ZIMBABWE

ZIMBABWE NATIONAL

HIV AND AIDS

STRATEGIC PLAN

[ZNASP II]

2011-2015

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

Revitalizing our commitment to:

Zero new HIV infections,

Zero stigma and discrimination,

Zero AIDS-related deaths.

OCTOBER, 2011

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
ATP	Ministry of Health and Child Welfare 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
CSW	Commercial Sex Worker
DAAC	District AIDS Action Committee
DAC	District AIDS Coordinator
DVA	Domestic Violence Act
EDLIZ	Essential Drug List of Zimbabwe
EDR-TB	Extreme Drug Resistant Tuberculosis
EID	Early Infant Diagnosis
EPP	Estimation and Projection Package
ESP	Expanded Support Programme
FBO	Faith Based Organisation
FP	Family Planning
GFTAM	Global Fund for AIDS, Tuberculosis and Malaria
GoZ	Government of Zimbabwe
GUD	Genital Ulcer Disease
HMIS	Health Management Information Systems
HIV	Human Immunodeficiency Virus
HIVDR	HIV Drug Resistance
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
IMPAC	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

MDGs	Millennium Development Goals
MDR-TB	Multi-Drug Resistance Tuberculosis
MCP	Multiple Concurrent Partners
MER	More Efficacious Regimens
MIPA	Meaningful Involvement of People Living with HIV
MoHCW	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
NAP	National Action Plan
NAFT	National AIDS Trust Fund
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
PPP	Public-Private- Partnership
PPT	Periodic Presumptive Treatment
PSI	Population Services International
PwP	Prevention with Positives
RUTF	Ready to use Therapeutic Foods
SBCC	Social and Behaviour Change Communication
SCMLT	State Certified Medical Laboratory Technician
SDPs	Service Delivery Points
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
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
VIDCO	Village Development Committee
VCT	Voluntary Counselling and Testing
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 the first in our region to have recorded a decline in HIV prevalence from 20.1% (2005) to 14.26% in 2009. My government, through the National AIDS Council (NAC) with the support of local and international organizations, is providing effective leadership and responsive stewardship for the national HIV and AIDS response despite significant funding, human resource, and material challenges. Our decentralized NAC structures provide a foundation upon which as a country we can build. Our vigorous national behaviour change campaign and the employment of several prevention strategies must be hailed. However, let me hasten to say, at 14.26%, our HIV prevalence is still unacceptably very high and therefore we need to augment our efforts to reduce it further to single digits by 2015.

The Zimbabwe National HIV and AIDS Strategic Framework implemented between 2006-2010 has guided us in the implementation of HIV and AIDS programmes over the past years. A review of this framework has shown that there are new emerging issues, which need to be taken on board in the fight against HIV and AIDS. Our commitments to international and regional goals such as The Millennium Development Goals of 2000, the UNGASS declaration, the Brazzaville Declaration and the Maputo Plan of Action, all of 2006, call upon us to put in place measures to ensure that we attain the MDGs by 2015 in a sustainable manner. As we endeavour to achieve Universal Access to HIV prevention, treatment and care, we must ensure availability, accessibility and affordability of HIV and AIDS services to the majority of our people through strengthening of both health and community systems.

As we embark on another journey of five years, guided by the Zimbabwe National HIV and AIDS Strategic Plan II 2011-2015, it is necessary to focus on specific measurable and achievable set targets in line with regional and international principles that we ascribe to. The new framework calls for concerted efforts and commitment at both 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 to fighting HIV and AIDS, which we are continuing to focus on under ZNASP II ensuring that all sectors play a synergistic role to prevent new HIV infections and to mitigate the impact of the pandemic. 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, under the 'Three Ones' principle (one multi-sectoral HIV and AIDS

Action Framework, one Coordinating Authority, and one Monitoring and Evaluation system) to achieve the set targets.

Let me recognize the contribution of International Partners, Non Governmental Organisations, Faith Based Organisations, Community Based Organisations, Traditional Leaders and the community in the fight against HIV and AIDS over the past decades. It is my sincere hope that the spirit of cooperation, the spirit of oneness that exists, will see us through as we implement this plan, so that by 2015 Zimbabwe will have further successes to reflect upon. In line with the theme of the ZNASP II, let us turn our commitments into action and ensure that we achieve 'Zero new HIV infections; Zero stigma and discrimination; and Zero AIDS-related deaths'.

R. G. MUGABE

PRESIDENT OF THE REPUBLIC OF ZIMBABWE

ACKNOWLEDGEMENTS

The Government of Zimbabwe through the National AIDS Council (NAC) wishes to thank all who contributed to the development of this new Zimbabwe National AIDS Strategic Plan 2010-2015 (ZNASP II). In particular, our profound gratitude is extended to the oversight committee which included representatives from the NAC (Dr. Tapuwa Magure, Raymond Yekeye, Amon Mpofu, and Albert Manenji), the Ministry of Health and Child Welfare AIDS and TB Unit (Dr. Owen Mugurungi), UNAIDS Country Office (Tatiana Shoulmina and Masauso Nzima), the Zimbabwe AIDS Network (Lindiwe Chaza-Jangira) and the Zimbabwe Network of People Living with HIV (Tabona Shoko) for their stewardship in the development of this strategy.

Special recognition to Dr. Richard Matikanya and Prof. Simbarashe Rusakaniko for their leadership in the development of this strategy. The core strategy development writing team comprised of Dr. Rosemary Mhlanga-Gunda, Dr. Gilbert Mawera, Dr. Tungamirirai Simbini and Dr. Fabian Taziwa.

The core writing team was ably assisted by thematic group strategy development committee members who are too many to acknowledge individually here but without whose technical inputs there would be no strategy. The development of this strategy was informed extensively by findings and analysis from the KYE/KYR Synthesis report.

We are extremely grateful to UNAIDS-RST, World Bank (ASAP) Patrick Osewe and Tom Mongeni, UNAIDS Zimbabwe office, World Health Organisation, and the NAC for funding and technical support provided which enabled the country to develop this strategy.

Last but not least, we would like to acknowledge Dr. Nyasha Madzingira for technical and copy editing of this document before its finalisation.

EXECUTIVE SUMMARY

The Zimbabwe National AIDS strategic Plan (ZNASPII) responds to the challenges of the HIV epidemic from 2011 to 2015. It builds on the achievements and lessons learnt from the implementation of the Zimbabwe National HIV Strategic Plan 2006-2010 and aims to align to the Millennium Development Goals (MDGs). The strategy identifies a set of strategic priorities and action tied to measurable results and provides a clear direction for moving forward. The ZNASP II will guide the national response in the next five years and will provide the guiding framework for decision making and resource mobilisation.

The strategy development process, which was led by the secretariat of the National AIDS Council (NAC), was designed to ensure broad participation in both the interpretation of the various available analyses, and the development of priorities and strategic actions for the new plan. This was done through thorough desk reviews; stakeholder consultations; on-going draft review and validation; and local, regional and international peer draft reviews.

With an estimated HIV prevalence of 14.26% among the adult population (2009), Zimbabwe is among several countries in southern Africa experiencing a mature HIV epidemic with a consistently documented decline in prevalence over the last decade (partially attributed to successful implementation of prevention strategies). It is estimated that between 1998 and 2010, adult HIV prevalence has declined from 27.2% to 14.3% (HIV estimates, June 2009). Heterosexual contact remains the main mode of transmission in all areas of 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.

A comprehensive review of the evidence attributed the decline in HIV incidence to high mortality as well as fundamental changes in behaviour suggesting that efforts to implement Zimbabwe's national behaviour change programme (NBCP) may have begun to pay off. Between 2008 and 2010, significant strides were made in preventing mother-to-child transmission of HIV. Male Circumcision (MC) was adopted as one of the prevention strategies and by end of September 2010, 11,102 men had been clinically circumcised. Under ZNASP 2006-2010, male condom distribution increased significantly between 2006 and 2008 and declined in 2009. The increase was attributed to the strong condom social marketing initiatives and distribution infrastructure from national to village level, whereas the decline may be due to further contraction of the retail and wholesale sector during the economic crisis. Major success has been achieved in female condom distribution which is now reported to be the highest in the world.

The annual total number of STIs treated has declined and is attributed to reductions in sexual risk behaviour, concerted STI programming efforts centred on strengthening and scaling up of STI prevention activities, improvements in STI treatment strategies and training of staff in

syndromic management of STIs, and the strategic deployment of such staff in health centres. The percentage of people ever tested for HIV increased from 36% at baseline to 50% with a noticeable increase in couple counselling and testing of TB clients.

The goal of Zimbabwe's ART programme is to reduce mortality and morbidity due to HIV and AIDS and to improve the quality of life of PLHIV. Coverage is at 54% based on the revised 2009 WHO guidelines against a target of 80% by the end of 2010. Key progress in diagnostic services includes the procurement, distribution and utilization of 71 CD4 count, 69 haematology and 45 biochemistry machines in the public health facilities. Mitigation and support activities include CHBC which has since evolved from focusing on palliative care to include psychosocial, spiritual as well as support to clients on ART; care and support for Orphans and Other Vulnerable Children (OVC); and therapeutic and supplementary feeding of children and adults living with HIV who are suffering from severe and moderate acute malnutrition respectively.

In line with the 'Three Ones' principle, Zimbabwe has already established the necessary coordination structures and systems for an effective response. NAC is responsible for coordinating the response with particular focus on national policy development, partnerships, resource mobilization, monitoring, evaluation and administration of the National AIDS Trust Fund (NATF). Health sector coordination is facilitated by the AIDS and TB Unit within the Ministry of Health and Child Welfare (MoHCW). A number of sub- sector coordinating agencies exist that undertake coordination functions without a specific national mandate. Thematic multi-agency Technical Working Groups (TWG) provide technical guidance and coordination in a number of intervention areas.

Despite these achievements, a number of gaps have been identified (as detailed in the strategy gap analysis) that include stigma and discrimination; poor and low quality of life skills education; low coverage of workplace based HIV and AIDS education interventions; suboptimal coverage of PMTCT prophylaxis among HIV positive pregnant women; unacceptably low coverage of virologic testing for exposed infants; low community awareness and education targeting both men, women, boys and girls on male circumcision; limited approaches for promoting condom use in PLHIV especially in the context of sero-discordance; myths, misconceptions and negative perception by many of the public sector distributed condoms; drug stock outs; inadequate human resources for health; weak laboratory services for adults and children for both pre ART and ART; weak referral system of the CHBC and HTC, ART, PMTCT, STI and TB interventions; lack of a conducive and enabling environment for promoting MIPA; limited financial resources; weak national M & E system; and weak health and community systems.

Based on the epidemic analysis, Zimbabwe's response will prioritize prevention of sexual transmission of HIV and prevention of mother-to-child transmission. ZNASP II prioritizes these populations for HIV prevention interventions to reduce new HIV infections and also for treatment and care and support services for those already infected by HIV. Measures to ensure infection control, blood safety and post-exposure prophylaxis will continue to be implemented as high priority interventions.

The ZNASP II operates under eight guiding principles namely: equitable access; evidence based planning; integrated service delivery; meaningful involvement of people living with HIV (MIPA) and other vulnerable and affected populations; building on good practices from Zimbabwe and other countries; the "Three Ones" Principle; gender sensitivity and national responsiveness to HIV and AIDS; and creation of an enabling environment.

This strategy identifies the impact, outcome and output level results to be achieved over the next five years. The impact results are outlined as:

Impact result 1: Reduction of incidence of HIV by 50% by 2015
Impact result 2: HIV and AIDS related morbidity and mortality reduced
Impact result 3: An enabling environment is created to reduce social impact of HIV on people affected and infected
Impact result 4: Effective management and coordination of the national HIV and AIDS response informed by a functional M & E system

The outcome, outputs and strategies to achieve the set targets are discussed under prevention of new infections; treatment, care and support; enabling environment; coordination, monitoring and evaluation; health systems strengthening; community systems strengthening; public sector response; policy and advocacy for ZNASP; and resource mobilisation and management. The outcomes are highlighted below:

Prevention of new infections:
Outcome 1.1: Risky sexual behaviour among key targeted populations reduced
Outcome 1.2: Mother to Child Transmission of HIV reduced from 30% to 5% by 2015
Outcome 1.3: Increase the number of males age 15-29 years circumcised from 10% to 80% by 2015
Outcome 1.4: Transmission of HIV through blood products, exposure to occupational hazards and defilement reduced

Treatment, Care and Support:
Outcome 2.1: The percentage of PLHIV eligible for ART who are on ART increased from 59% among adults and 31.5% among children in 2010 to 85% for all by 2015
Outcome 2.2: Improved Survival for PLHIV on ART to 85% by 2015.
Outcome 2.3: Improved nutritional status of adults and children LHIV by 50% by 2015
Outcome 2.4: Increased number of PLHIV receiving CHBC services from 48% in 2010 to 85% by 2015
Outcome 2.5: Increase the number of OVC receiving minimum package of service from 20.9% in 2009 to 80% by 2015

Enabling Environment:
Outcome 3.1: A conducive environment for effective HIV responses created and national policy index increased from 6.2 in 2010 to 9.0 in 2015
Outcome 3.2: Women and men expressing accepting attitudes towards PLHIV increased from 17% to 75% for women and men from 11% to 60% by 2015 for men

Coordination, Monitoring and Evaluation:
Outcome 4.1: Effective strategic information available
Outcome 4.2: National response to HIV effectively coordinated and managed
Outcome 4.3: Financial gap for ZNASP reduced to less than 20%

Health Systems Strengthening:
Outcome 5.1: Strong leadership and governance structures exist at all levels of the health sector
Outcome 5.2: Adequate Human Resources for Health available and equitably deployed
Outcome 5.3: Healthcare consumers are accessing quality health services at all levels of care
Outcome 5.4: The HMIS improved
Outcome 5.5: Health commodity security is assured at all levels at all times
Outcome 5.6: Increased levels of sustainable and predictable financial resource base to ensure provision of high quality services to the population
Outcome 5.7: People are accessing the health services they want at a cost they can afford

Community Systems Strengthening:
Outcome 6.1: Key CBOs, FBOs NGOs, networks of PLHIV, community level leadership and social structures contribute to the achievement of HIV and AIDS response outcomes

Public Sector Response:
Outcome 7.1: Mainstreaming of HIV into core business of key line ministries strengthened
Outcome 7.2: HIV related institutional and infrastructural capacity of line Ministries, strengthened

Policy and Advocacy for ZNASP:
Outcome 8.1: The National HIV Response operates within enabling policy environments

Resource Mobilisation and Management:
Outcome 9.1: Resource mobilisation, tracking and use of funds for the ZNASP II improved

SECTION 1: INTRODUCTION

1.1 Background

This document describes Zimbabwe's national strategy to respond to the continuing challenge of HIV and AIDS over the next five years (2011-2015). It builds on the achievements and lessons learnt from the implementation of the Zimbabwe National HIV and AIDS Strategic Plan ZNASP (2006-2010) and aims to align to the national efforts to attain the Millennium Development Goals (MDGs) by 2015. This evidence informed plan identifies a set of priorities and strategic actions tied to measurable results and provides a clear direction for moving forward. It is based on a rigorous analysis of epidemic trends, assessment of key opportunities, as well as gaps and challenges that hinder achievement of universal access.

Purpose of ZNASP

The purpose of the ZNASP II is to provide a national framework for the HIV-related interventions implemented in Zimbabwe by all stakeholders and to offer policy and strategic direction. The ZNASP II articulates the agreed targets and results for the national response over the period 2011-2015 and provides the basis for programming, resource mobilization and advocacy during this period.

