanisms.</li> <li>• Weak procurement and supply chain management system</li> </ul>	<ul style="list-style-type: none"> <li>• ZNASP will focus on strengthening health systems to make services available, accessible and affordable especially in rural areas.</li> <li>• Health facilities will be improved (rehabilitated/ refurbished) or new ones constructed to make services easily accessible nearer the people.</li> <li>• Procurement and supply management systems will be strengthened through service providers training, development of guidelines etc. Review and improve procurement policies will be</li> <li>• Communities will be mobilised and awareness created on services available.</li> </ul>
Human Resources	Skilled and competent human resources are a pre-requisite for efficient health service delivery.	<ul style="list-style-type: none"> <li>• Inadequate human resources</li> <li>• No retention strategy for experienced and skilled personnel</li> <li>• High vacancy rates among different health cadres</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitate recruitment of new personnel. Zimbabwe hopes to reduce the vacancy rates by 50% by 2013.</li> <li>• Accelerate task shifting</li> <li>• Development of a retention policy of health services personnel.</li> <li>• Development of human resources capacity, and technical competence through skills training, mentorship, supervision and knowledge improvement.</li> <li>• Review of the training curricula for the various cadres</li> <li>• Facilitate upgrading of training facilities and equipment</li> </ul>
Leadership and governance	Political, community and religious play an important role in health services uptake at community level. However, their engagement in advocating for health seeking behaviours,	<ul style="list-style-type: none"> <li>• Weak leadership and governance – lack of clarity on mandates, roles and responsibilities</li> <li>• Inadequate social and resource accountability</li> <li>• Inadequate partnership building</li> <li>• Inadequate strengthening of provincial, district and community leadership capacities</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthening leadership skills and facilitating understanding and appreciation of oversight responsibility and accountability</li> <li>• Build capacity for leaders on advocacy on health issues. Mobilise and engage leaders in community based health initiatives,</li> </ul>
Service Delivery	The efficiency of health services delivery systems has been	<ul style="list-style-type: none"> <li>• Inadequate awareness of available services</li> <li>• Inadequate integration of services</li> </ul>	<ul style="list-style-type: none"> <li>• Create demand through social and community mobilisation</li> <li>• Facilitate implementation of strategies that remove barriers that</li> </ul>

	<p>compromised by lack of adequate human resources, policy guidelines, infrastructure, and financial resources. This is in addition to lack of or adherence of quality standards. Inadequate integration of services has equally compromised the services.</p>	<ul style="list-style-type: none"> <li>• Stigma and discrimination, user fees and transport costs remains barriers to services uptake</li> <li>• Inadequate private sector, including some public sectors participation in the provision of health services</li> </ul>	<p>prevent services uptake for example – stigma and discrimination, user fees, transport / distance to service points</p> <ul style="list-style-type: none"> <li>• Facilitate mainstreaming of HIV and AIDS by non-health public and private sector institutions</li> <li>• Facilitate mobilisation of males to participate and support HIV and AIDS related services</li> </ul>
Strategic Information	<p>Strategic information provides the evidence required to make informed choices and decision in planning, resource allocation and planning. Management of such information requires a harmonised and aligned system that contribute to common results /obejectives. Currently strategic information collection, analysis is fragemented, and many people don't have the pre-requisite skills and experience.</p>	<ul style="list-style-type: none"> <li>• Lack of capacity in data collection, anaysis and reporting</li> <li>• Inadequate caapcity for strategic inforamtion management – including that of Centre for Health Information Management (CHIM)</li> <li>• Inadequate use of strategic information by decision makers and planners</li> <li>• Inadequate application of appropriate technologies for strategic information management</li> </ul>	<ul style="list-style-type: none"> <li>• Facilitate capacity development for data collection, analysis and management</li> <li>• Strengthening the M&amp;E systems including harmonisation and alignment of various systems</li> <li>• Promote and encourage the use of appropriate technology. Facilitate computerisation of HRIS, and LMIS in health facilities, medical records system, Human Resource Information System (HRIS) and Logistics Management Information System (LMIS).</li> <li>• Procure and provide appropriate technology</li> </ul>
Sustainable Financing	<p>Zimbabwe currently spends 15USD per capita on health, which falls far short of the globally recommended figure of 34USD. The health sector has recently developed an investment case to quantify levels of investment required to impact on progress towards attainment of the MDG targets on health. The need to resource mobilize becomes apparent to bridge the gap in funding. Successful implementation of ZNASP II is dependent on provision of sustainable and predictable financial resource base and accountability of resources mobilized</p>	<ul style="list-style-type: none"> <li>• Financial demand for HIV and AIDS services are more than supply</li> <li>• Declining donor commitment for HIV and AIDS funding</li> <li>• Inadequate domestic funding for HIV and AIDS interventions</li> </ul>	<p>Advocate for increased domestic funding for HIV and AIDS, Improve the efficiency of the use of the National HIV Levy funds</p> <p>Advocate for increased external funding and expansion of the donor base.</p> <p>Advocate for the improvement of the Public Finance Management System (PFMS) at all levels. Encourage evidence and results based funding mechanisms.</p> <p>Advocate for enhanced accountability of financial resources.</p> <p>Review of Health services user fee policy</p> <p>Advocate for efficiency in services delivery and commodities and products procurement.</p>

#### 4.4.4.2 Community Systems Strengthening<sup>30</sup>.

Community systems are community- led structures and mechanisms used by communities through which community members, community based organizations and groups interact, coordinate and deliver their responses to address the challenges and needs affecting their communities. Community systems strengthening involves a broad range of community actors, enabling them to contribute as equal partners alongside other actors to the long- term sustainability of social and health issues.

Given the burden of care and support, and diminishing livelihoods, communities are organising themselves to find community based solutions and implement strategies that are appropriate for them. It is for this reason that community systems strengthening become strategic.