1.2 Process for development of the strategic plan

A number of important analytical initiatives took place during the period 2009-2010 that helped to inform the development of this strategy including: (1)The Mid-Term Review of ZNASP I 2006-2010;(2) The 2009 ANC sentinel survey; (3)Development of Zimbabwe's 2009 UNGASS Report; (4)2009 HIV estimates based on EPP/Spectrum analysis; (5) Gap Analysis for the development of Zimbabwe's Round 10 proposal to the Global Fund; and (6)Development of Zimbabwe's HIV Epidemic, Policy and Response Synthesis report based on the Modes of Transmission (MOT) modelling and Know Your Epidemic (KYE)/Know Your Response (KYR) review.

The strategy was developed between September 2010 and May 2011. The process, which was led by the secretariat of the National AIDS Council (NAC), was designed to ensure broad participation in both the interpretation of the various analyses described above, and the development of priorities and strategic actions for the new plan. The key stages in the process were as follows:

- Desk review of existing data and analysis on Zimbabwe's HIV epidemic and the national response by the core writing team identifying achievements to date, key challenges and priority actions for the new strategic plan;

- Stakeholder consultation with participants representing The Government of Zimbabwe, development and financing partners, civil society organizations and PLHIV networks, initially to identify gaps and priority areas and define key results and strategies;

- Sensitisation and engagement of the wider public in the strategy development process through the media;
- Development of draft strategy by the lead consultant based on outputs from the strategy development workshops;

- Final stakeholder consultation to review and validate the draft strategy and provide additional input for its finalization;

- Peer review of the draft strategy by the World Bank's AIDS Strategy and Action Plan (ASAP);

An oversight committee chaired by the Chief Executive Officer of the NAC Secretariat was established to oversee the development and finalisation of this strategy and comprised members from the AIDS and TB Unit within the Ministry of Health and Child Welfare (MoHCW), The United Nations Joint Programme on HIV and AIDS (UNAIDS), development partners, civil society organizations and networks of PLHIV.

1.3 The Structure of ZNASP II

Section One: Dwells on the background to the ZNASP II, gives the main purpose for its development and the process undertaken.

Section Two: The country context is covered in section two, including the HIV epidemic analysis, projections to 2015 and the main modes of transmission. A detailed gap analysis is presented in this section for all HIV and AIDS programme components as implemented under ZNASP I 2006-2010.

Section Three: Presents ZNASP II priority areas and the guiding principles for its implementation.

Section Four: This strategy identifies the impact, outcome and output level results to be achieved over the next five years. The priority strategies to achieve the set targets are detailed in Section Four.

Section Five: This section provides the rationale for the inclusion of the health delivery system in this strategy because of the interaction between HIV and AIDS with the Health System. It discusses the Health Systems Strengthening strategy premised on 6 building blocks. The HSS outcomes from the building blocks include system responsiveness and efficiency leading to social and financial risks protection and ultimately resulting in improved HIV and health outcomes.

Section Six: A discussion on Community Systems Strengthening is covered in this section. CSS aims to create an enabling environment that is conducive to effective participation in the response at community level by community based organisations, community level leadership and community members.

Section Seven: Highlights the role of the public sector in mainstreaming HIV and AIDS in sector ministries since every ministry has a unique response to make in achieving the outcome and impact targets determined by the ZNASP II

Section Eight: The outcomes and outputs set in this strategy cannot be achieved without a supportive policy environment. This section outlines the key interventions to be implemented to strengthen the policy and advocacy environments for the national HIV response.

Section Nine: Discusses the resource mobilisation and management strategies to ensure adequate financial and technical resources for the national HIV response are availed.

Section Ten: A number of risks that may affect implementation of the strategy were identified during the development of ZNASP II . These potential risks and proposed risk mitigation strategies are listed in section five.

SECTION 2: SITUATIONAL ANALYSIS

2.1 Country Context

Zimbabwe is a land-locked country in the south-eastern part of the African continent. She is bordered by Mozambique on the east, South Africa on the south, Botswana on the west and Zambia on the north and northwest. For administrative purposes the country is divided into 10 provinces– Harare, Bulawayo, Mashonaland West, Mashonaland East, Mashonaland Central, Matabeleland North, Matabeleland South, Masvingo, Midlands and Manicaland. The provinces are further subdivided into geo-political districts which currently stand at 62, but for the purposes of operationalising NAC activities, the districts are 85. The country has approximately 400,000 square kilometres of land area and has an agro-based economy.

According to the Central Statistical Office (CSO) census report the population of Zimbabwe was estimated to be 11 631 657 in 2002 CSO [Zimbabwe] and Macro International Inc, 2007[1]. The annual population growth rate is 2.6%. The literacy level in the country is estimated at 92% for both males and females (Index Mundi 2011[2]). Life expectancy is estimated at 50 years for males and 49 years for female (CIA Fact book, 2011[3]).

From 2000 to 2009, the country went into recession and registered negative growth rates in all sector. This resulted in a humanitarian crisis, lack of investor confidence and a collapse of social services. Notwithstanding all these hardships the country went through, the prevalence of HIV continued to be on the decline. Implementing the HIV and AIDS response in this challenging environment compounded by a decline in health service delivery system and manpower coupled with inadequate financing of the national response means that this strategic plan should focus on regaining lost ground.

2.2 Zimbabwe HIV epidemic analysis

With an estimated HIV prevalence of 14.26% among the adult population (2009), Zimbabwe is among several countries in Southern Africa experiencing a mature HIV epidemic with a consistently documented decline in prevalence over the last decade (partially attributed to successful implementation of prevention strategies). The epidemic remains predominantly

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

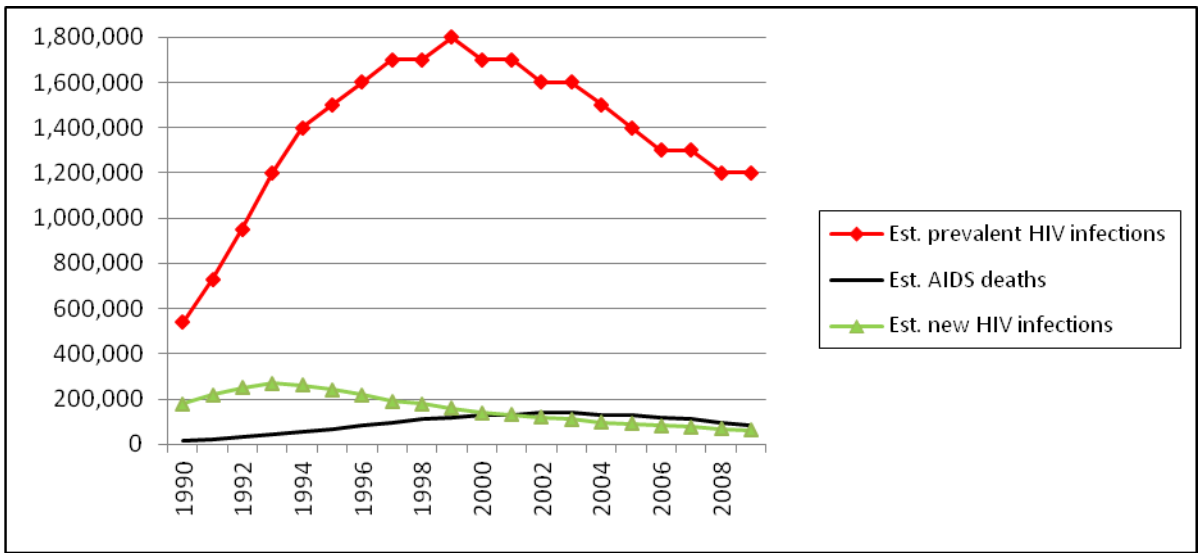
[2] Index Mundi (2011 11 July 2011) Zimbabwe life expectancy at birth http://www.indexmundi.com/zimbabwe/demographics_profile.html accessed 11July 2011

[3] CIA World Fact Book (2011 11 Jul 2011) Zimbabwe Literacy http://www.indexmundi.com/zimbabwe/literacy.html

sexually driven with the majority of new infections occurring in the 20 - 29 year age group. Over 80% of these infections are transmitted through heterosexual contact. Among the key drivers of the epidemic are low and inconsistent condom use, concurrent sexual partnerships and low male circumcision prevalence reported as 10.3% (ZDHS 2005/6). Approximately 17,000 new infections were estimated to take place in infants and young children in 2009, predominantly as a result of vertical transmission from mother-to-child, the second major transmission route in Zimbabwe.

It is estimated that between 1998 and 2010, adult HIV prevalence has declined from 27.2% to 14.26% (HIV estimates, 2009). The decline in HIV prevalence is attributed to significant changes in sexual behaviour and high mortality due to low coverage of ART provision during this time (less than 5% of PLHIV had access to ART between 1999 and 2006).

Figure 1 : Estimated prevalence and incidence of HIV and AIDS mortality in Zimbabwe (1990-2009)



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

HIV projections

The total number of people both adults and children living with HIV in Zimbabwe by 2010 was estimated at 1, 168,263 comprising about 414,338 men and 608,700 women. This figure is projected to increase to 1,187,087 by 2015. It is also estimated that about 61,461 new infections are likely to occur in 2010 with a projected increase in annual new infections to 65,215 in 2015. The estimated number of AIDS related deaths in 2010, was 71,299 with a projected decrease to about 51,808 deaths in 2015. It is also estimated that 14,152 children are likely to be infected by HIV in 2010. The number of children infected by HIV annually is expected to decrease to 11,162 by 2015. Table 1 below indicates the extent of HIV infection

and its impact on various populations and projections to 2015 based on the SPECTRUM modelling.

Table 1: 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

Main Modes of Transmission

The 2009 Modes of Transmission modelling exercise confirmed that heterosexual contact remains the main mode of transmission in all areas of Zimbabwe, but this was represented by several different situations including both casual and long term partnerships and assorted degrees of transactional sexual relationships. The contributors to new HIV infections across different adult populations are shown in Table 2 below:

Table 2: Sources of new adult infection in Zimbabwe

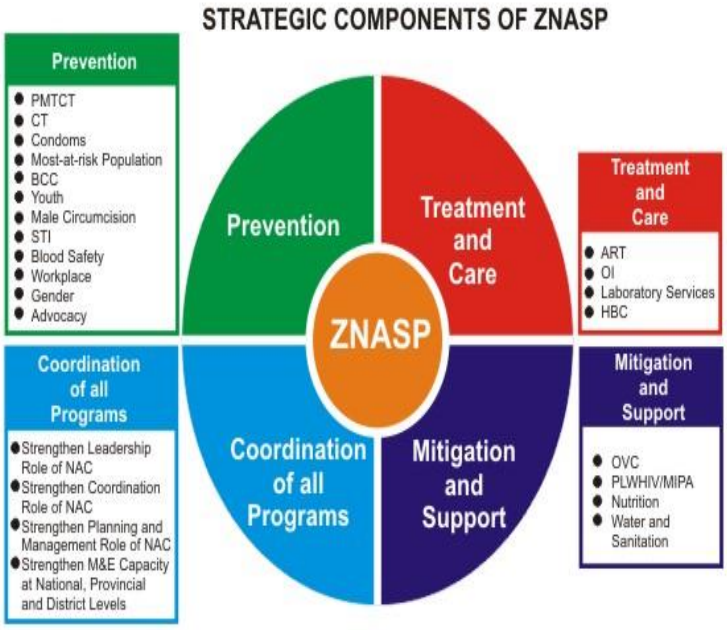
Source of Incidence	% of National Incidence
Low risk heterosexual sex (LHS)	55.88
Casual heterosexual sex (CHS)	23.92

Sex workers and their clients	14.05

Source: Zimbabwe Modes of Transmission report

2.3 Zimbabwe HIV response analysis 2006-2010

The outgoing ZNASP (2006-2010) articulated four priority areas- *prevention of new infections, treatment and care*, *mitigation and support* and *effective management and coordination of the national HIV and AIDS response as indicated in the diagram below:*



2.3.1 Prevention of New Infections

HIV incidence is the most recommended way for assessing whether or not interventions undertaken have led to a reduction in the number of new infections over the past 5 years in which the ZNASP was being implemented. As noted earlier, 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 (see Table 3).

Table 3: Trends in annual HIV incidence, 2006-2009

Year	Estimated annual incidence (%)	Range (low and high estimates %)
2006	1.14	0.86 - 1.46
2007	1.02	0.75 - 1.35
2008	0.91	0.63 - 1.24
2009	0.85	0.56 - 1.17

Source: HIV Estimates (June 2010) Zimbabwe

Social and Behaviour Change Communication (SBCC)

A comprehensive review of the evidence attributed the decline in HIV incidence to high mortality as well as fundamental changes in behaviour suggesting that efforts to implement Zimbabwe's national behaviour change programme (NBCP) which has been rolled out to all 62 districts of the country after operating in 26 districts first may have begun to pay off. An interim evaluation survey conducted in 6 districts in 2009[4] reported that: more people had comprehensive knowledge of HIV; an increase in condom use at last sex with all non-regular partners; an increase in the number of people ever tested for HIV and couples tested together; and HIV prevalence among young pregnant women in sites in SBCC focus districts declined. In addition the survey reported improvements in community norms about partner concurrency between the baseline and interim survey.

However, despite these commendable efforts, gaps do exist in the implementation of the framework, and these are highlighted below.

- Lack of overall national guidance on HIV prevention in discordant couples including on issues of reproductive choices, there is limited counselling capacity on discordance and knowledge on discordance is still low;
- No size estimation or bio-behavioural surveillance on MSM as proposed under the ZNASP has been done to date severely hampering opportunities to develop appropriate evidence based SBCC interventions for this population and other more at risk social groups;
- Poor and low quality of life skills education provided
- Insufficient coverage, intensity and duration of interventions targeting young people out of school
- Stigma and discrimination not adequately addressed in the NBCP.
- Coverage of people reached through workplace based HIV and AIDS education has declined over the period in which ZNASP has been implemented[5].

Prevention of Mother to Child Transmission (PMTCT)

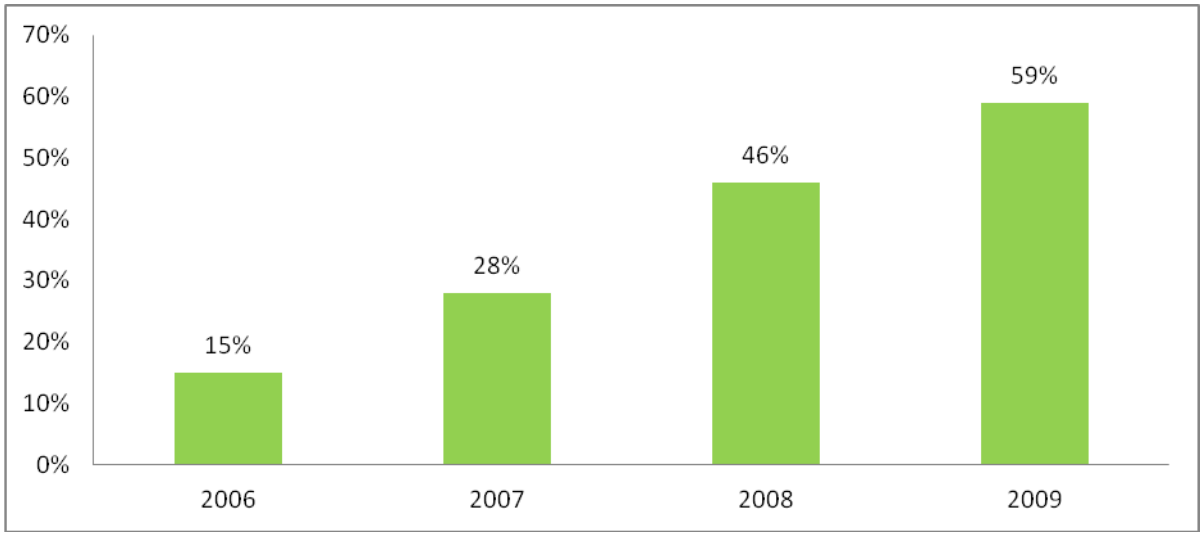
At the end of October 2010, 1, 560 facilities were providing ANC services, of which 60% were offering both on-site HIV testing and ARVs for prophylaxis while the remaining 520 offered ARVs for PMTCT but did not yet offer on-site HIV testing. In 2009, 85% of pregnant women attending ANC services were tested for HIV, compared with 78% in 2008, 77% in 2007 and 73% in 2006.

In 2009, 59% of pregnant women living with HIV received antiretroviral (ARV) drugs to prevent HIV transmission to their infants. This represents a significant increase in coverage from just 15% in 2006, 28% in 2007 and 46% in 2008 (Figure 2).

[4] UNFPA/NAC. 2009. National Behaviour Change Strategy Interim Survey

[5] Fraser et al (2010)

Figure 2: Trends in percentage of pregnant women with HIV receiving ART for preventing mother to child transmission of HIV, 2006-2009



Source: MoHCW PMTCT Program Database

The coverage of infant antiretroviral prophylaxis also increased in accordance with the increasing uptake of ART by pregnant women living with HIV. In 2008, 80% of infants born to HIV positive mothers were provided with ARV prophylaxis for PMTCT at birth, up from 65% in 2007 and 60% in 2006[6].

Key gaps

Despite the impressive achievements of the national PMTCT programme, many significant gaps still exist:

- Lack of a standardised comprehensive gender sensitive package in PMTCT services inclusive of contraception and ART for mothers taking into consideration 2009 WHO guidelines
- Suboptimal coverage of PMTCT prophylaxis among HIV positive pregnant women at 59%
- Unacceptably low coverage at 13% of virologic testing for exposed infants hence many HIV positive infants remain unidentified postnatally thereby missing out on critical interventions;
- ANC user fees at point of service have also hampered efforts to increase access to and utilization of PMTCT services as they discourage pregnant women who do not have the means to pay for services
- HIV related stigma impedes the utilization of PMTCT services in Zimbabwe[7].

[6] MOHCW data base
[7] Sibanda, I (2010) Pregnant teens shun HIV treatment for fear of stigmatization. http://ipsnews.net/news.asp?idnews=52243

Male Circumcision (MC)

Zimbabwe adopted Male Circumcision (MC) as one of the HIV prevention strategies. As a result, a national MC strategy and implementation plan were developed and disseminated. By the end of September 2010, 11,102 men had been clinically circumcised[8].

Key gaps and challenges related to scaling up male circumcision

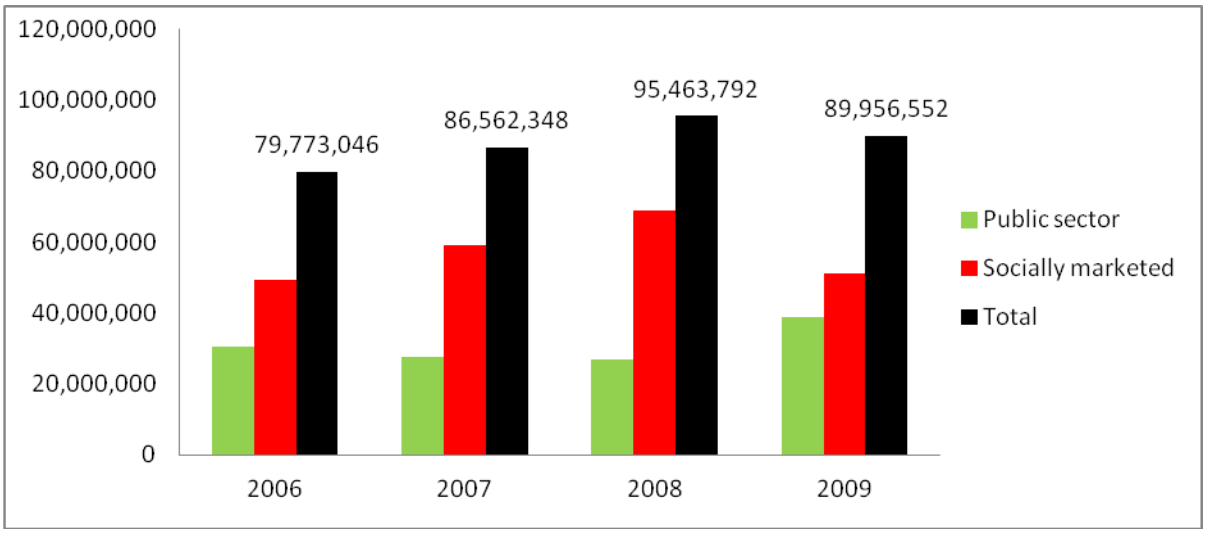
The national MC strategy has set an ambitious target as captured above which is needed to achieve population based impact in HIV incidence reduction. Key challenges and gaps identified over the past 12 months of the pilot are:

- Unavailability of affordable male circumcision services at decentralized levels
- Community awareness and education targeting both men, women, boys and girls on male circumcision as well as its benefits remain low; and
- Only doctors are allowed to undertake circumcisions. Given the shortage of doctors, it would be impossible to achieve the proposed targets with this cadre alone;

Condom Programming

The ZNASP 2006-2010 sought to make both public sector and socially marketed condoms more widely available through the annual distribution of 150 million condoms by 2010. Figure 3 below shows male condom distribution from 2006 to 2009.

Figure 3: Trends in Male Condom Distribution, 2006-2009



Source: **MOHCW AIDS and TB Unit**

[8] MOHCW data base

Male condom distribution increased significantly between 2006 and 2008 and declined in 2009. The increase was attributed to the strong condom social marketing initiatives and distribution infrastructure from national to village level, whereas the decline may be due to further contraction of the retail and wholesale sector during the economic crisis.

Major success has been achieved in female condom distribution which is now reported to be the highest in the world. The national female condom strategy had forecast female condom consumption of 14,055,004 by end of 2010. This was surpassed with distribution and consumption of 15,426,325 female condoms between 2006 and 2009. The impact of the increases in condom distribution on actual levels of condom use remains to be determined based on the 2010 ZDHS.

Key gaps and challenges relating to condom promotion and distribution

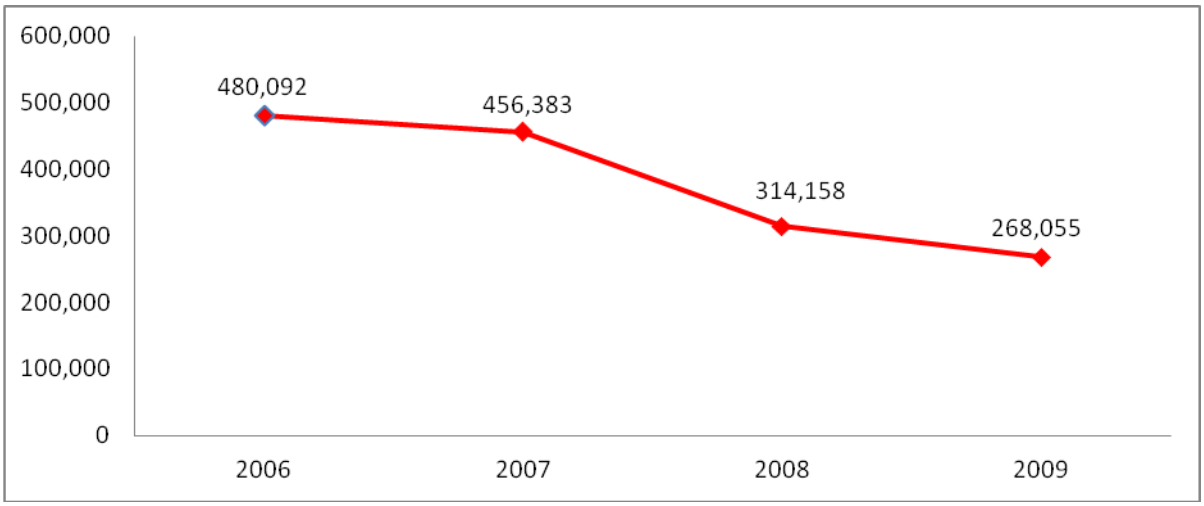
- Limited approaches for promoting condom use in PLHIV especially in the context of sero-discordance;
- Myths, misconceptions and negative perception by many of the public sector distributed condoms persist
- Inadequate understanding of condom use.

Sexually Transmitted Infections (STIs) prevention, treatment and management

Key approaches for STI prevention and management include condom distribution and promotion, as well as encouraging early treatment of STIs. STI policy and case management guidelines have been developed and disseminated throughout the country[9]. The annual total number of STIs treated has declined by approximately 55% from just over 480,000 in 2006 to 268,000 in 2009 as indicated in Figure 4.

[9] Ministry of Health and Child Welfare : The Zimbabwe Health Sector HIV Prevention Strategic Framework 2007-2010

Figure 4: Trends in cases of Sexually Transmitted Infections, 2006-2009



Source: MOHCW AIDS and TB Unit

This decline in STI cases is attributed to reductions in sexual risk behaviour, concerted STI programming efforts centred on strengthening and scaling up of STI prevention activities, improvements in STI treatment strategies and training of staff in syndromic management of STIs, and the strategic deployment of such staff in health centres.

Key gaps and challenges relating to STI prevention, treatment and management

- Frequent stock outs of key STI drugs have been noted;
- Some health workers are yet to be trained in management of STIs;
- Lack of partner contact tracing

Post-Exposure Prophylaxis (PEP)

A national PEP policy and guidelines were developed in 2007. However the uptake of PEP among health workers remain low.

Key gaps and challenges related to the provision and use of PEP

- PEP is not widely available in all health facilities;
- Limited awareness and coordination among service providers in response to survivors of sexual violence
- Cultural norms and practices that hinder women from reporting sexual violence
- Low awareness of PEP among the general population and key service providers; and
- Emphasis of PEP provision to date has been on occupationally exposed with limited coverage on those exposed through sexual violence- this is of concern in light of findings in the ZDHS 2005-6 that 3 in 10 women reported experiencing physical or sexual violence in past year.

Blood safety

All blood used in Zimbabwe is provided by the National Blood Services of Zimbabwe (NBSZ), an independent private registered non-profit organization. The NBSZ is a WHO collaborating centre for blood safety in Southern Africa[10].

Key gaps and challenges related to Blood safety

- Uptake of post donation counselling has been low: In 2008, only 15% of donors came back to obtain their results and post donation counselling in 2008[11];
- The voluntary blood donor system has not been able to collect a sufficient quantity of blood units to meet demand for safe blood and overall blood collections have been on the decline: In 2009, 42,000 units were collected, compared to 80,000 units in 2000;
- Weak integration between the national blood service and other services such as HIV testing and counselling services;

HIV Testing and Counselling (HTC)

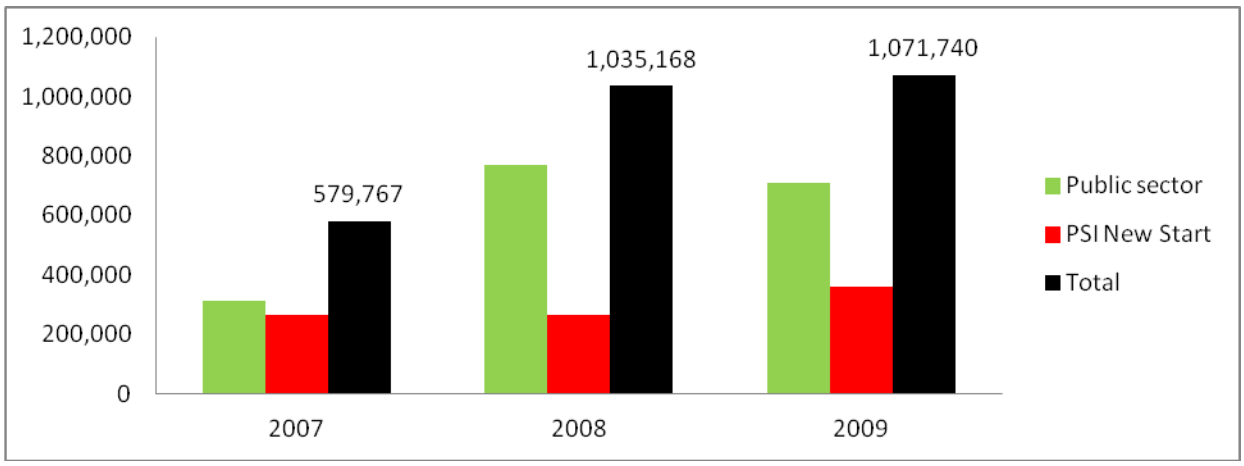
The Zimbabwe National HIV Testing and Counselling Strategic Plan 2008-2010 (ZNHTCSP) was launched in 2008 with an overall goal to increase the proportion of Zimbabweans who know their HIV status from 20% to 85% by the end of 2010 through expanding access to and utilization of HTC services.

As a result of the expansion of Provider Initiated Testing and Counselling (PITC), approximately 64% of health facilities were providing HTC at the end of June 2010 compared to just 35% in 2006 significantly increasing availability of HTC services in the country.

The graph that follows shows data on annual uptake of HIV testing and counselling public sector facilities as well as at PSI's New Start centres between 2007 and 2009[12]. The HTC programme was strengthened in 2008 as a consequence of an increase in the number of funding partners and the implementation of PITC in all MoHCW health clinics and hospitals.

[10] It also attained ISO certification in 2006 and retained the certification since.
[11] National Blood Service Zimbabwe 2008 Annual Report
[12] These data must be interpreted carefully because they may include individuals re-testing for HIV during the reporting period

Figure 5: Trends in Number of Individuals Counselled and Tested for HIV, 2007-2009



Source: MOHCW AIDS and TB Unit

The NBCP interim survey established that the percentage of people ever tested increased from 36% at baseline to 50%. There were also significant increases in couple counselling from 12% in 2007 to 25% in 2009[13].

Key gaps and challenges relating to HIV testing and Counselling (HTC)

The following are key gaps and challenges that must be overcome:

- Couple counselling rates remain low as only 20% of individuals accessed HTC as couples in 2009;
- Primary Counsellors are only able to offer pre and post-test counselling and are unable to perform rapid testing
- Policy on testing of minors needs to be reviewed

2.3.2 Treatment and Care

Provision of Antiretroviral Therapy (ART)

The goal of Zimbabwe's ART programme is to reduce mortality and morbidity due to HIV and AIDS and to improve the quality of life of PLHIV. As at December 2010, 326,241 of the 593,168 were receiving treatment representing a coverage of 54% based on the revised 2009 WHO guidelines. Of the 326,241 people on ART in 2010 60% were females while ***32,000 were children***. Facilities providing follow up ART services increased from 32 in 2006 to 387 by June 2010. The expansion of ART coverage reduced annual AIDS deaths from 123,000 in 2006 to 71,299 at the end of 2010. At the end of 2009, the ART Programme began to undertake HIV drug resistance (HIVDR) prevention surveys that focus on consecutively selected cohort of

[13] UNFPA/NAC. 2009. National Behaviour Change Strategy Interim Survey

eligible patients starting ART in each of the selected representative sentinel sites and evaluates HIVDR outcomes 12 months after ART begins[14].