In the context of ZNASP II, community systems strengthening will focus on community based systems that strengthen community leadership and governance, community organisation, local resource mobilisation, management to developing community skills in advocacy, monitoring and resource management. Community systems will be strengthened to ensure adequate, equitable and sustained provision of services. The process will take cognisance of the need to support alternative sustainable livelihoods that largely depend on locally available resources. The capacity of community-based organisations (NGOs, FBOs, CBOs and PLHIV support groups) will be strengthened to provide backstopping support to communities.

Community systems strengthening will revolve around the following issues –

- **Strengthening the enabling environment:** The social, legal and policy environment at community level will be improved. Efforts will be made to reduce or eliminate stigma and discrimination. Stakeholders will address social and cultural norms that prevent people from accessing and utilising available services. Meaningful involvement of community based CBOs, FBOs and NGOs will be supported and strengthened.
- **Mobilising and engaging community leaders:** Community and religious leaders will be mobilised and sensitised on community based HIV and AIDS interventions. It is anticipated that the leaders will play a critical role in advocating for health seeking and prevention behaviours including HTC, PMTCT, MC, and PEP among others. Through community based meetings, conversations and forums, the leaders will be expected to create awareness of HIV and AIDS and in particular prevention, human rights and gender dimension of the epidemic.
- **Communication and social mobilisation:** Community systems will be reviewed and strengthened to support community advocacy work, communication and feedback, and social mobilisation. Community forums, workshops and conversations will be used as platforms for advocacy and dialogue. Advocacy initiatives will focus on change of practices in discrimination, policies and laws, harmful cultural practices and social norms that fuel HIV infections and improved access to HIV services by all affected populations. Best practices will be documented. It is anticipated that through advocacy communities will be able to sustain HIV and AIDS on the community social, political and development agenda.
- **Community networks, linkages, partnerships and coordination:** The challenges of HIV and AIDS transcend community and household boundaries. This demands a multi-sectoral and

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<sup>30</sup> Note: Information on these section is based on the “Community Systems Strengthening Framework” by -GFATM (May 2010):

collaborative approach. Consequently existing strategic partnerships and alliances will be consolidated and new ones established. Networking mechanisms will be improved and expanded. Leadership will be strengthened through training and provision of strategic information. Resources will be provided for CBOs, FBOs and NGOs, including organisations working with key populations to implement selected interventions.

- **Strengthening district, provincial and national level planning and coordination mechanisms:** To ensure establishment of effective coordination mechanisms and sustainability of community networks, linkages and partnerships will be established. Information flow between the various organisations will be facilitated. The PAACs and DAACs will be expected to provide technical assistance to lower level institutions. Roles and responsibilities will be clarified and communicated.
- **Resources and capacity building:** A key challenge facing community systems in Zimbabwe is lack of sustainable financing of activities. CBOs, FBOs and NGOs will require resources (money, human and material), technical expertise and organisational capacity to manage and implement programmes and deliver services. ZNASP II will facilitate community based organisations access to technical assistance, capacity building for local resource mobilisation and adequate resource allocations from central level. Additional capacity development will focus on organisational management and leadership and delivery of HIV services. The organisations will be trained in advocacy and human rights issues, M&E and gender analysis among others.
- **Improve community based HIV services availability, use and quality:** Community based HIV services are meant to complement the social and health facility based HIV services. Recognising the critical role played by communities in provision of care, and the weak linkages that are evident between these systems, the aim of the strategic plan is to strengthen and improve linkage and referral between health facilities and community level service providers. During the ZNASP II, quality standards guidelines will be developed for community-based services. Linkages will be consolidated between community initiatives with CHBC and OVC programmes.
- **Improve monitoring and reporting on community based HIV services:** To ensure monitoring and quality of services provided, a system for reporting on community-based HIV services will be established. This system will ensure that all organisations working on community-based HIV services report on their activities. Health and social workers will facilitate monitoring of community-based HIV services with technical support from district level personnel and by civil society organisations.
- **Capacity of CBOs, FBOs and NGOs in planning, monitoring and evaluation strengthened:** To encourage community led planning monitoring and evaluation CBOs, FBOs and NGOs will be trained in participatory approaches, on community planning, leadership and governance. Accountability and ownership will be enhanced. Skills in data collection, analysis and reporting will be developed. Communities will be encouraged to use strategic information collected to improve their interventions. Part of the training will focus on but not limited to-
  - ✓ Evidence and results based planning and programming
  - ✓ Financial planning and management
  - ✓ Human resource capacity development
  - ✓ Advocacy and networking

## Gaps and challenges in health and community systems

**Table 26:** Gaps and challenges in health and community systems

System	Gaps and challenges
<b>Health systems</b>	<ul style="list-style-type: none"> <li>• Fragmentation and vertical approach to health systems strengthening</li> <li>• Inadequate resources for health systems strengthening</li> <li>• Inadequate understanding of the core principles underpinning health systems strengthening</li> <li>• A weak strategy and policy for services integration</li> </ul>
<b>Community systems</b>	<ul style="list-style-type: none"> <li>• Under-developed community systems and structures</li> <li>• Weak leadership and governance – many of the leaders don't understand their roles and responsibilities.</li> <li>• A weak strategy for addressing community based barriers to services access and up take including weak enabling environment where stigma and discrimination is prevalent.</li> <li>• Inadequate resources – financial, human and materials</li> <li>• Inadequate capacity for planning, monitoring including data analysis, and use of strategic information.</li> <li>• Lack of community based M&amp;E systems and evidence based programming; and</li> <li>• Poor community linkages, collaboration and coordination among communities and community based organizations and structures that reflect the overall lack of a coordinating mechanism for community participation.</li> </ul>

### Priority strategies

- Strengthen community systems based on the six health and community systems blocks respectively
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**Table 27:** Health and community systems strengthening outcome results

OC-22	The NCPI rating on efficiency and effectiveness of health and community systems improved to 5 by 2013 and to 8 by 2015
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## 4.5 Strategic Information Management

### Overview

An effective strategic information management (SIM) is necessary with the adoption of a human rights evidence-based and results based planning and management approaches. SIM is premised on the existence of an effective and efficient monitoring and evaluation system coupled with a functional operational research system. Data collection, analysis and reporting constitute the basis for SIM. Strategic information is necessary for decision-making, planning and resource mobilisation and allocation.

Zimbabwe has developed a national M&E plan that will be used for purposes of tracking the implementation of the ZNASP II. In the short term the M&E plan will be used to establish baselines and

to track annual performance of ZNASP II. In the long term the M&E plan will facilitate a process of measuring the outcome and impact results. These are articulated in the ZNASP II results framework and the M&E plan itself.

An assessment of the national M&E System was undertaken in 2010 utilizing the 12 M&E components - M&E Strengthening tool (MESS tool). The assessment revealed that both NAC and MoHCW AIDS and TB unit had insufficient staff to enable them to fulfil their roles in coordinating the M&E of the national response. Therefore, ZNASP II will prioritize the capacity building of staff within the two institutions in order to bridge the gaps identified in addition to advocating for recruitment of new staff.

Several strategies have been adopted to strengthen the national M&E system. These are -

- i. Capacity development of human resources for M&E at all levels i.e. national, provincial and district levels and in the private sector and civil society organisations.
- ii. Mainstreaming of the national M&E results and indicators in other sectors to ensure harmonisation and alignment within M&E frameworks in line with the three one principles
- iii. Development of the M&E guide with clearly defined indicators and targets
- iv. Strengthening the capacity of stakeholders to use the data in decision making and programming

Training of M&E personnel will be conducted at community, district, province and national levels. As part of developing the national monitoring and evaluation training curricula, the UNAIDS regional monitoring and evaluation training curricula shall be adopted and customized to suite the national M&E system. The customized training curriculum will be institutionalised in tertiary institution so as to cater for various levels of training requirements. NAC will spearhead the adoption and customization the training curricula.

The M&E capacity development process will also include development and production of the M&E indicator protocol and revised data collection tools. Periodical supervisory and mentoring field trips will be conducted by designated M&E expertise. Although NAC regularly conducts district support visits, there has been a major challenge of standardised assessment tools. During the period of ZNASP II, tools for field assessments of the M&E system and data collection processes will be standardised.

Improved strategic information management will enhance Zimbabwe's reporting capacity on its regional and international commitments including the MDGs, UNGASS, SADC and Africa Union Commitments on HIV and AIDS.

### **Monitoring ZNASP II**

Monitoring of the ZNASP II will be an on-going activity during the life cycle of ZNASP. The process will involve routine data collection by implementing partners using the standardised data collection tools. Additional monitoring will be premised on desk review of periodical reports submitted by implementing and development partners to the National AIDS Council. Routine monitoring will focus on annual targets, and output results. Overall routine monitoring process will aim at ascertaining

- i. Whether ZNASP implementation is on track, and making desired progress towards attaining the set targets.
- ii. Whether resources (human, financial and material) are being used efficiently
- iii. Whether services are available and being easily accessed by all people especially key populations and most at risk populations.



- iv. Whether the involvement and participation of beneficiary communities, and civil society organisations is sustained at desired levels.
- v. Whether emerging barriers that have the potential to negatively impact on the project implementation are being addressed on time.
- vi. How the ZNASP II strategies are facilitating capacity development, knowledge and skills transfer, the improvement of service delivery systems, and strategic information management

## **Evaluation of the ZNASP**

Assessment of the extent to which objectives of the strategic plan (ZNASP II) are met requires an array of periodic reviews and evaluations. These evaluations are critical to collection of specific outcome and impact indicator values as well as evaluating some fundamental attributes of programs such as efficacy, equity, relevance, appropriateness etc. The Evaluation component therefore has to be strategically planned for utilizing national surveys and surveillances, project evaluations and other similar researches

ZNASP evaluation will be conducted twice during the life cycle of the strategic plan. The evaluation will assess the extent the strategic plan has or is moving towards the achievement of planned annual targets, outcome and impact results.

A midterm review of the ZNASP II will be conducted in 2013 to assess progress being made in reaching set results and targets. The mid-term evaluation will provide an opportunity to rethink national strategies for scaling up the national HIV and AIDS response. The assessment will involve a desk review including routine M&E data generated by the national system, key informant interviews, the compilation of any relevant data and information, and the organisation of a review workshop where findings are presented and deliberated on by stakeholders. The priorities and strategies of ZNASP II will be modified as necessary based on emerging evidence.

By mid 2015, the end-of-term evaluation of the ZNASP II will be undertaken to inform the development of a successor strategic plan.

## **HIV Research**

The current HIV and research priorities will expire in 2012. The research agenda will be reviewed and updated in 2013 and aligned with the ZNASP II. NAC will spearhead a consultative process to develop, share and implement the priorities. The research agenda will take into account research proposals contained in the M&E plan and the National Operational Plan

## **Reporting**

Although routine monitoring is an on-going process reporting will be done quarterly on the basis of the targets set. Data will be analysed at district level where district quarterly services coverage reports will be compiled for submission to National AIDS Council through the Provincial M&E Officers. NAC will conduct a secondary data analysis to ensure data quality at national level. NAC will compile a national quarterly and annual services coverage reports as the case maybe.

## Gaps and Challenges

- The national M & E system is weak. Many of the indicators don't have baselines. Zimbabwe does not have a one-stop shop for strategic data. Databases are fragment and largely un-coordinated.
- Inadequate capacity for data collection, analysis and use at various levels of the response.
- Stakeholders have not been guided by common results neither are they using common indicators.
- Inadequate use of strategic information.