Key gaps and challenges relating to the provision of ART

Although substantial progress has been made towards providing ART, the country managed to achieve 58% against a target of 80% by the end of 2010. Key gaps in the roll out of the ART programme include:

- Inadequate human resources for rollout of ART services
- Financial resource constraints in rolling out the recommended WHO 2009 guidelines.
- Inaccessibility of ART services due infrastructural and equipment as well policy constraints.
- Weak referral systems
- Weak M&E system for the ART programme

Prevention, Care and Management of TB/HIV co-infection

TB is highly associated with HIV infection in Zimbabwe and it is estimated that approximately 80% of TB cases are co-infected with HIV[15]. As a consequence of that association, TB is a leading cause of mortality among PLHIV in the country. Collaborative activities between TB and HIV programmes are therefore essential in preventing, diagnosing and treating TB among PLHIV.

The country has developed 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. Table 4 below shows progress in TB/HIV programming.

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

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

As the table indicates, there has been substantial progress in expanding HIV testing and counselling for people with TB since 2007. This increase in the uptake of HIV Testing and Counselling was mainly attributed to training of health workers and the revision of the TB M&E tools to capture HIV activities.

[14] Report on the National HIV Drug Resistance Prevention and Assessment Strategy2006-2008, MOHCW
[15] National TB Control Programme Database, MOHCW, 2009

Key gaps and challenges relating to the prevention, care and management of TB/HIV co-infection

Although some progress has been made in recent years, the data above clearly show that access to essential interventions to decrease the burden of HIV related TB co-infection remains far from the goal of universal access. Key gaps and challenges include:

- Limited capacity and competence among health workers in TB/HIV co-management as well as intensive case finding
- The policy on Isoniazid preventive therapy (IPT) had not been implemented by the end of 2010
- TB infection control measures are overlooked and the expansion of HIV services without these measures in place has created optimal conditions for hospital related TB transmission among vulnerable patients, their families and health care workers
- Weak integrated monitoring and evaluation systems to assess the progress and outcomes of collaborative HIV/TB interventions

Diagnostic services for treatment and care

Key progress in diagnostic services includes the procurement, distribution and utilization of 71 CD4 count, 69 haematology and 45 biochemistry machines in the public health facilities. In order to expand human resources (HR) 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 deployed to districts. Training of microscopists has also been expanded: 320 have so far been trained out of a 2010 target of 520. As mentioned in earlier sections, 13% of districts offer early infant diagnosis (EID) and viral load testing has recently been launched.

Key gaps and challenges relating to the provision of diagnostic services for HIV and AIDS

- Weak laboratory services for adults and children for both pre ART and ART
- Laboratory monitoring for Pre-ART and ART is largely centralized
- Electricity backup systems are inadequate;
- Support and supervision systems for quality assurance are inadequate

2.3.3 Mitigation and Support

Community and Home Based Care (C&HBC)

Zimbabwe developed a national C&HBC policy, strategy and guidelines which have been guiding C&HBC activities in Zimbabwe. C&HBC has since evolved from focusing on palliative care to include psychosocial, spiritual as well as support to clients on ART.

The number of people receiving C&HBC increased from 450,000 in 2007 to 489,000 in 2008 and 697,000 at the end of 2009.

Key gaps and challenges relating to the provision of community and home based care

- The capacity of service providers to offer quality and appropriate C&HBC for adults and children living with HIV is still limited.
- Supply and replenishment of C&HBC kits is inadequate and inconsistent thereby compromising the quality of care and support provided;
- Weak referral system of the C&HBC and HTC, ART, PMTCT, STI and TB interventions severely limiting effectiveness and efficiency of interventions
- Weak monitoring and evaluation systems for C&HBC

Nutrition Programming for children and adults living with HIV

The Government has to date provided guidance on nutrition programming for children and adults living with HIV[16]. Another priority of the Government has been to support therapeutic and supplementary feeding of children and adults living with HIV who are suffering from severe and moderate acute malnutrition respectively.

Key gaps and challenges relating to nutrition programming for children and adults living with HIV

- Weak coordination of national efforts to address nutritional needs of PLHIV.
- No significant preventive nutrition intervention targeting HIV is in place despite development of guidance on nutrition programming including preventive strategies that is yet to be disseminated and implemented;
- Lack of programmatic data on nutrition and other related interventions (e.g. food distribution) limit ability to ensure quality of program, decision making and advocacy.
- Unsustainable supply chain for nutritional commodities.

Care and Support for Orphans and Other Vulnerable Children (OVC)

Zimbabwe has the third highest proportion of orphaned children with the best available estimates suggesting that approximately 1.6 million of children in Zimbabwe are OVC, 62% of them due to HIV and AIDS[17].

A National Action Plan for OVC (NAP) for 2006-2010 was developed and was supported by an $86 million multi-donor Programme of Support (PoS) administered by UNICEF. By the end of 2010, 410,000 OVC (25%) had received support through the PoS.

Key gaps and challenges relating to care and support for OVC

[16] 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.
[17] ZDHS 2006-2010 and EPP/Spectrum estimates (June 2010)

However despite the achievements noted above and the significant progress made to date in mitigating the impact of the epidemic on OVC, several gaps and challenges relating to care and support have been noted[18]:

- Coordination of care and support for OVC at provincial, district and ward levels has been ineffective due to the limited capacity of the Department of Social Services;
- There has been limited capacity development for government structures negatively impacting on quality service delivery;

Meaningful Involvement of PLHIV (MIPA)

MIPA was one of the guiding principles in the outgoing national strategic plan. Consequently there has been considerable progress in the representation and participation of PLHIV in key national governance structures such the National AIDS Council (NAC) and the country coordinating mechanism (CCM). Participation and involvement of PLHIV is most significant at lower levels of implementation of the national response and MIPA structures have been created at district, ward and village level.

Key gaps and challenges relating to the meaningful involvement of PLHIV in the national response

- Social, institutional and personal stigma towards PLHIV;
- PLHIV lack the capacity to exercise their voice and to participate effectively in national HIV and TB policy formulation, legislation, advocacy, governance, implementation, monitoring and evaluation of the response.
- Lack of conducive and enabling environment for promoting MIPA

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

In line with the 'Three Ones' principle Zimbabwe has already established the necessary coordination structures and systems for an effective response. To facilitate effective coordination NAC has decentralized structures (AIDS Action Committees) at Provincial, District, Ward and Village levels. NAC is responsible for coordinating the response with particular focus on national policy development, partnerships, resource mobilization, monitoring, evaluation and administration of the National AIDS Trust Fund (NATF).

Health sector coordination is facilitated by the AIDS and TB Unit within the Ministry of Health and Child Welfare (MoHCW). A number of sub- sector coordinating agencies exist that undertake coordination functions without a specific national mandate. Thematic multi-agency Technical Working Groups (TWG) provide technical guidance and coordination in a number of intervention areas.

Multi-sectoral National Coordination and Monitoring and Evaluation

[18] *Programme of Support for the National Action Plan for Orphans and Other Vulnerable Children: Outcome Assessment*, Harare. and MTR of the ZNASP (2009).

A number of informal coordinating entities are involved in the national response in Zimbabwe include: The Zimbabwe Business Coalition on HIV and AIDS (ZBCA) which coordinates the private sector response to HIV and AIDS; The Zimbabwe AIDS Network (ZAN) which coordinates civil society responses to HIV and AIDS; The Zimbabwe Network of PLHIV (ZNNP+) which coordinates associations of PLHIV in Zimbabwe; The UN Joint Team on HIV and AIDS (UNJT) which coordinates the UN family's response to HIV and AIDS and The Country Coordinating Mechanism (CCM) which coordinates resource mobilization to the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and provides oversight over the implementation of Global Fund HIV related grants in the country.

Key gaps and challenges

- Lack of coordinated financing mechanism by donors and other financing partners to the HIV and AIDS national response.
- A number of coordination fora are dysfunctional, duplicate coordination and have not met regularly and consistently and a significant majority lack clear terms of reference;
- No accompanying resource mobilization strategy was developed to resource mobilise for ZNASP I and support its implementation.

Monitoring and Evaluation

In compliance to the "three ones" principle, National AIDS Council is mandated to ensure an effective, monitoring and evaluation system for HIV and AIDS programmes. A national Monitoring and Evaluation framework was developed and a set of core indicators were identified and described. Additionally Monitoring and Evaluation Plan for the previous strategic plan was also developed. National AIDS Council has facilitated a National research agenda and provided seed money for operational research. Research priorities were identified and documented. Currently NAC is using CRIS database for processing and management of Data.

Key gaps and challenges

- The national M & E system in NAC and AIDS and TB Unit is still weak.
- There is no subsidiary legislation to the NAC Act in the form of Statutory Instruments to operationalize the Act.
- No joint annual planning and review process for the national response to HIV and AIDS;
- Weak M&E systems in partner organisations

2.3.5 Health Systems in Zimbabwe

The health delivery system in Zimbabwe is organised around a four tiered system namely primary, secondary, tertiary and quaternary with varying services offered at each level. Delivery of health services continues to be guided by the National Health Strategic Plan (NHSP) 2009-13 and is based on the primary health care concept. An assessment of the Health Information System (HIS) was conducted[19] and culminated in the development of an Health Information Systems Strategic Plan 2009-14.

Key gaps and challenges

- Poor working conditions and inadequate trained health work force
- Inaccessibility of health centres in rural areas and among resettled populations
- Inadequate and unsustainable financing for the health sector
- Weak National Health Information System

2.3.6 Community Systems

Communities in Zimbabwe have been at the forefront of responding to the epidemic in the last three decades. The outgoing strategic plan recognised the critical role and contribution made by communities in the response to the HIV and AIDS epidemic. Given their strategic position in the national response, communities know what is needed, what will work best in their own settings, and have tremendous power to change the course and experience of the epidemic at grassroots level, if given adequate room to contribute. However, the deterioration of the socio-economic environment of the last decade disempowered communities and affected meaningful engagement in the HIV and AIDS response.

Despite a decade of hardships, community based initiatives have benefited from human, material, and financial support from local, international NGOs and civil society organizations. Under the Global Fund, the Expanded Support Programme and other national funding mechanisms, a number of community initiatives *(the Ward and District AIDS Action Committees (WAACs, DAACs) Ward Health teams, development structures such as VIDCO, WADCO and DDCOs and Child Protection Committees*) have been established to provide an enabling environment and community advocacy for all the three focus diseases of the GFATM.

Key gaps and challenges

- Poor structures for CBOs, a limited funding base and failure to utilize local knowledge reduce the overall impact of community mobilization and participation efforts;
- Lack of strong leadership, with some organizations operating without strategic and operational plans; weak proposal, report writing, monitoring and data analysis skills; lack of sustainable strategies by communities;
- Top down approach to programming resulting in communities not being involved in the entire project management cycle and decision making bodies (e.g. ward development

[19] Zimbabwe Health Information System Assessment, 2009

committee) in monitoring and reporting to the public on the implementation of health policies;

- Marginalisation of community resource mobilisation and lack of community based M&E systems and evidence based programming; and
- 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.

2.3.7 Financing of the National Response to HIV and AIDS

The national response has been funded through a number of mechanisms such as the NATF, Global Fund, ESP, USG and the PoS. Other bilateral and multilateral funding has supplemented the resources for the response.

The GOZ through the national budget contributed US$10.6 million in 2007, US$354,000 in 2008 and US$7.5 million in 2009 towards HIV and AIDS programmes. The AIDS levy has increased significantly since the adoption of the multicurrency system, from US$5 million in 2006 to US$19 million in 2010. At least 50% of the levy is used for procurement ART commodities whilst the rest went to programmes such as prevention, mitigation, advocacy and support to coordination.

Bilateral and multilateral partners as well as international foundations contributed about US$35 million in 2007, US$25 million in 2008 and US$38 million in 2009 towards HIV and AIDS programs[20]. These amounts may not reflect the true total financial contribution from the international sources for these years, as not all of them provided information during the National AIDS Spending Assessment (NASA) exercise for the periods.

Zimbabwe also received funding from the Global Fund through a Round 5 grant that provided $60 million from 2009. The grant supported to HIV interventions focusing on maintaining and strengthening health service delivery and mitigating the impact of HIV and AIDS in 22 priority districts. At the end of September 2010, Zimbabwe had also received $46 million as part of a Round 8 application which supported the provision of ART, strengthening of the health workforce as well as behaviour change communication activities.

The Expanded Support Program (ESP), a grouping of the following development partners, CIDA, DFID, Norwegian Aid, Irish Aid and SIDA contributed US$42 million during the period 2007-9, of which 50% was for care and treatment, 12% was for prevention, and 10% for M&E. The ESP primarily supported activities in 16 districts of Zimbabwe although for certain components such as treatment and care supported at national level.

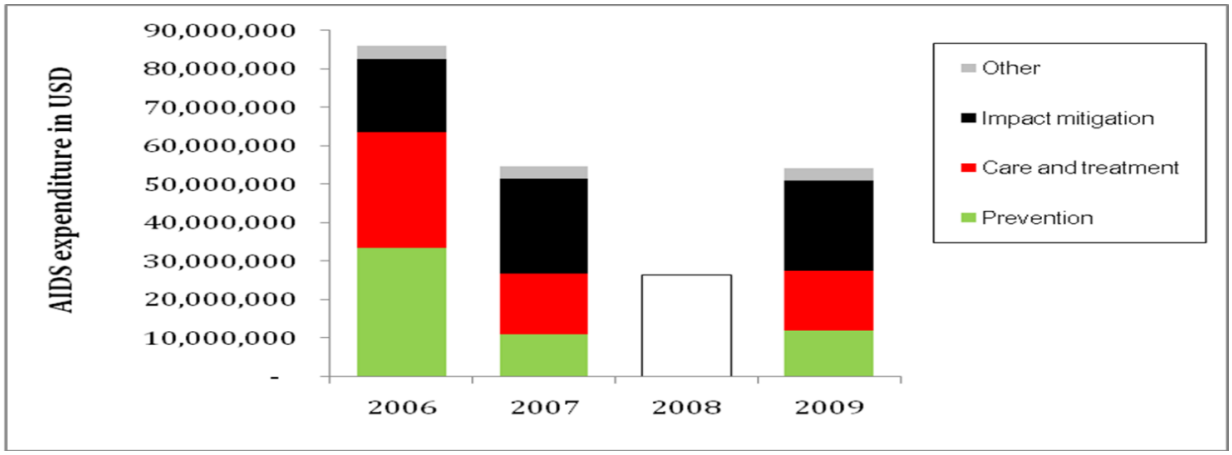
The mitigation programme for OVC received significant funding from the Programme of Support (PoS), a pooled donor which contributed US$84 million for 3-years to support OVC

[20] Reporting on 2009 funding matrix by Bilaterals, Multilaterals and International Foundations for Zimbabwe UNGASS
2010 Report

education, healthcare, birth registration and access to HIV and AIDS prevention, treatment, and care and support services[21.]

Figure 6 below shows relative and absolute amounts of AIDS expenditure by thematic area in Zimbabwe from the National AIDS Spending Assessments for the period 2006-2009**.**

Figure 6: Relative and absolute amounts of AIDS expenditure by thematic area in Zimbabwe, 2006-9



Source: **National AIDS Spending Assessment (NASA) 2009**

An analysis of the spending on key priorities shows funding for the national response was largely evenly spent on prevention, care and treatment and impact mitigation although more funding for HIV prevention declined significantly between the period 2006 and 2009. Due to the severe hyperinflation Zimbabwe faced in 2008, it was difficult to accurately assess expenditure and thus data is not included in the table.

Key gaps and challenges in financing the national response to HIV and AIDS to date

- 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

21 Programme of Support to the National Action Plan for Orphans and Vulnerable Children in Zimbabwe Annual Report, June 2009.

SECTION 3: ZNASP II PRIORITIES AND GUIDING PRINCIPLES

This section of the strategy sets out the priorities of ZNASP II as gleaned from the in-depth situation and response analysis. It also outlines the principles that will guide the implementation of the national response, the results to be achieved in ZNASP II and strategies for delivering HIV services to the targeted populations.

3.1: Prioritisation for ZNASP II

The priorities for this second ZNASP 2011-2015 have been informed by the analysis of epidemiological, behavioural and in-depth analysis data of the national HIV response. The prioritisation has also taken into account the need for the strategic plan to support progress towards universal access targets and the MDGs. Prioritisation has also been based on areas likely to achieve maximum impact in the response. The prioritisation is focused on three dimensions: i.e. ***measures to ensure prevention of sexual transmission of HIV, prevention of mother-to-child transmission; measures to ensure infection control, blood safety and post-exposure prophylaxis.*** The priorities outlined below show the thrust of the strategic plan in order to maximise its impact on the HIV epidemic

The epidemic analysis indicated that the majority of new HIV infections in the country are acquired through unsafe sexual intercourse within a casual or stable relationship. Multiple sexual partners increase exposure to HIV infection. Vertical transmission i.e. transmission from an infected mother to her child during pregnancy, labour and delivery or breastfeeding of HIV has also been identified as another major source of new HIV infections among children in Zimbabwe. In this regard, Zimbabwe's response will prioritize prevention of sexual transmission of HIV and prevention of mother-to-child transmission. ZNASP II prioritizes these populations for HIV prevention interventions to reduce new HIV infections and also for treatment and care and support services for those already infected by HIV. Measures to ensure infection control, blood safety and post-exposure prophylaxis will continue to be implemented as high priority interventions.

3.2: Guiding Principles for ZNASP II

Implementation of ZNASP II will be anchored on the following eight guiding principles: ***Equitable access; Evidence based planning; Integrated service delivery; Meaningful involvement of people living with HIV and other vulnerable and affected populations; Building on good practices from Zimbabwe and other countries; The "Three Ones" Principle; Gender sensitivity and national responsiveness to HIV and AIDS and Creating an enabling environment.***

i. Equitable access

Equity in accessing quality health care goods and services is a fundamental human right regardless of one's gender, social and economic standing, language, religion, race and creed. This strategic plan recognizes the strong link between HIV and AIDS and equity in access to

health care goods and services. Some subgroups of the population engage in illicit sex and hence go underground for fear of reprisals. These include sex workers and their clients, MSM, and prisoners among others. HIV related stigma is also evident at general population level and within health delivery settings. Discrimination and stigma of PLHIV impacts on disclosure and health seeking behaviour hence become barriers to accessing optimal HIV services. This strategic plan has identified specific strategies for reaching high-risk populations and addressing HIV related stigma and discrimination by addressing discrimination in its wider context through an all inclusive approach to women, men, girls and boys in prevention, treatment, care, support and mitigating the impact of HIV and AIDS. A comprehensive and multi-sectoral approach to empowering both the affected and infected will be used.

ii. Evidence based planning

The impact, outcome and output level results to be achieved in this strategy in the next five years have been articulated. As the basis for informing resource mobilization for the strategy, a results based framework has been drawn to guide resource allocation linked to outcomes, measuring the performance of the national response and to enhance accountability of all implementing partners. Results based management will be key in managing performance and ensuring accountability in the implementation of this strategic plan. This principle has been adopted in this strategic plan to ensure effective coordination and implementation of the national response. In scaling up the HIV services, the country will prioritize interventions that address the key determinants of the HIV epidemic. Monitoring of implementation of the national response will be generated by the national M&E system, including operational research, population based surveys, surveillance, mapping and population size estimation of key populations and evaluation studies.

iii. Integrated service delivery

Available evidence shows that lack of holistic and comprehensive service provision has impacted negatively on uptake of prevention interventions including treatment, care and support. To ensure that interventions are continuously addressing key aspects of the epidemic, this strategy will focus on integrating (*Supermarket approach)* as far as possible preventative, treatment, care and support services to maximise on uptake of the various interventions. Where this is not possible strong service linkages that are well coordinated will be developed and operational referral mechanisms put in place, in order to optimize expenditure, increase service coverage to enhance improved prevention, treatment and care outcomes.

iv. Meaningful involvement of people living with HIV (MIPA) and other vulnerable and affected populations:

PLHIV play a critical role across all the thematic areas of the response because ***they have walked the talk*** and there is no substitute for their experience. Yet evidence points to the contrary with most PLHIV found at the lowest level of participation in the response with very few found at the highest levels i.e. decision making and policy levels. In ZNASP II particular mechanisms will be created and implemented in supporting PLHIV to meaningfully participate

in the planning, management and implementation of the response for people living with HIV and other key populations. PLHIV networks, support groups and civic society will be capacitated to lobby and advocate for their rights.

v. Building on good practices from Zimbabwe and other countries:

To maximize impact of the interventions and direct finite resources to interventions likely to produce maximum effect on the course of the epidemic, the response is designed based on strategies that have proven effective internationally, regionally and nationally. Thus, this strategy will ensure resources are used effectively and efficiently.

vi. The "Three Ones" Principle

In ZNASP II the 'Three Ones Principle' will remain key and fundamental in implementing the country's HIV response to give direction, ensure accountability, avoid duplication and wastage of resources. The 'Three Ones Principle', encompasses one multi-sectoral action framework, one national coordinating authority and one monitoring and evaluation system, will guide and consolidate HIV-related activities at all levels across sectors under the guidance and stewardship of NAC.

vii. Gender sensitivity and national responsiveness to HIV and AIDS

Intervention programmes across all thematic areas of the response need to be gender sensitive and responsive to needs of both men and women equitably. Available evidence shows that the country has a gendered epidemic with high prevalence among women in comparison to men and hence the impact is bound to be different on both men and women. The context of gender roles and relations substantially influences how women and men will respond to initiatives designed to reduce risk or vulnerability or to alleviate the impact of AIDS. Hence it is important in this strategy to ensure a gender-based comprehensive response that strengthens the multi-sectoral approach to HIV and AIDS programming.

viii. Creating an enabling environment

Tenets of an enabling environment include: policies, laws and standard guidelines that guide operations. Without an enabling environment, the implementation of this strategic plan will be impossible as the policy and regulatory framework have to be conducive. Political commitment to allocation of resources essential to conduct interventions in order to achieve universal access to services by all key populations proposed in this strategy is essential. An enabling policy and legal environment is essential for the implementation of this strategic plan. ZNASP II will seek to create the required enabling environment for most of the strategies in the plan to be implemented effectively.

SECTION 4: EXPECTED IMPACT LEVEL RESULTS FOR ZNASP II

This strategy identifies the impact, outcome and output level results to be achieved over the next five years. The impact results are outlined below:

Impact result 1: Reduction of incidence of HIV by 50% by 2015
Impact result 2: HIV and AIDS related morbidity and mortality reduced
Impact result 3: An enabling environment is created to reduce social impact of HIV on people affected and infected
Impact result 4: Effective management and coordination of the national HIV and AIDS response informed by a functional M & E system

4.1: Impact Results by Thematic Area

Prevention

<u>Impact Result 1:</u> Reduction of new HIV infections by 50% by 2015

This strategic plan focuses on prevention of new HIV infections in order to maintain a low HIV prevalence (less than 10%) in the next five years. In 2007 new infections were estimated at 57,426 in adults with estimates of 2009 showing a decline in number to 48,168 (approximately 132 new HIV infections daily). Projections into the future indicate that the number of newly infected adults will increase to 54,000 by 2015, unless further risk reduction is achieved. Evidence shows that the majority of new adult infections in the country occur in low risk heterosexual sex which accounts for 55.9% of HIV incidence followed by casual heterosexual sex at 24.0%. This strategic plan sets out strategies to prevent new infections among low risk heterosexual sex and other populations with high vulnerability to HIV infections in order to "halve" new infection by 2015.

Table 5: Prevention Impact Result, Indicators and Targets

Result No.	Impact Result	Indicator	Baseline		Target by 2015
			Value	Source and Year	
1	Reduction of new HIV infections by 50% by 2015	Estimated number of annual HIV infections among adults 15-49 years	48,168	EPP/ SPECTRUM modelling 2009	27,027
		Percentage of HIV infected infants born to HIV infected mothers who are infected	30%	MOHCW 2009 database	<5%
		Percentage of young women and men aged 15-24 who are HIV infected	Females: 11.0% Males: 4.2%	ZDHS 2005/6	Females: 5% Males: 3%

Treatment, Care and Support

<u>Impact Result 2:</u> Reduction of mortality among PLHIV

The estimated number of annual AIDS related deaths stood at 70,543 and 13,393 (2009) for adults and children respectively. ART coverage for adults and children was at 31.5% (28,149) and 59% (298,092) respectively as of December 2010. This presents a significant gap in access to ART services. It is projected that ART coverage will be increased from 31.5% in children and 59% in adults in 2010 to 85% in 2015 for both populations. Reflecting a commitment to achieving an impact within the population, the ZNASP II is structured around achieving an impact level result that will translate to the reduction of AIDS related annual deaths from 71,299 in 2010 to 51,808 by 2015. Table 6 below shows ZNASP II impact result with indicator, baseline value and target by 2015.

Table 6: Treatment Impact Result, Indicators and Targets

Result No.	Impact Result	Indicator	Baseline		Target by 2015
			Value	Source and Year	
2	Reduction of mortality among PLHIV by 38.0% by 2015	Estimated number of annual adult AIDS related deaths	70,543	SPECTRUM Modelling 2009	45,134
		Estimated number of annual children AIDS related deaths	13,393	SPECTRUM Modelling 2009	6,674
		Estimated number of annual AIDS related deaths in children and adults	83,936	SPECTRUM Modelling 2009	51,808

Enabling environment

<u>Impact Result 3:</u> An enabling environment is created to reduce social impact of HIV on people affected and infected by increasing the composite policy index from 6.2 in 2010 to 9.0 by 2015

Evidence shows that adult HIV prevalence is higher among women age 15-49 (21%) than among men in the same age cohort (14.5%). This gender gap is also evident and even wider among young people: Females age 15-19 years have higher HIV prevalence rates than men among the same age group. The MIPA baseline survey conducted in 2009 revealed that participation and involvement of PLHIV is most significant at lower levels of implementation of the national response and MIPA structures have been created at district, ward and village level. One of the biggest and critical impediments to MIPA implementation is HIV related stigma at three levels: social, institutional and personal. This is largely attributed to a non conducive environment caused by weak policies, gender disparities and stigma and discrimination. This plan aims at increasing accepting attitudes among the general population from a baseline of 17% for women

and 11% for men in 2005-6 to 75% for women and 60% for men and increasing the composite policy index from 6.2 in 2010 to 9.0 in 2015.

Table 7: Enabling Environment Impact Result, Indicators and Targets

Result No.	Impact Result	Indicator	Baseline		Target by 2015
			Value	Source and Year	
3	Enabling environment created by reducing social impact of HIV on people affected and infected	% of population expressing accepting attitude toward PLHIV	17% women 11% men	ZDHS 2005/6	75% women 60% men
		Increased National Composite Policy Index Score	6.2	UNGASS report 2010	9.0

Coordination, Monitoring and Evaluation

<u>Impact Result 4:</u> Effective management and coordination of the national HIV and AIDS response informed by a functional M & E system

Zimbabwe's multi-sectoral response to HIV and AIDS is managed and coordinated by the National AIDS Council (NAC). Zimbabwe's health sector response is coordinated by the MOCHW while the NAC is mandated to coordinate HIV and AIDS response. Zimbabwe adopted the "Three Ones" principle: *the existence of one national coordinating body, one strategic national plan of action and one national monitoring and evaluation framework*. Currently there are a number of de facto coordinating bodies with no specific mandate to coordinate their respective activities. Many of these agencies are often perceived as representing their own interests undermining the authority and credibility of NAC and MoHCW. Coordinating the mobilisation and strategic allocation of financing to different areas of the national HIV and AIDS response has been difficult due to many parallel financing systems, hence the need to have a coordinated financing system.

In line with the "three ones" principle the national M & E system and that of the HMIS are not integrated and run in parallel resulting in dual reporting and increasing reporting burden among implementing partners and stakeholders. Therefore, there is need to harmonise these parallel systems to adhere to the "Three ones" principle.

4.2 Outcomes, Outputs and Strategies by Thematic Areas

The following section is an analysis of the outcomes, outputs and strategies by thematic areas that will inform and direct ZNASP II interventions.

4.2.1 Prevention

<u>OUTCOME 1.1:</u> Risky sexual behaviour among key targeted populations reduced

Evidence from the situational analysis shows that heterosexual contact remains the main mode of transmission with low risk sexual sex contributing 55.9% of national incidence followed by casual sex at 24.0% and sex work and their clients 14.1%. This strategy has prioritised prevention of new infections and aims at reducing sexual transmission of HIV through: ***Provision of quality, up to date, gender- and age-specific information on the transmission and prevention of HIV infection, Culturally appropriate gender- and age-specific social and behaviour change communication, encourage uptake of HIV prevention services and consistent and correct condom use, ensuring availability and accessibility of HTC, male circumcision, STI treatment services.***

Table 8: Prevention Outcome Indicators and Targets

Result No.	Indicator	Baseline	Source and Year	Target	
				2013	2015
1.1a	Percentage 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%
1.1b	Percentage of women and men 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Females: 1.3% Males: 14.1%	ZDHS 2005/6)	Females: 1.0% Males: 10.9%	Females: 1.0% Males: 9.9 %
1.1c	Percentage of women and men in sero-discordant relationships reporting condom use in last sex	Special studies	Special Studies	50%	80%
1.1d	Percentage 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)	Women: 20% Men: 20%	Women: 35% Men: 35%
1.1e	% of key affected populations reached with HIV services	Special studies	Special studies	50%	80%

<u>Output 1.1.1:</u> Increased uptake of HIV testing and counselling (HTC) through strengthened health delivery systems

High quality HIV counselling and Testing (HCT) is one of the most successful interventions in the national response to HIV and AIDS in Zimbabwe to date. As a result of the expansion of Provider Initiated Testing and Counselling (PITC), approximately 64% of health facilities were providing HTC at the end of June 2010 compared to just 35% in 2006 significantly increasing availability of HTC services in the country. It is anticipated that by 2015 all health facilities will be providing HTC as a means of HIV prevention. Currently 1,6 million people know their HIV status and the current strategy will scale up HTC to reach 2,2 million people by 2015. To achieve this goal

ZNASP II will target priority populations that will be targeted in the six largest high HIV burden provinces who will be couples (formal and informal unions); partners of PLHIV on the national Pre-ART and ART programme; young people aged 15-24 and young men aged 15-29.

Priority Strategies

1. **Establishment of HTC sites in existing health facilities**

Many health facilities do not have appropriate physical infrastructure to provide privacy for HIV counselling and testing. This strategic plan seeks to upgrade and refurbish these physical facilities to provide privacy and equip them to provide HTC services. The HTC sites will be increased from the current 1218 to 1578 by 2015. This increase is aimed at improving access to both provider-initiated and client initiated HIV testing and counselling.

2. **Building capacity of health workers in HTC**

Health workers will be trained and re-trained to support the scale up of HTC sites. In each health facility, at least two counsellors and nurses will be trained on HTC. The training will be rolled out in phases over the next five years in tandem with the HTC site scale up. The training will comprise an initial comprehensive training and refresher training carried out 2 years later. The training should result in the provision of improved HTC services that are also youth, MARPs and older people friendly.

3. **Strengthen logistics management**

To meet the increased demand for HTC services, there is need to strengthen logistics and supply chain management for HIV test kits and related commodities including consumables. This will ensure that commodities for provision of HTC are available at all health facilities earmarked for HTC services.

4. **Scale up community mobilisation for HTC**

Massive community mobilisation will be undertaken in order to achieve an increase in people tested for HIV among adult population to achieve set targets. Couple counselling and targeting of youths is critical for achieving an AIDS free generation. The youths will be mobilised for HTC services through the In-school HIV and AIDS Life skills based education, tertiary institutions programme, youth groups, associations and organisations working with youths to improve the interest of the youth out of school. HTC will be strengthened in both rural and urban areas encouraging couple counselling to support the overall PMTCT scale up plan.