## Priority strategies

- Strengthening of the capacity of the national M & E system based on the 12 M&E component
- Generating baselines and indicator values of ZNASP II indicators in the first year 2012/13
- Development of a national database for HIV and AIDS.
- Advocacy on the use of strategic information in decision-making, planning and resources allocation.
- Review and alignment of data collection tools and processes.
- Review and updating of national research agenda.

**Table 28:** Strategic information outcome result

OC-23	National M&E systems provide 100% of the indicator values (baselines and targets) by 2013 and maintained by 2015
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### 4.5.1 Sustainable financing of the national response and resource mobilisation

The cost of HIV and AIDS response in Zimbabwe is escalating against a backdrop of declining domestic and international financial resources for HIV and AIDS. The increase in cost is associated with the scale-up of services, adoption of the new ART treatment guidelines (CD4-350) and the expansion of the national response through sector mainstreaming of HIV. The gap between resource needs and available funding continue to expand raising concerns for overall sustainability of the response. The Government's commitment to address the issue of sustainable financing for HIV is demonstrated by the establishment of the National HIV and AIDS levy. The levy system is anchored in the national tax system. This commitment becomes crucial given the impact of the recent global economic crisis that has significantly reduced global funding for HIV and AIDS.

The decline in resources has serious implications on the sustainability of strategic HIV and AIDS interventions including prevention of new infections and sustained provision of ART. The growing resource gap means that Zimbabwe will continue to face difficulties in financing the national response from domestic resources using existing strategies. The consequence is the likelihood of compromising the health outcomes in prevention of new infections, ART, PMTCT and treatment of TB/HIV co-infections through services interruptions.

During the implementation of ZNASP II, efforts to strengthen and consolidating existing sustainable financing mechanisms (i.e. HIV Levy, and direct Government budget allocation) will be accelerated and new strategies developed.

In developing a sustainable financing strategy, Zimbabwe will adopt a multi-pronged approach premised on the New Investment Framework for HIV proposed by UNAIDS. The strategy will focus on

- i. Increasing domestic and international funding.
- ii. Strengthening effectiveness and efficiency in the use financial resources, and in service delivery.
- iii. Prioritisation of the national response strategies,
- iv. Cost reduction in services delivery.

Zimbabwe has committed itself to allocate 15% of national budget to health sector (including HIV and AIDS) by 2015. This commitment is reiterated by subsequent declarations such as MDG, UNGASS, Maseru and Paris declarations respectively. Government through the national budget increased from US\$354,000 in 2008 to US\$7,5 million in 2009. External funding by development partners and donors increased from US\$25 million in 2008 to US\$38 million in 2009. Collections from the AIDS levy have increased from US\$5.7 million in 2009 to \$15.9 million in 2010. This data illustrates the dependency of the national response on external funding.

In line with the Paris Declaration of harmonising funding mechanisms, some donors have come together and support the national response through the collective initiative known as the Expanded Support Programme. Between 2007 and 2009, a total of US\$46 million was made available to the national response. Zimbabwe will advocate for the continuation of the programme and encourage more donors participate in the programme. The Government will mobilise additional donors while advocating for an increase in funding from existing ones.

The ZNASP II will be costed and will serve as the tool for national resource mobilisation. In order to address this priority, a capacity development and resource mobilisation strategy will be developed, aligned to the Zimbabwe National AIDS Strategic Plan

Sustainable financing of the national response goes beyond provision of finances to efficient and effective use of available resources. The application of principles of efficiency and effectiveness starts with government commitment to use of empirical evidence to support prioritisation of effective strategies and interventions for the national response. This is coupled with a focus on measurable results rather than mere service delivery. The ZNASP II, has prioritised prevention of new infections and reduction of AIDS related mortality by 50% by 2015. Priority interventions are set out in section four of the strategic plan. The prioritisation was premised on available evidence and in line with the Government's commitment to reduce new infections and mortality rates by 50%.

During the ZNASP service delivery systems will be reviewed and strengthened to improve their efficiency and effectiveness. Issues of equitable distribution, availability, access and coverage of services will be considered. In strengthening efficiencies and effectiveness critical considerations around human resources (skills, competencies and retention), procurement and supply chain management systems, and use of strategic information will be critical success factors. Overall health and community systems will be strengthened to support efficient services delivery.

Integration of services and service delivery systems will be used as a strategy to expand the availability and access to services while supporting cost cutting in service delivery. Integration of services and service delivery systems will address the challenges associated with rapid vertical scale-up of services that are characterised by less emphasis on results-based, cost-effectiveness, cost efficiency and priority setting for national response. During the period of ZNASP II, Zimbabwe will institutionalise human rights based planning that will address issues of equitable distribution of services, an integrated service delivery system and focused on the results. Efforts will be made to reduce cost were necessary by supporting service delivery systems integration

In line with the New Investment Framework, a systematic process towards sustainable financing will involve three stages: 1) data collection (of expenditures, costs (current and future), 2) data analysis (including macroeconomic modelling) and interpretation, and 3) an informed decision making process.

In a dynamic environment such as Zimbabwe financing circumstances will change and analyses and decisions will need to be updated on a continuous basis. The pivotal point in the process towards sustainable financing will involve the development of a long-term sustainable financing map and resource mobilisation strategy. The strategy will also encompass the need to examine other critical aspects of sustainability and systems strengthening, such as human resources, and organizational arrangements that are critical in ensuring efficiency and effectiveness of the response. Existing strategic partnerships will be consolidated with development partners, private sector institutions, civil society organisations, and organisations of PLHIV. In particular Public Private Partnerships will be established. Zimbabwe will strengthen its HIV and AIDS resource tracking system, improve accountability at all levels, and ensure that financial management systems are transparent.

### Gaps and Challenges

- There was no resource mobilisation strategy for the outgoing ZNASP I
- The economic crisis that engulfed Zimbabwe during the life of ZNASP I resulted in a significant contraction in government revenues, the AIDS Levy and consequently GOZ funding for the national response was limited; and
- Inadequate costing of ZNASP I due to lack of clear targets to guide costing
- Lack of accountability and tracking of resources for the national response
- Most services are not integrated, and hence rationalization of financial resource and cost benefits have not been considered adequately.