5. **Strengthening HTC services**

The HTC services will be strengthened through review of national policies and guidelines, and ensure there implementation to cover emerging issues, strengthen linkages and referral systems between other interventions such HTC and MC, FP, SBCC, PMTCT, TB/HIV, CHBC,

school health services and nutrition services and monitoring and evaluation systems for HTC services.

Table 9: HTC Output Indicators and Targets

Result no.	Indicator			Targets				
		Baseline	Source and Year	2011	2012	2013	2014	2015
1.1.1a	Number of provider initiated Testing and Counselling (PITC) sites operational	1,218	HTC program database, MoHCW	1,300	1,400	1,500	1,530	1,560
1.1.1b	Number of Client Initiated Testing and Counselling (CITC) sites operational	18	HTC program database, MoHCW	18	18	18	18	18
1.1.1c	Number of men and women tested for HIV and and received results	1,600,000	HTC program database, MoHCW	1,696,000	1,797,600	1,905,626	2,019,963	2,141,161
1.1.1d	Number of HTC sites strengthened	1,218	HTC program database, MoHCW	1,300	1,400	1,500	1,530	1,560

<u>Output 1.1.2:</u> Increased knowledge on the use of male and female condoms for young men and women age 15-24 years and other targeted populations.

In Zimbabwe, condom promotion and distribution is spearheaded by the MoHCW, the Zimbabwe National Family Planning Council (ZNFPC) and Population Services International (PSI). In ZNASP I the main objective was to make both public sector and socially marketed condoms more widely available through the annual distribution of 150 million condoms annually by 2010. The following priority populations will be targeted: sexually active young people and adults with intense focus on couples in discordant relationships, pregnant women within PMTCT services, PLHIV enrolled in the Pre-ART and ART programme, men and women testing positive in HTC sites, sex workers and their clients. ZNASP II seeks to expand access to and correct and consistent utilization of male and female condoms among a number of key populations through social and public sector condom promotion and management.

Priority strategies

1. **Develop and implement communication plan to address barriers to uptake of condoms among target populations and generate demand for both male and female condoms**

There are social norms that create barriers to communication on sex and negotiating safer sex, in particular within marriage and young people in-schools. There is inadequate enquiry into understanding of who is using condoms, with what partners, in what kinds of sexual acts, how consistently and how correctly. This strategy aims to enhance communication on sex through multi-media channels.

2. **Promote condom use among target populations**

Some of the barriers that hinder condom use include myths, misconceptions and negative perception of the public sector distributed condoms. Condom promotion will be aimed at increasing the use of both female and male condoms among the MARPs, STI patients, clients of sex workers, partners of clients of sex workers, men with multiple partners, prisoners, MSM and women especially those attending ANC. In addition, condom promotion will also be integrated into reproductive health and family planning services and life-skills education targeting the youth. The interventions for condom promotion will, therefore, be designed to effectively reach the targeted populations using strategies appropriate for each target group.

<u>Output 1.1.3:</u> Increased knowledge on the importance of using condoms in sero-discordant relationships

ZDHS 2005-2006 found out that about 13% of HIV-positive individuals identified are in sero-discordant relationships. Condom use in stable relationships is generally low. The Behaviour Change situation and response analysis established that knowledge levels on sero- discordance are generally low. Priority intervention populations will be discordant couples, to prevent transmitting HIV to the uninfected partners and unintended pregnancies among women in sero-discordant relationships.

Priority strategies

1. **Promotion of safer sex among discordant couples**

This strategy will enhance sex communication and negotiation among discordant couples to promote the practise of safer sex in order to remain discordant. For this purpose and as part of the intervention in prevention with positives (PwP), condom promotion will be a key strategy for prevention of HIV.

<u>Output 1.1.4:</u> Increase male and female condoms distributed annually from 78m to 95m by 2015

To prevent condom stock outs, this strategy aims to ensure that male and female condom quantification are accurately done, adequate and appropriate storage facilities are available, quality control of condoms effectively and efficiently done and logistics for condom distribution improved. Adequate quantities of condoms, both male and female, will be procured to ensure availability and accessibility.

Priority Strategies

1. Expand condom distribution outlets

The main outlet for condom distribution currently is through health facilities. In this strategy, condom distribution outlets will be diversified to social places and networks that effectively reach the target populations. For instance, outlets targeting young people 15 -24 years, utilise the social networks for these populations and social places accessible to sex workers.

2. Strengthen government capacity to provide national leadership in condom programming and quality assurance

Despite considerable training efforts, many service providers still lack the technical capacity and confidence to promote the use of the female condom. This strategy aims at strengthening capacity of health providers in condom programming and quality assurance.

Table 10: Condom Use Output Indicators and Targets

Result no.	Indicator			Targets				
		Baseline	Source & Year	2011	2012	2013	2014	2015
1.1.2	Percentage of young women and men 15-24 years who report being able to correctly use the male and female condoms	72%	Condoms Program database, MoHCW	75%	80%	85%	90%	95%
1.1.3	Percentage of sero-discordant couples reporting consistent use of condoms. Number of service providers trained in CCP and safer sex negotiation	3,000 (between 2007 & 2010)	Condoms Program database, MoHCW	425	900 HWs (district-level)	900 HWs (district-level)	900	900
1.1.4	Number of male and female condoms distributed	78,624,344 Male	Condoms Program database, MoHCW	81,800,000 Male	85,100,000 Male	88,500,000 Male	92,000,000 Male	95,700,000 Male
		4,612,681 Female	Condoms Program database, MoHCW	4,890,000 Female	5,180,000 Female	5,490,000 Female	5,820,000 Female	6,170,000 Female

<u>Output 1.1.5:</u> Increased availability of evidence- informed social behaviour change communication reaching at least 80 % of the population annually and enhance high quality school based life skills HIV and AIDS education.

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. A similar decline was reported among pregnant women aged 15-49 in which HIV prevalence declined from 17.7 % in 2006 to 16.1% in 2009 (p <0.001). An analysis of the evidence attributed the decline in HIV to fundamental changes in behaviour suggesting that efforts to implement Zimbabwe's national behaviour change programme (NBCP) which has been rolled out to all 62 districts of the country (initially in 26 districts only) may have begun to pay off. Under this strategic plan, it is proposed that a mechanism for coordinating SBCC interventions be put in place to ensure they have sustained impact by targeting the following priority populations: men and women in stable relationships, Commercial Sex Workers, Uniformed Forces, Men having sex with Men, mobile populations; young people in 15-24 age group and young men age 15-29.

Priority Strategies

1. **Develop and disseminate a national SBCC policy and plan**

To improve coordination of SBCC interventions, a national SBCC policy and plan addressing key determinants of HIV will be developed and disseminated to all key actors. The plan will guide the design, dissemination and implementation of communication activities. Key interventions will include use of print and electronic media, peer education, community drama, life skills education for in and out of school youth, use of outdoor advertising including posters and bill boards. SBCC interventions will be implemented at community level, work places, schools, tertiary institutions as part of the public and private sector, FBOs, traditional leaders and CBOs HIV programme interventions.

Table 11: SBCC Output Indicators and Targets

Result no.	Indicator			Targets				
		Baseline	Source and Year	2011	2012	2013	2014	2015
1.1.5a	Number of persons 15-49 reached through interpersonal communication (person exposures)	4,434,290	B C & ESP report coverage 2010	4,480,000	5,220,000	5,480,000	5,620,000	5,820,000
1.1.5b	Percentage of people aged 15-49 reached through mass media	50%	B C & PSI, ESP report coverage 2010	60%	70%	75%	75%	75%
1.1.5c	Number of girls and boys reached through HIV and AIDS life-skills education	No data	Programme Data NAC and Ministry of education	2,100,000	3,300,000	3,300,000	3,300,000	3,300,000
1.1.5d	Number of service delivery points for key affected populations increased by 50 %	16	UNFPA sex work report	16	18	24	24	24

Sexually Transmitted Infections (STIs)

Results of a review conducted in Zimbabwe on the STI programme in 2007 showed that all the 10 provinces conduct health education and promotion programmes on STIs. Key strategies that have been utilized in STI prevention and management include condom distribution and promotion, as well as encouraging early treatment of STIs and strong referral linkages to the HTC, TB, PMTCT and ART services. Policy and case management guidelines have been developed and disseminated throughout the country (STI guidelines were revised in 2007 flowcharts printed and distributed; and the curricula was reviewed and expanded to include other HIV prevention). 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 which cause genital ulcer disease. ANC sentinel surveillance report of 2009 showed that women with current or past genital ulcer disease (GUD) had a higher HIV prevalence nearly three times than those without a history of GUD. Among young ANCs attendees age 15-24; those with GUD had a HIV prevalence of 31%.

<u>Output 1.1.6:</u> Women and men treated for STI increased from 204,819 to 290,000 by 2015

Although there has been an increase in the number of men and women seeking treatment for STIs, efforts need to be intensified to ensure that effective diagnosis and management of STIs is strengthened to reduce the risk of acquiring HIV infection through untreated STI. To enhance health seeking behaviour among patients seeking treatment for STI partner contact tracing needs to be strengthened.

Priority Strategies

1. **Create demand for STI services through awareness creation and community mobilisation**

Awareness on STI treatment will be targeted at the youth and most at risk populations. These awareness interventions will seek to provide information on prevention of STIs, appropriate health seeking behaviour to promote early detection and treatment of STIs and generate demand for STI services.

2. **Improve the capacity of health facilities to provide STI management services according to national guidelines**

Two gaps that were identified that affect effective management of STIs are: frequent stock outs of key STI drugs and lack of training of some health providers in STIs management. To reduce HIV transmission through STIs the capacitation of health providers is vital. This will be achieved through training of health personnel on the national guidelines for treatment and syndromic management of STIs, strengthening procurement and supply of test kits and drugs to the health facilities and improving supervision to ensure quality of service provided.

3. **Improve STI surveillance**

In order to improve effective and efficient management of STIs, surveillance systems will be put in place to inform patient management and care. Data collection and reporting on STIs will continue to be maintained in order to track implementation of the STI interventions effectively.

Table 12: STI Output Indicators and Targets

Result No.	Indicator	Baseline	Source and Year	Targets				
				2011	2012	2013	2014	2015
1.1.6	Women and men treated for STI increased from 204,819 to 290,000 by 2015	204,819	M & E report MoHCW	250,000	320,000	320,000	290,000	290,000

Prevention of Mother to Child Transmission (PMTCT)

OUTCOME 1.2: Mother to Child Transmission of HIV reduced from 30% to 5% by 2015

In Zimbabwe, the rate of mother to child transmission (MTCT) of HIV was estimated at 30% in 2010 (based on EPP modelling) thus contributing a significant proportion of new HIV infections in the country. To reduce vertical transmission of HIV, ZNASP II has set a target of less than 5% by 2015 which is in line with a move towards the global target of universal elimination of MTCT of HIV. An opportunity for expanding PMTCT services to achieve the set target will be provided through strategies that encourage a high rate of ANC attendance among pregnant women in Zimbabwe.

Table 13: PMTCT Outcome Indicator and Targets

Result No.	Indicator	Baseline	Source and Year	Target	
				2013	2015
1.2	% of Infants born to HIV-infected mothers who are HIV positive	30%	PMTCT Annual Report (2009)	10%	Less than 5%

Output 1.2.1: Increase the number of pregnant women attending ANC annually from 270,527 to 552,788 by 2015

Based on current evidence as captured in the output above, close to half (49.0%) pregnant women attend ANC annually. In view of the universal target of eliminating vertical transmission of HIV among pregnant women, ANC sites including labour wards and post natal care will need to be refurbished. Furthermore, ANC sites will need to be equipped with trained health staff and commodities to conduct HTC. A comprehensive standardised package of PMTCT services should be defined and the package should be inclusive of HTC; counselling and support on family planning, maternal nutrition, infant & young child feeding; ART eligibility assessment and provision of ARVs for PMTCT; ARVs for exposed infants; Cotrimoxazole for mothers and babies; and Early Infant Diagnosis (EID) of HIV.

Priority Strategies

1. **Increasing awareness of and generating demand for HTC services among communities with specific targeting of women in reproductive age and their partners**

This strategy seeks to scale up demand for PMTCT services. Provision to communities, families and individuals of quality, up to date information related to vertical transmission of HIV and PMTCT strategies, including exclusive breastfeeding is vital to reducing mother to child transmission. It is imperative that culturally appropriate, gender- and age-specific social and behaviour change communication interventions that encourage uptake of SRH/family planning, ANC, HTC and PMTCT services are designed. The strategy will, therefore, prioritise women in reproductive age and their partners in both urban and rural areas, to increase awareness of HTC and PMTCT and generate demand for both services. To support increasing access to HTC by women in the reproductive age and their partners as well as increasing access to PMTCT, key avenues that will be used to create awareness will be community systems, civil society including NGOs and CBOs, faith based organisations and community leaders. Male champions will also be trained as peer fathers to advocate and raise awareness on PMTCT at community level. There is evidence to suggest that HIV related stigma impedes the utilization of PMTCT services in Zimbabwe. The interventions will also address HIV related stigma in the community and health care settings. The interventions to be implemented include media and community based awareness campaigns on HTC including couple testing and counselling and promotion of male involvement in PMTCT.

2. **Integrating PMTCT and Sexual and Reproductive Health (SRH) including FP services**

Studies conducted in Zimbabwe have shown that HIV positive women are more likely than HIV negative women (63% vs 42.4% respectively, p<.001) to not want any more children. Therefore, the need to integrate PMTCT and Sexual and Reproductive Health (SRH) becomes paramount. This approach ensures wider access to both services as the clientele for both services is the same: women in reproductive age and their partners. Emphasis will be placed on ensuring FP services are available to women and their partners who want to plan their families and on preventing unintended pregnancies among women living with HIV, preventing HIV transmission from a woman living with HIV to her infant, and providing appropriate treatment, care and support to mothers living with HIV and their children and families.

<u>Output 1.2.2:</u> Increase the number of pregnant women attending ANC, counselled and tested for HIV annually from 233,568 to 525,249 by 2015

Currently, not all ANC sites provide HTC. This strategic plan aims to increase the number of women who will attend ANC. It is envisaged that an increase in ANC attendance will also increase the demand for HTC. Hence the need to ensure availability of adequate staff trained

on HTC in health facilities and provision of commodities to conduct HTC. There is need to define a standardised package of PMTCT services that should be inclusive of HTC; counselling and support on family planning, maternal nutrition, infant & young child feeding; ART eligibility assessment and provision of ARVs for PMTCT; ARVs for exposed infants; Cotrimoxazole for mothers and babies; and Early Infant Diagnosis (EID) of HIV.

Priority Strategy

1. **Strengthening Provider Initiated Testing and Counselling (PITC) for HIV at ANC**

This strategy will address the supply side of PMTCT services. The increase in the proportion of pregnant women tested and counselled for HIV will require that most of the ANC sites provide HTC services. A PITC approach will be adopted to increase this coverage. Sites offering this critical intervention have been on the increase with 1 560 reportedly offering ante-natal care services, of which 60% offered both on-site HIV testing and ARVs for prophylaxis while the remaining 520 offered ARVs for PMTCT but not on-site HIV testing. Very few of the facilities offering PMTCT services were also implementing the more efficacious regimen (MER) which is more effective in averting infections- only 8 out 62 districts offer the MER. This strategy aims at ensuring that all health facilities in the country (1560) offer PITC services, ARVs for PMTCT and MER. This will be strengthened through increasing the number of health facilities providing PMTCT; training of health staff (midwives and other cadre of staff) in HIV testing and counselling; and improving the supply and logistics management for the supply of HIV test kits and other commodities to the ANC sites.