### Priority strategies

- Strengthening strategies to mobilise and increase domestic funding from government and private sector in particular. This may entail consideration for incentives including tax exemptions of funds used to support HIV and AIDS related work
- Strengthening and scaling up strategies that show greater efficiency in services delivery.
- Strengthen strategies for the collection and management of the HIV and AIDS levy tax
- Strengthening public-private partnerships.
- Strengthening Health Systems to allow integration of services including HIV and AIDS
- Development of and operationalization of a resource mobilization strategy
- Increased resource mobilize funding for the ZNASP II
- Strengthening the capacity for resource mobilisation.
- Establishment of an effective accountability and oversight system for HIV funding

**Table 29:** Sustainable financing and resource mobilisation outcome results

OC-24	100% of financial resource needs (as costed in the ZNASP) for the national response are mobilised and efficiently utilised by 2013 and maintained above that level by 2015
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## Annex 1: Outcome results and indicator index with values

Code	Outcome results	Indicator	Baseline		Target	
			Value	Data source	2013	2015
	<b>Prevention of new HIV infections</b>					
	<b>Social and behaviour change communication</b>					
OC-1	Men and women aged 15 and above whose personal HIV risk perception improved by 50% by 2013 and 80% by 2015	% of key affected populations reached with HIV services	Special studies	Special studies	50%	80%
		Percentage women and men aged 15 – 49 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	W = 44.2% M = 47.2%	ZDHS 2005/6)	W = 66.3% M = 70.8%	W = 80% M = 85%
OC-2:	Men and women 15-49 years who had 2 or more sexual partners in the last 12 months reduced from 14.1% for men and 1.3% for women in 2006 to 10.9% for men and 1.0% for women by 2013 to 9.9% for men and 1.0% for women by 2015	% of women and men 15-49 who have had sexual intercourse with more than one partner in the last 12 months <i>(disaggregated by age 15-24, and 25-49)</i>	F = 1.3% M = 14.1%	ZDHS 2005/6)	F = 1.0% M = 10.9%	F = 1.0% M = 9.9 %
	<b>Condoms – correct and consistent use</b>					
OC-3	Female and Male aged 15–49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse increased from 50% in 2010, to 70% in 2013 and 80% by 2015	% of young women and men 15-24 using a condom in the last sex with a non regular partner	50%	ZDHS 2005/6)	70%	80%
OC-4	Women and men in sero-discordant relationships who reported using condoms consistently in the last sexual intercourse increased to 50% by 2013 and to 80% by 2015.	% of women and men in sero-discordant relationships reporting consistent condom use	Special studies	Special Studies	50%	80%
	<b>Safe and voluntary Male circumcision</b>					
OC-5	Men aged 15-49 who reported being circumcised increased from 11% in 2006 to 50% by 2013, and to 80% by 2015.	% of men 15-29 years circumcised	10%	ZDHS 2005/06	50%	80%
	<b>Prevention of Mother to Child Transmission of HIV (PMTCT)</b>					
OC-6	Infants born to HIV positive mothers who are infected reduced from 14% in 2010 to 7% in 2013 and to less than 5% by 2015	% of Infants born to HIV-infected mothers who are HIV positive	14%	PMTCT Annual Report (2010)	7%	Less than 5%
		% of infants born of HIV positive women receiving ART prophylaxis to prevent	74%	PMTCT annual report 2015	95%	100%

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Code	Outcome results	Indicator	Baseline		Target	
			Value	Data source	2013	2015
		infection				
		% of pregnant women attending ANC tested for HIV and received results.	82%	PMTCT annual report 2010	95%	97%
		Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission	84%	PMTCT annual report, 2010	95%	95%
	<b>HIV Testing and Counselling (HTC)</b>					
OC-7	Women and men aged 15-49 who received an HIV test in the last 12 months and know their results increased from 6.6% for women and 6.7% for men in 2006 to 50% in 2013 and 85% for both by 2015	% of women and men 15-49 who were tested for HIV in the past 12 months and received their results	Women: 6.6 % Men: 6.7 %	DHS 2005/6)	W = 20% M = 20%	W = 35% M = 35%
	<b>Prevention and control of sexually transmitted infections (STI)</b>					
OC-8	Female and Male who reported having STI in the past 12 months reduced from 204,819 in 2010 by 20% (163,855 of 204 819) in 2013 and by 50% (81,928 of 163,855) in 2015	% of adults 15-49 that had STI in the last 12 months <i>(disaggregated by age and gender)</i>	F = 4% M = 3%	ZDHS 2005/6	F = 3.9% M = 2.9%	F = 3.8% M = 2.8%
	<b>Bloods safety</b>					
OC-9	100% of donated blood screened in a quality assured manner for HIV according to national guidelines and maintained at that level by 2015	% of donated blood units screened for HIV	100%	NBTS annual programme data	100%	100%
	<b>Post Exposure Prophylaxis (PEP)</b>					
OC-10	100% of people in need of PEP in the last 12 months received PEP services as per national guidelines and maintained at that level by 2015. <i>(Disaggregated by exposure: occupational, rape/sexual abuse, other non-occupational)</i>	% of people exposed receiving post-exposure prophylaxis (PEP) <i>By exposure type: Occupational, Rape/Sexual Assault Victims, or Other Non-Occupational</i>	Occupational = 41%	MOHCW report 2009	100%	100%
			Non-occupational = X	MOHCW	100%	100%
	<b>Treatment care and support</b>					
	<b>Antiretroviral Therapy (ART)</b>					
OC-11	PLHIV (adults and children) with HIV still alive at 12 months after the initiation of ART increased from 86.35% in 2009 to 89% by 2013, and by 90% by 2015	% of HIV infected children and adults known to be on treatment 12 months after initiation of ARVs	86.35%	M&E reports 2010	89%	90%

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Code	Outcome results	Indicator	Baseline		Target	
			Value	Data source	2013	2015
OC-12	PLHIV who are eligible and are receiving ART increased from 59% for adults and 31.5% for children in 2010 to 81% for adults and 63% for children in 2013 and by 85% for both by 2015	# / % of Adults living with HIV on who are ART	59% (298,092)	M &E reports, 2010	81%	85%
		# / % of children living with HIV who are on ART	31.5% (28,149)	M &E reports, 2010	63%	85%
OC-13	TB deaths in PLHIV reduced by 30% in 2013 and by 50% by 2015	% of TB deaths among PLHIV reduced	TBD		30%	50%
<b>Nutrition</b>						
OC-14	Adults and children PLHIV who are malnourished reduced from 41,742 in 2010, by 25% (31,307) in 2013 and 50% (20,871) by 2015	% of malnourished adults LHIV	20%	MoHCW / MSF, 2011	15%	10%
		% of malnourished children LHIV	60%	MoHCW CMAM routine data, 2010	40%	20%
<b>Community Home Based Care (CHBC)</b>						
OC-15	PLHIV receiving CHBC services increased from 48% in 2010 to 72% in 2013 and 85% by 2015	Percentage of clients accessing minimum standard CHBC services	48% (112,244)	GF R5 Evaluation (2010)	72% (139,060)	85% (207,651)
<b>Orphans and Vulnerable Children (OVC)</b>						
OC-16	OVC receiving minimum package of services is increased from 20.9% in 2009 to 60% (800,000) by 2013 and to 80% (1,360,000) by 2015.	% of OVC receiving minimum package of service	20.9% (334,400)	MIMS (2009)	60% (535,040)	80% (601,920)
OC-17	The rating for OVC policy and planning efforts index rating is improved to 5 by 2013 and maintained above that level by 2015.	OPPEI		OPPEI	5	>5
<b>Coordination &amp; Management and Systems Strengthening</b>						
<b>Enabling policy and legal environment</b>						
OC-18	The national composite policy index improved from 6.2 in 2010 to 9.0 by 2013 and maintained at that level by 2015.	NCPI	6.2	NCPI	9.0	>9.0
OC-19	Women and men aged 15 – 49 expressing accepting attitudes towards people living with HIV increased from 17% for women and 11% for men in 2010, to 35% for women and 30% for men by 2013 to 75% for women and 60% for men by 2015	% of men and women aged 15 – 49 expressing accepting attitude towards PLHIV	W = 17% M = 11%	ZDHS 2005/6	W = 47% M = 35%	W = 75% M = 60%

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<b>Coordination and management</b>						
<b>OC-20</b>	The NCPI rating on efficiency and effectiveness of national response coordination improved from 6.2 in 2010 to 9.0 by 2013 and maintained at that level by 2015	% of sectors <sup>31</sup> that are implementing response harmonised and aligned their HIV responses with the national response	60% <sup>32</sup>	NAC 2010	100%	100%
<b>HIV, gender and Human rights mainstreaming</b>						
<b>OC-21</b>	100% of prioritised (13) public sector (ministries) and 50% of key private sector companies have mainstreamed HIV, relevant HIV gender and human rights dimensions in their development work by 2013 and maintained above that level by 2015	% of public and private sector institutions that have reviewed their policies to mainstream HIV,	Public = 62% (8/13) Private = (TBD)		Public = 100% Private = 20%	Public = 100% Private = 50%
		# of sectors with functional HIV and AIDS workplace programmes	212	Workplace baseline survey 2009	400	700
<b>Health and community systems strengthening</b>						
<b>OC-22</b>	The NCPI rating on efficiency and effectiveness of health and community systems improved to 5 by 2013 and to 8 by 2015	NCPI	NCPI rating	NCPI	5	8
<b>Strategic information management</b>						
<b>OC-23</b>	Evidence based decision making, planning, implementation and management of the national response	% decision makers, planners and managers accessing and using M&E strategic information	TBD	M&E reports	50%	100%
		% of operational research report disseminated	TBD	M&E reports	50%	100%
		100% of the indicator values (baselines and targets) provided	TBD	M&E reports	100%	100%
<b>Sustainable financing and resource mobilisation</b>						
<b>OC-24</b>	100% of financial resource needs (as costed in the ZNASP) for the national response are mobilised and efficiently utilised by 2013 and maintained above that level by 2015	% of ZNASP financial resources mobilized	58%	ZNASP I MTR 2009	80%	100%
		% increase in domestic funding for HIV and AIDS	20%	NASA 2010/11 (check info)	45%	75%
		Domestic and international AIDS spending by categories and financing sources	TBD	NASA 2010/11 (check info)	TBD	TBD

<sup>31</sup> Sectors means – public, private, civil society, PLHIV and MOHCW

<sup>32</sup> By 2010, MOHCW, Public sector, and PLHIV had harmonized their responses with the national response