<u>Output 1.2.3:</u> Increase the number of pregnant women who are HIV positive receiving ARV prophylaxis from 29,692 to 40,508

Evidence from the Zimbabwe cascade model noted that the percentage of pregnant women who were counselled and tested was 83.0%. The percentage who tested positive and proceeded to get ARVS PMTCT prophylaxis was 82.0%. The increase in the number of pregnant women tested and counselled for HIV will lead to a high detection rate of pregnant women in need of ARVs for PMTCT. Zimbabwe aims at ensuring that 95% of the detected HIV positive pregnant women are provided with ART. To achieve this target, PMTCT sites will be supplied with ARVs for PMTCT and support of ANC sites that have limited capacity to provide this service will be assessed and strengthened.

Priority Strategies

1. **Strengthen the supply and logistics management for ARV drugs to PMTCT sites**

The increase in coverage of pregnant women on ARVs for PMTCT will require an increase in the supply of drugs to PMTCT sites. The logistics and supply management system will be improved to ensure no stock-outs.

2. **Strengthen referral system from PMTCT to ART sites**

The referral system for pregnant HIV positive women to ART sites will also increase access to ART for PMTCT. The referral system will be strengthened for the ANC sites that have limited capacity to provide ART for PMTCT. The referral system will also be established for blood samples for CD4 testing and viral load to improve the quality of PMTCT services.

3. **Scale up laboratories with CD4 machines**

To ensure availability and accessibility of ARVs for PMTCT for pregnant mothers who need the service the decentralised approach to service provision will be accelerated. District level laboratories will be equipped with CD4 machines to support the provision of quality ART services to pregnant women. Support will also be provided to PMTCT sites (who do not have laboratory services to ensure effective referral system for blood samples for CD4 testing in the selected laboratories).

<u>Output 1.2.4:</u> Increase the number of HIV exposed infants receiving ARV prophylaxis from 23,042 to 40,507 by 2015

Based on the cascade model, evidence shows that while ARV PMTCT prophylaxis among pregnant women was 82.0%, ARV prophylaxis for infants remained suboptimal at 58.0%. This strategy seeks to increase the proportion of infants on Cotrimoxazole prophylaxis. The strategy aims at scaling up the proportion of infants receiving ARV prophylaxis to more than 95% by 2015.

Priority Strategies

1. **Strengthen male involvement in PMTCT services and improve retention of mother-infant pairs within PMTCT services**

Parallel activities targeting men will be strengthened. PMTCT mentor mothers and support groups will be capacitated through training and small incentives.

2. **Strengthen Provider Initiated Testing and Counselling (PITC) for children at service delivery points (SDPs) through training of health staff and providing ARV drugs**

The health staff at the PMTCT sites will be trained to undertake HIV testing and counselling for children and IMAI/IMPAC. The staff will also link with community workers to ensure effective follow up on women with newborns. The monitoring system will also be improved to ensure effective data collection and reporting on children tested for HIV and those put on ART. ARVs for prophylaxis for infants born of HIV infected women will be procured in sufficient quantities.

<u>Output 1.2.5:</u> Increase the number of 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

Male involvement in PMTCT has been identified as a barrier to uptake of this intervention. To reduce mother to child transmission and encourage shared responsibility among couples, the aim of this strategy is to increase the proportion of pregnant women whose male partner takes an HIV test in the last 12 months from 8% in 2010 to 30% in 2015.

Priority Strategy

1. **Strengthen PMTCT Awareness among Men**

Awareness and advocacy campaigns targeting men in the reproductive age group, traditional, religious leaders and policy makers will be conducted through civil society, FBOs, CBOs and NGOs. Programmatic interventions will be informed by operations research. Male champions will be trained as peer fathers to increase male engagement for PMTCT.

Table 14: PMTCT Output Indicators and Targets

Result no.	Indicator			Targets				
		Baseline	Source	2011	2012	2013	2014	2015
1.2.1	Number of pregnant women attending ANC	270,527	PMTCT annual report (MoHCW) 2009	420,083	484,880	525,126	538,779	552,788
1.2.2	Number of pregnant women attending ANC tested for HIV and received results	235,568	PMTCT annual report (MoHCW) 2009	442,193	399,079	460,636	498,870	525,249
1.2.3	Number of HIV positive pregnant women who are receiving ARV prophylaxis	29,692	PMTCT annual report (MoHCW) 2009	41,061	42,062	41,221	40,631	40,508
1.2.4	Number of HIV exposed infants who receive ARVs for prophylaxis	23,042	PMTCT annual report (MoHCW) 2009	38,780	39,848	41,221	40,631	40,507
1.2.5	Number of male partners tested for HIV in the last 12 months at the ANC	27,285	PMTCT annual report (MoHCW) 2009	42,008	72,732	105,025	134,695	165,836

Male Circumcision (MC)

<u>OUTCOME 1.3:</u> Increase the number of males age 15-29 years circumcised from 10% to 80% by 2015

A national MC policy was developed and disseminated in November 2009. In order to develop a knowledge base to further inform the development of a MC strategy and implementation plan and to provide detailed costing data, five learning sites were also established. A strategy covering the period 2010-2015 was developed in early 2010 whose goal is to reduce HIV incidence by 25%-35% through circumcising 80% of 15-29 year old HIV negative men by 2015

(1.2 million men). At the end of September 2010, 11,102 men had been circumcised[22]. ZNASP II will focus on scaling up demand and access to MC services. Males age 15-29 years will be targeted for male circumcision in the next five years in order for MC to have impact on the incidence of HIV in Zimbabwe.

Table 15: MC Outcome Indicator and Targets

Result No.	Indicator	Baseline	Source and Year	Target	
				2013	2015
1.3	Percentage of men 15-29 years circumcised	**10%**	ZDHS 2005/06	50%	80%

<u>Output 1.3.1:</u> Increased access to Male Circumcision

Based on lessons learnt in the previous pilot phase of MC, services will be scaled up to cover the whole country. MC services will be offered through static and mobile outreach sites to increase accessibility of services to all communities.

Priority Strategy

1. **Strengthen health delivery system to provide medical MC and decentralise MC services**

Training of health workers will be intensified to mainstream MC in the health delivery system with consideration on task shifting. To cater for increased demand for MC and promote efficiency, there will be strengthening of logistics and supply management of MC consumables. Services will be offered at district level of health care to ensure increased access to services. Health facilities will be assessed for preparedness to offer quality MC. Regular site visits will be conducted to ensure that facilities abide to the set standards.

<u>Output 1.3.2:</u> Increase demand of male circumcision as an HIV prevention strategy among women and men

Zimbabwe is a non circumcising country with 10% of the male population being circumcised for mainly traditional and religious reasons according to the ZDHS 2005-6.

Priority Strategies

1. **Increased awareness for MC.**

ZNASP II aims at increasing awareness and education on MC through multi-media channels targeting men, women, boys and girls on MC benefits as an HIV prevention strategy. The strategy will also address myths and misconceptions surrounding MC. Intensive training of service providers and key community leaders will be conducted so that they become advocates for MC.

2. Information dissemination

Standard information packages will be developed and distributed to lower levels to increase access to information on MC. Regular reviews on community perception on MC will be conducted to determine community attitudes towards MC and inform nature of MC information distributed. There will be maximum utilisation of community based workers through interpersonal communication mechanisms.

Table 16: MC Outputs and Targets

Result no.	Indicator			Targets				
		Baseline	Source and Year	2011	2012	2013	2014	2015
1.3.1	Percentage of men and women reporting being aware of MC as an HIV prevention strategy	10%	NAC/MOH&CW Baseline Study	20%	30%	60%	70%	90%
1.3.2	Number of males circumcised	23,244	MC data, MOHCW 2010	1,553,875 (25%)	3,107,750 (50%)	3,729,300 (60%)	4,350,850 (70%)	4,972,400 (80%)

Bloody Safety

<u>OUTCOME 1.4:</u> Transmission of HIV through blood products, exposure to occupational hazards and defilement reduced

Zimbabwe has attained 100% blood safety. All blood used in Zimbabwe is provided by the National Blood Services of Zimbabwe (NBSZ), an independent private registered non-profit organization. The NBSZ is a WHO collaborating centre for blood safety in Southern Africa. However, it has been observed that uptake of post donation counselling has been low as only 15% of donors came back to obtain their results and post donation counselling in 2008. In addition the voluntary blood donor system has not been able to collect a sufficient quantity of blood units to meet demand for safe blood and overall blood collections have been on the decline: In 2009, 42,000 units were collected, compared to 80,000 units in 2000. The outcomes, outputs, and strategies and broad activities detailed below will ensure that blood transfusion transmissible infections including HIV remain at nil % thus contributing to the overall impact of reducing new HIV infections by half by 2015.The current Blood Transfusion Policy seeks to instil efficiency in donor education, recruitment, selection and retention; blood collection, laboratory testing, component preparation, storage and distribution. The policy also emphasizes quality assurance in clinical transfusion practices and adherence to code of ethics.

Table 17: Blood Safety Outcome Indicator and Targets

Result No.	Indicator	Baseline	Source and Year	Target				
				2011	2012	2013	2014	2015
1.4	% of donated blood units screened for HIV in a quality assured manner	100%	NBTS data base 2010	100%	100%	100%	100%	100%

Output 1.4.1: 100% of blood Units screened for HIV

The virtual elimination of blood transfusion transmissible HIV infection will be facilitated by ensuring that all donated blood is screened for HIV antibodies and other transmissible blood borne viruses and bacteria. This will ensure health facilities obtain blood products that are safe for transfusion from NSBZ. Quality assurance and quality improvement systems will be maintained to minimize transfusing blood already infected with HIV and maintain transmission through blood products at zero percent.

Priority Strategies

1. **Increase availability of safe blood and blood products**

The decrease in the number of blood units collected in 2009 needs remedial action to boost blood products supply. To ensure that adequate safe blood products supplies, the ZNBS will procure vans and equip them for the voluntary blood donation outreach activities. Awareness campaigns targeting the general population particularly young population in schools will be conducted to promote voluntary blood donation.

2. **Strengthen and expand capacity of NSBZ to screen blood and blood products to ensure 100% blood safety**

The capacity of the NSBZ to provide safe blood and blood products will be improved through modernizing laboratory services, establishing quality management systems and improving quality of clinical transfusion practices. Provincial blood collection centres will be set up and equipped. Laboratory and clinical staff will be trained in all aspects of blood collection, storage, testing and utilization. Blood safety policies will be reviewed to ensure that procedures meet international standards and address emerging viruses and bacteria.

3. **Ensure availability of screened blood at all health facilities that carry out blood transfusion**

To ensure availability of screened blood at all facilities HIV test kits will be procured for screening all blood units. The storage and distribution system of the NSBZ will be improved and cold storage facilities for blood will be installed in all hospitals that provide blood transfusion services. Quality assurance and quality control systems for blood safety will be improved. This

will ensure safe blood is available in all public and private hospitals that provide blood transfusion services.

Post Exposure Prophylaxis

In line with universal precautions to minimise risk of HIV transmission through occupational incidents rape and defilement cases, post Exposure Prophylaxis (PEP) is offered in the health sector. Within health settings PEP in exposed persons consists of counselling and risk assessment, HIV testing and counselling, short term ARV depending on the assessed risk and provision of ARV with support and follow up. ART sites are equipped to provide PEP services. To effectively contribute towards the impact of reducing new HIV infections, PEP would need to be scaled-up. ZNASP II seeks to improve access to PEP in order to reduce HIV transmission through occupational incidents, rape and defilement. To achieve the overall impact of reducing new HIV infections, the strategy proposes implementation of a number of strategies.

Output 1.4.2: The percentage of health facilities providing post exposure prophylaxis (PEP) increased from 7.8% (122) to 100% (1560) by 2015

PEP is short term antiretroviral therapy to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. A national policy as well as guidelines for its application and use was developed in 2007. PEP is offered in the health sector for occupational incidents, rape and defilement cases. PEP for health care settings consists of a comprehensive set of services to prevent infection developing in an exposed person including counselling and risk assessment, HIV testing and counselling, short term ARV depending on the assessed risk and provision of ARV with support and follow up. Results from pilots undertaken at a number of learning sites in Zimbabwe show that in 2008, 66% of health workers who reported a work related injury received PEP, while 69% of them completed treatment.

Priority Strategies

1. **Strengthen and expand provision of PEP to all health facilities**

The scale up of PEP is essential to prevent HIV transmission from occupational incidents, rape and defilement cases. To ensure availability and accessibility of PEP in all health facilities health personnel working in PMTCT and ART units will need to be capacitated through training and provision of adequate supplies of drugs for PEP and integrating PEP into the reporting system for ART and PMTCT. Universal precaution for infection prevention will be taught to all health workers.

2. **Develop and implement communication plan to generate awareness of PEP among the general population**

Awareness on the significance and availability of PEP services will target police officers, and the community and this will be raised through collaboration between health facilities and civil society organisations to enable rape survivors to seek this service on time.

3. **Training staff from key sectors including judiciary and police on PEP in rape cases**

The police and judiciary officers, police officers will be trained on PEP to enable them to play a key role in referring rape and defilement survivors that are in need of this service.

Table 18: PEP Output Indicators and Targets

Results no.	Indicator	Baseline	Source and year	Targets				
				2011	2012	2013	2014	2015
1.4.2	Health facilities providing post exposure prophylaxis (PEP) increased from 7.8% (122) to 100% (1560) by 2015	122 7.8%	M &E data, MOHCW 2010	25%	50%	70%	90%	90%

4.2.2: HIV Treatment, Care and Support

<u>OUTCOME 2.1:</u> The percentage of PLHIV eligible for ART who are on ART increased from 59% among adults and 31.5% among children in 2010 to 85% for all by 2015

Zimbabwe intends to achieve the universal access target for treatment, care and support by increasing the number of eligible PLHIV on ART from the current 31.5% and 59% in children and adults respectively to 85% in both by 2015. This will entail expansion of ART services which will result in an increase of PLHIV on ART from 326,241 in 2010 to 539,916 by 2015.

Table 19: HIV Treatment, Care and Support Outcome Indicators and Targets

Result no.	Indicator	Baseline	Source and year	Target				
				2011	2012	2013	2014	2015
2.1a	Number / percentage of Adults LHIV on who are ART	298,092 (59%)	M &E reports (2010)	71%	77%	81%	84%	85%
2.1b	Number / percentage of Children LHIV who are on ART	28,149 (31.5%)	M &E reports (2010)	43%	52%	63%	72%	85%
2.1c	Percentage of TB patients LHIV who are on ART	30%	NTP Database, MoHCW (2009)	45%	55%	65%	75%	85%

<u>Output 2.1.1:</u> Number of PLHIV on ART increased from 326,241 in 2010 to 539,916 by 2015

Available evidence shows that despite the increase in the number of PLHIV accessing the life saving drugs since the ART roll out began in 2004, demand outstrips supply as half of all eligible adults and two thirds of children are still not on treatment. This strategy aims at increasing the number of patients on ART from 326,241 in 2010 to 539,916 by 2015.

Priority Strategies

1. Procurement and supply of ARVs.

Procurement and supply of 1st line and 2nd line ARVs for adults and children will be implemented as per requirements and targets set by the National ART programme. Procurement and supply guidelines will be adhered to.

2. Strengthen coordination of national level efforts for TB/HIV collaborative activities.

HIV testing and counselling will be provided to TB patients as planned. Efforts will be made to screen PLHIV for TB and vice verse. To further strengthen activities, TB/HIV collaborative meetings will be conducted at National, Provincial and District levels. This will be complimented with joint support & supervision for HIV and TB programmes at all levels by national, provincial and district teams. Joint trainings for HIV and TB will be held at all levels (integrated into the basic HIV and AIDS management curriculum).