Annex 2: ZNASP Results framework

Code	Impact Results	Code	Outcome results	Code	Output results <sup>33</sup>
<b>Prevention of new HIV infections</b>					
<b>Social and behaviour change</b>					
Impact -1	HIV incidence reduced by 50% from 0.85% (48, 168) in 2009 to 0.435% (24,084) by 2015	OC-1	Men and women aged 15 and above whose personal HIV risk perception improved by 50% by 2013 and 80% by 2015	OP1	Increased availability of evidence- informed social behaviour change communication reaching at least 80 % of the population
				OP2	Output: Increased coverage of high-quality life skills HIV and AIDS education for in and out of school youths
				OP3	Increased availability of HIV prevention services among key affected populations
				OP4	Increased availability of HIV prevention services among key affected populations
Impact -1	HIV incidence reduced by 50% from 0.85% (48, 168) in 2009 to 0.435% (24,084) by 2015	OC-2:	Men and women 15-49 years who had 2 or more sexual partners in the last 12 months reduced from 14.1% for men and 1.3% for women in 2006 to 10.9% for men and 1.0% for women by 2013 to 9.9% for men and 1.0% for women by 2015	OP5	Men and women reached with SBCC interventions
<b>Condoms – correct and consistent use</b>					
Impact -1	HIV incidence reduced by 50% from 0.85% (48, 168) in 2009 to 0.435% (24,084) by 2015	OC-3	Female and Male aged 15–49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse increased from 50% in 2010, to 70% in 2013 and 80% by 2015	OP6	Condoms distributed annually increased from 78 million in 2010 to 95 million by 2015
				OP7	Increased knowledge on the use of male and female condoms for young men and women 15-24 years
				OP8	Knowledge on the importance of using condoms in sero-discordant relationships increased
Impact -1	HIV incidence reduced by 50% from 0.85% (48, 168) in 2009 to 0.435% (24,084) by 2015	OC-4	Women and men in sero-discordant relationships who reported using condoms consistently in the last sexual intercourse increased to 50% by 2013 and to 80% by 2015.	x	See OP 6, 7 and 8 above
<b>Safe and voluntary Male circumcision</b>					
Impact -1	HIV incidence reduced by 50% from 0.85% (48, 168) in 2009 to 0.435% (24,084) by 2015	OC-5	Men aged 15-49 who reported being circumcised increased from 11% in 2006 to 50% by 2013, and to 80% by 2015.	OP9	Increased awareness of male circumcision as an HIV prevention strategy among women and men
				OP10	Increased demand of MC in men aged 15-29 by 80 %

<sup>33</sup> The output results are sourced out of the M&E plan and the costing plan

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	168) in 2009 to 0.435% (24,084) by 2015				
			<b>Prevention of Mother to Child Transmission of HIV (PMTCT)</b>		
Impact -1(b)	HIV incidence in children reduced by 50% from 14,152 in 2009 to 7,076 by 2015	<b>OC-6</b>	Infants born to HIV positive mothers who are infected reduced from 30% in 2010 to 10% in 2013 and to less than 5% by 2015	<b>OP11</b>	Pregnant women attending ANC increased from 270, 527 to 552,788 by 2015
				<b>OP12</b>	Increase pregnant women attending ANC counselled and tested for HIV annually from 233,568 to 525,249
				<b>OP13</b>	Increase pregnant women who are HIV positive receiving ARV prophylaxis from 29,692 to 40,508
				<b>OP14</b>	Increase HIV exposed infants receiving ARV prophylaxis from 23,042 to 40,507 by 2015
				<b>OP15</b>	Increase pregnant women whose male partner was tested for HIV in the last 12 months at the ANC from 8% in 2010 to 30% in 2015
			<b>HIV Testing and Counselling (HTC)</b>		
Impact -1	HIV incidence reduced by 50% from 0.85% (48, 168) in 2009 to 0.435% (24,084) by 2015	<b>OC-7</b>	Women and men aged 15-49 who received an HIV test in the last 12 months and know their results increased from 6.6% for women and 6.7% for men in 2006 to 50% in 2013 and 85% for both by 2015	<b>OP16</b>	HIV counselling and testing functioning sites increased from 1218 to 1578 by 2015
				<b>OP17</b>	Men and women tested for HIV increased from 1,600,000 to 2,141,161 by 2015 annually
				<b>OP18</b>	HIV counselling and testing service delivery system strengthened in all sites
			<b>Prevention and control of sexually transmitted Infections (STI)</b>		
Impact -1	HIV incidence reduced by 50% from 0.85% (48, 168) in 2009 to 0.435% (24,084) by 2015	<b>OC-8</b>	Female and Male who reported having STI in the past 12 months reduced from 204,819 in 2010 by 20% (163,855 of 204 819) in 2013 and by 50% (81,928 of 163,855) in 2015	<b>OP19</b>	Women and men treated for STI increased from 204,819 to 290,000 by 2015
			<b>Bloods safety</b>		
Impact -1	HIV incidence reduced by 50% from 0.85% (48, 168) in 2009 to 0.435% (24,084) by 2015	<b>OC-9</b>	100% of donated blood screened in a quality assured manner for HIV according to national guidelines and maintained at that level by 2015	<b>OP20</b>	100% of blood units screened for HIV
			<b>Post Exposure Prophylaxis (PEP)</b>		
Impact -1	HIV incidence reduced by 50% from 0.85% (48,	<b>OC-10</b>	100% of people in need of PEP in the last 12 months received PEP services as per national guidelines and	<b>OP21</b>	Health facilities providing post exposure prophylaxis (PEP) increased from 7.8% (122) to 100% (1560) by 2015

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	168) in 2009 to 0.435% (24,084) by 2015		maintained at that level by 2015. <i>(Disaggregated by exposure: occupational, rape/sexual abuse, other non-occupational)</i>		
<b>Treatment care and support</b>					
<b>Antiretroviral Therapy (ART)</b>					
<b>Impact -2</b>	HIV and AIDS related mortality for adults reduced by 38% from 71299 (2010) to 44,205 by 2015	<b>OC-11</b>	PLHIV with HIV still alive at 12 months after the initiation of ART increased from 86.35% in 2010 to 89% by 2013 and 90% by 2015	<b>OP22</b>	Increase PLHIV on care from 500 000 in 2010 to 800 000 by 2015
<b>Impact -2</b>	HIV and AIDS related mortality for adults reduced by 38% from 71299 (2010) to 44,205 by 2015			<b>OP23</b>	Capacity of laboratories to provide ART related services strengthened
<b>Impact -2</b>	HIV and AIDS related mortality for adults reduced by 38% from 71299 (2010) to 44,205 by 2015	<b>OC-12</b>	PLHIV who are eligible and are receiving ART increased from 59% for adults and 31.5% for children in 2010 to 81% for adults and 63% for children in 2013 and by 85% for both by 2015	<b>OP24</b>	PLHIV on ART increased from 326 241 in 2010 to 539 916 by 2015
				<b>OP25</b>	Increase sites offering ART Services from 530 in 2010 to 1560 by 2015.
				<b>OP26</b>	Procurement and supply of ARVs, OI drugs and commodities improved
				<b>OP27</b>	Pharmacovigilance system for ART Programme strengthened
<b>Impact -2</b>	HIV and AIDS related mortality for adults reduced by 38% from 71299 (2010) to 44,205 by 2015	<b>OC-13</b>	TB deaths in PLHIV reduced by 30% in 2013 and by 50% by 2015	<b>OP28</b>	TB patients tested for HIV increased by 50% by 2014 and by 85% by 2016/17
<b>Nutrition</b>					
<b>Impact -2</b>	HIV and AIDS related mortality for adults reduced by 38% from 71299 (2010) to 44,205 by 2015	<b>OC-14</b>	Adults and children PLHIV who are malnourished reduced from 41,742 in 2010, by 25% (31,307) in 2013 and 50% (20,871) by 2015	<b>OP29</b>	Increase eligible malnourished PLHIV (adults and children) receiving therapeutic or supplementary food from xx to yy by 2015
<b>Community Home Based Care (CHBC)</b>					
<b>Impact -2</b>	HIV and AIDS related mortality for adults reduced by 38% from 71299 (2010) to 44,205 by 2015	<b>OC-15</b>	PLHIV receiving CHBC services increased from 48% in 2010 to 60% in 2013 and 85% by 2015	<b>OP30</b>	Increase PLHIV receiving C&HBC services increased from 112,244 in 2010 to 269,958 in 2015

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<b>Orphans and Vulnerable Children (OVC)</b>					
<b>Impact -2</b>	HIV and AIDS related mortality for adults reduced by 38% from 71299 (2010) to 44,205 by 2015	<b>OC-16</b>	OVC receiving minimum package of services is increased from 44% (410,000) in 2009 to 50% (800,000) by 2013 and to 80% (1,360,000) by 2015.	<b>OP31</b>	OVCs receiving minimum package of services increased from 410,000 in 2009 to 1,400,000 by 2015
<b>Impact -2</b>	HIV and AIDS related mortality for adults reduced by 38% from 71299 (2010) to 44,205 by 2015	<b>OC-17</b>	The rating for OVC policy and planning efforts index rating is improved to 5 and above by 2013, and 8 by 2015.	<b>OP32</b>	OVC Strategic plan implemented by 2015
<b>Coordination &amp; Management and Systems Strengthening</b>					
<b>Enabling policy and legal environment</b>					
<b>Outcome 3</b>	A social, policy and legal enabling environment is created	<b>OC-18</b>	The national composite policy index improved from 6.2 in 2010 to 9.0 by 2013 and maintained at that level by 2015.	<b>OP33</b>	Enabling policy, legal, regulatory and social environment for national HIV responses created and strengthened
				<b>OP34</b>	% of PLHIV meaningfully involved PLHIV in HIV coordination structures as decision makers increased from 10% to 25% by 2015
				<b>OP35</b>	PLHIV meaningfully involved in programme activities increased from 5% to 25% by 2015
<b>Outcome 3</b>	A social, policy and legal enabling environment is created	<b>OC-19</b>	Women and men aged 15 – 49 expressing accepting attitudes towards people living with HIV increased from 17% for women and 11% for men in 2010, to 35% for women and 30% for men by 2013 to 75% for women and 60% for men by 2015	<b>OP36</b>	Districts reached with anti-stigma and discrimination awareness campaigns
				<b>OP37</b>	Members of civil society networks and associations trained in advocacy by 2013
<b>Coordination and management</b>					
<b>Outcome 4</b>	National HIV and AID response is effectively coordinated and efficiently management	<b>OC-20</b>	The NCPI rating on efficiency and effectiveness of national response coordination improved from 6.2 in 2010 to 9.0 by 2013 and maintained at that level by 2015	<b>OP38</b>	Implementing partners trained in efficiency and effectiveness strategies for the implementation of the national response
<b>HIV, gender and Human rights mainstreaming</b>					
<b>Outcome 4</b>	National HIV and AID response is effectively coordinated and efficiently management	<b>OC-21</b>	100% of prioritised public sectors (ministries) and 50% of key private sector companies have mainstreamed HIV, relevant HIV gender and human rights dimensions in their development work by 2013 and maintained above that level by 2015	<b>OP39</b>	Capacity of organizations and institutions mainstreaming gender increased

<b>Health and community systems strengthening</b>					
<b>Outcome 4</b>	National HIV and AID response is effectively coordinated and efficiently management	<b>OC-22</b>	The NCPI rating on efficiency and effectiveness of health and community systems improved to 5 by 2013 and to 8 by 2015	<b>OP40</b>	Health and community systems strengthened (see respective building blocks)
<b>Strategic Information management</b>					
<b>Outcome 4</b>	National HIV and AID response is effectively coordinated and efficiently management	<b>OC-23</b>	National M&E systems provide 100% of the indicator values (baselines and targets) by 2013 and maintained by 2015	<b>OP41</b>	HIV and AIDS implementers registered with National AIDS Reporting system
				<b>OP42</b>	Human resources capacity for M&E at NAC and AIDS and TB Units strengthened
				<b>OP43</b>	M&E system established and functioning
<b>Sustainable financing and resource mobilisation</b>					
<b>Outcome 4</b>	National HIV and AID response is effectively coordinated and efficiently management	<b>OC-24</b>	100% of financial resource needs (as costed in the ZNASP) for the national response are mobilised and efficiently utilised by 2013 and maintained above that level by 2015	<b>OP44</b>	Resource mobilisation strategy for ZNASP in place by December 2011