3. Strengthen human resource development for ART in the context of overall health workforce development.

Training for nurse tutors will be conducted using the revised HIV curriculum. Basic Integrated HIV & AIDS curricular (IMAI, IMCI, IMPAC, TB/HIV and nutrition) will be developed, printed and implemented for training of primary level health workers, while, an advanced HIV and AIDS management curriculum will be developed for health workers at secondary level health facilities. Additional district multidisciplinary clinical mentoring teams to provide mentorship on integrated HTC, PMTCT, Pre-ART, ART, TB/HIV and Nutrition will be established. Clinical attachment SOPs will also be printed and distributed.

4. Improve treatment retention and drug adherence among adults and children on ART

TV and Radio spots promoting treatment literacy and treatment adherence will be developed. These will be broadcast regularly on the national TV and radio. Adherence monitoring of all patients on ART for both adults and children will be intensified at ART sites through counselling and psychosocial support. Peer support systems will be established and strengthened through PLHIV support networks and groups.

5. Strengthen mechanisms for quality assurance and improvement of ART services

To further enhance mechanisms for quality assurance and improvement of ART services, quarterly integrated Clinical Mentorship and Quality Improvement (QI) Steering Committee meetings will be conducted. In addition, QI monitoring activities will be rolled out to selected sites.

Table 20: PLHIV on ART Output Indicators and Targets

Result no.	Indicator			Targets				
		Baseline	Source and Year	2011	2012	2013	2014	2015
2.1.1a	Number of Adults on ART	298,092	M &E Reports, 2010	360,000	400,000	430,000	455,000	472,227
2.1.1b	Number of Children on ART	28,149	M &E Reports, 2010	37,000	44,000	51,000	58,000	67,689
2.1.1c	Number of TB patients LHIV who are initiated on ART	8,658	M &E Reports, 2009	14,112	17,952	21,996	26,505	30,654

<u>Output 2.1.2:</u> Increase the number of sites offering ART Services from 530 in 2010 to 1560 by 2015.

Barriers to ART access identified during the situational analysis include: inaccessibility of ART services in rural areas due to transport costs, long distance and long waiting time at ART treatment centres for women and men; policy and regulatory framework that allows only doctors to prescribe ART and yet there is an acknowledged shortage of doctors in the country. To increase availability and accessibility of ART services ZNASP II seeks to scale up ART sites from 530 in 2010 to 1,560 by 2015.

Priority Strategy

1. Expand access and availability of ART services

New sites will be assessed using set criteria to determine readiness for ART services (adults and children). In addition, outreach activities for comprehensive HIV services including HTC, PMTCT, OI/ART, TB/HIV and Nutrition HIV will be conducted.

Table 21: Access and Availability of ART Services Output Indicator and Targets

Result no.	Indicator			Targets				
		Baseline	Source and Year	2011	2012	2013	2014	2015
2.1.2	Number of sites offering ART Services	530	M &E Reports, 2010	650	811	980	1248	1560

<u>OUTCOME 2.2:</u> Improved Survival for PLHIV on ART to 85% by 2015.

It is estimated that annual AIDS deaths decreased from 123,000 in 2006 to 84,000 at the end of 2009. Reduction in AIDS related mortality could be attributed to the ART programme despite evidence showing that a large percentage of ART patients are dropping out of treatment programmes in selected sites. The percentage of adults and children with HIV known to be on treatment at 12 months and 24 months after initiation of ART was 75% and 69% respectively in two Cohort Analysis studies carried out. Mechanisms for tracing loss to follow up will be put in place to ensure accurate statistics are reported on mortality ZNASP II 2011-2015 plans to enhance clinical and laboratory monitoring in order to improve survival outcomes for PLHIV on ART.

Table 22: PLHIV Survival Outcome Indicators and Targets

Result no.	Indicator	Baseline	Source and Year	Target				
				2011	2012	2013	2014	2015

2.2a	Percentage of adults and children known to be alive and on treatment 12 months after initiation of ART	75%	2007 Cohort Analysis	77%	79%	81%	83%	85%
2.2b	Percentage of adults and children known to be alive and on treatment 24 months after initiation of ART	69%	January 2008 Cohort Analysis	72%	74%	76%	78%	80%

Output 2.2.1: Capacity of laboratories to provide ART related services strengthened

Diagnostic services are a key component of ART delivery and critical to patient management and quality of care. Inadequate laboratory services (especially CD4 machines) to monitor clients on OI/AR and viral load testing at public health sector compromises the quality of care. To improve patient management and quality of care this strategy aims at strengthening the capacity of laboratories and related services.

Priority Strategies

1. Strengthen and expand diagnostic services for adults and children on ART.

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 will be procured and distributed based on needs.

2. Strengthen mechanisms for quality assurance and improvement of ART service.

Efforts to ensure that laboratories are registered and participating in an external quality control program, ZINQAP will be mandated to with the coordination of this task. Registration and participation in external quality control programs that involve supranational laboratories (regionally or other continents) will be sought for relevant tests.

3. Improve electrical power and water backup systems for minimal test interruption at all laboratories.

Electricity and water backup systems will be established at all sites based on requirements. Support generators will be procured and supplied as back up for continuity in laboratory services.

Table 23: Capacity of laboratories to provide ART Output Indicators and Targets

Result no.	Indicator			Targets				
		Baseline	Source and Year	2011	2012	2013	2014	2015
2.2.1a	Number of labs whose capacity strengthened	180	Lab Services Database, 2010	180	190	200	210	220
2.2.1b	Number of labs with capacity to run CD4 cell counts	74	Lab Services Database, 2010	85	95	105	115	126

Result no.	Indicator			Targets				
		Baseline	Source and Year	2011	2012	2013	2014	2015
2.2.1c	Number of Health facilities with capacity to run POC CD4 cell counts	10	Lab Services Database, 2010	105	179	252	325	400
2.2.1d	Number of labs with capacity to conduct viral load testing	1	Lab Services Database, 2010	4	7	10	12	12
2.2.1e	Number of labs with capacity to conduct biochemistry testing	44	Lab Services Database, 2010	61	78	94	110	126
2.2.1f	Number of labs with capacity to conduct microbiological testing for opportunistic infections	33	Lab Services Database, 2010	42	51	60	69	76
2.2.1g	Number of laboratories that are registered and participating in external quality assurance program	170	Lab Services Database, 2010	180	190	200	210	220

Output 2.2.2: Procurement and supply of ARVs, OI drugs and commodities improved

The increase in number of patients on ART will need to be matched with corresponding procurement and continued supply of ARVs, OIs and other commodities in sufficient quantities. ZNASP II seeks to ensure procurement of sufficient supply of ARVs, OIs and other commodities to match the increase/demand and avoid stock outs at all levels.

Priority Strategies

1. Harmonize distribution of HIV and AIDS commodities

This strategy will require a harmonized HIV AND AIDS commodities distribution system, coordination and management committee to be established and quarterly stakeholders meetings to be conducted.

2. Strengthen Supply Chain Management of HIV and AIDS commodities.

Standard operating procedures (SOPs) will be established for the harmonised HIV and AIDS ordering and distribution systems ('Push' and ' Pull' systems) which will be reviewed as per requirements. In addition, central and site level stock Audits will be conducted. Health professionals will be trained on HIV and AIDS ordering and distribution system SOPs.

3. Strengthen Decentralized distribution of ARVs and other HIV and AIDS related commodities. Decentralized storage & 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.

Table 24: Procurement and supply Output Indicators and Targets

Result no.	Indicator			Targets				
		Baseline	Source	2011	2012	2013	2014	2015
2.2.2	Percentage of health facilities dispensing ARV medicines that have experienced a stock out of at least one ARV in the last 12 months	12 (2%)	LMIS Reports, 2010	1%	0%	0%	0%	0%

Output 2.2.3: Pharmacovigilance system for ART Programme strengthened

Available evidence shows that Pharmacovigilance of ART and OI drugs has not been fully implemented by Medicines Control Authority of Zimbabwe (MCAZ) due to financial constraints, and yet this is critical to patient management as adverse effects can be detected early and addressed swiftly especially in the treatment of HIV disease. In ZNASP II pharmacovigilance system will be strengthened.

Priority Strategy

1. **Strengthen and expand pharmacovigilance of ARVs, Anti-TBs and other OI drugs in adults and children including PMTCT.**

A stakeholder consultative meeting will be held to develop pharmacovigilance M & E tools which will be printed and distributed. TOT training for 20 pilot sites will be conducted. M & E support and supervision site visits will be conducted quarterly. WHO CemFlow software for monitoring drug resistance will be installed and maintained.

Table 25: Pharmacovigilance system for ART Programme Output Indicator and Targets

Result no.	Indicator			Targets				
		Baseline	Source	2011	2012	2013	2014	2015
2.2.3	Number of patients(adults & children) on ART monitored for adverse events for a period of 12 months	0	MCAZ Database, 2010	5,000	10,000	15,000	15,000	20,000

OUTCOME 2.3: Improved nutritional status of adults and children LHIV by 50% by 2015

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 OIs and to optimise benefits of antiretroviral therapy. Several programmes have reported high mortality in the first 90 days of ART treatment correlated strongly with low body mass index (BMI<16).

Table 26: Nutritional status of Adults and Children LHIV Outcome Indicators and Targets

Result no.	Indicator	Baseline	Year and Source	Target	
				2013	2015
2.3a	Percent of malnourished adults LHIV	20%	MoHCW/MSF, 2011	15%	10%
2.3b	Percent of malnourished children LHIV	60%	2010, MoHCW CMAM routine data	40%	20%

Output 2.3.1: Increase eligible malnourished PLHIV (adults and children) receiving therapeutic or supplementary food from 41,742 to 65,000 by 2015

Adequate nutrition is vital in the management of HIV disease in order to boost the immune system and in the case of those patients taking ARVs for effective drug absorption. Adequate nutrition also minimises side effects of ARVs which have reportedly been observed to be severe if patients take ART on an empty stomach. Therefore, this strategy seeks to increase eligible malnourished PLHIV (both adults and children) receiving therapeutic supplementary feeding to enhance immune system restoration and drug absorption.

Priority Strategies

1. Strengthen coordination of national level efforts to address nutrition among PLHIV

This will be done through mainstreaming nutrition activities into HIV programming at National, Provincial and District level through quarterly meetings. A needs assessment for the Nutrition/HIV collaborative activities will be conducted to identify gaps in programming. An integrated national nutritional plan will be informed by the results, developed and implemented.

2. Strengthen health sector capacity to address nutrition among PLHIV

Nutrition Care and Support for PLHIV manuals and guidelines for facilitators and participants will be reviewed, printed and distributed. Health workers and facilitators will be trained in Nutrition Care and Support for PLHIV. Job aids and posters in nutrition assessment and counselling for TB and HIV infected patients and infant feeding counselling will be printed and distributed to all health facilities as per requirements.

3. Strengthen monitoring and evaluation systems for nutrition programming

This strategy will be implemented through the integration of nutrition indicators into the national HIV and AIDS monitoring and evaluation system.

4. Improve procurement and supply chain management systems for nutrition programming

Equipment for assessing and monitoring malnutrition will be procured. To address severe malnutrition in PLHIV, cartons of Ready to use therapeutic foods (RUTF) will be procured annually.

Table 27: Nutritional status of Adults and Children LHIV Output Indicator and Targets

Result no.	Indicator	Baseline	Year and Source	Target				
				2011	2012	2013	2014	2015
2.3.1	Number of PLHIV receiving nutritional or therapeutic supplements	41,742	Nutrition Programme Database, MoHCW/WFP (2010/11)	45,000	50,000	55,000	60,000	65,000

<u>OUTCOME 2.4:</u> Increased number of PLHIV receiving CHBC services from 48% in 2010 to 85% by 2015

Community home based care (CHBC) services provided in Zimbabwe over the past 5 years have comprised of a broad range of activities for HIV-infected and affected individuals that include: palliative care, psychosocial and social support, spiritual and preventive services to increase retention in care, maximize functional ability, and minimize morbidity but issues of ART in CHBC have been excluded. ZNASP II strategic plan will focus on ensuring the program is linked to the ART, TB/HIV, nutrition/HIV programs and other community based programs.

Table 28: PLHIV receiving CHBC Services Outcome Indicator and Targets

Result no.	Indicator	Baseline	Year and Source	Target				
				2011	2012	2013	2014	2015
2.4	Percentage of clients accessing minimum standard CHBC services	48%	GF R5 Evaluation (2010)	56%	64%	72%	80%	85%

<u>Output 2.4.1:</u> Increase the number of PLHIV receiving CHBC services such as psychosocial and treatment support from 112,244 in 2010 to 269,958 in 2015

As ART is scaled up and mortality and morbidity among PLHIV decreases, it is envisaged that the number of PLHIV who need hospice care will also be on the decline but psychosocial support will continue to be given in treatment adherence. Therefore ZNASP seeks to increase the number of PLHIV receiving psychosocial support from 112, 244 to 269,958.

Priority Strategies

1. Strengthen capacity of service providers to provide quality and appropriate community and home based care and support for adults and children living with HIV and AIDS

In order to increase the number of PLHIV accessing CHBC services, grants will be offered to additional community based organizations in all districts of the country to provide appropriate services to PLHIV in need. The CHBC Training Package will be revised to reflect the care and support needs in the era of adult and paediatric HIV treatment. The training package will be disseminated through the training of health workers and community level workers working in the different CHBC implementing organizations throughout the country so that they can provide the appropriate services. Advocacy for community leaders to support clients in the CHBC programme who are on ART will be strengthened.

2. Improve and strengthen procurement, logistics and distribution systems for community home based care and support

A system of procurement and distribution of CHBC supplies to all districts of the country will be established and maintained. The number of CHBC kits must be kept at an optimum level allowing all clients to have sufficient supplies as the pool of clients on CHBC will vary based on need. Motorcycles will be procured and supplied to district programme supervisors to enable continued monitoring of programme activities.

3. Strengthen monitoring and evaluation systems for CHBC

A review of the CHBC monitoring tools will be done on an annual basis in order for these to be in harmony with the new focus of CHBC and in line with upcoming issues. Operational research will be conducted and disseminated widely in order to tap into good practices. Task forces will be maintained at all levels to provide technical support, and guidance in terms of monitoring and evaluation of the programme.

Table 29: PLHIV receiving CHBC services Output Indicator and Targets

Result no.	Indicator	Baseline	Year and Source	Targets				
				2011	2012	2013	2014	2015
2.4.1	Number of HIV positive clients receiving psychosocial support	112,244	Programme Data (2010)	167,224	193,058	220,408	264,843	269,958

<u>OUTCOME 2.5:</u> Increase the number of OVC receiving minimum package of service from 20.9% in 2009 to 80% by 2015

Over 410,000 OVC *(2005-2010)* have been reached with appropriate care and support services through the Program of Support (PoS). The support from the PoS constitutes 25% of OVC in need as the national estimates indicate that there are 1.6 million OVC in Zimbabwe. The

strategic focus for 2011-2015 is to increase the number of OVC who are receiving the appropriate treatment and care services in order to achieve Universal access.

Table 30: OVC receiving Minimum Package of Service Outcome Indicator and Targets

Result no.	Indicator	Baseline	Year and Source	Target				
				2011	2012	2013	2014	2015
2.5	Percentage of OVC receiving minimum package of service	20.9%	MIMS (2009)	50%	60%	60%	70%	80%

<u>Output 2.5.1:</u> OVCs receiving minimum package of services increased from 410,000 in 2009 to 1,280,000 by 2015

Considerable progress has been achieved in providing for the basic needs of OVC. Available data indicates demand for resources outstrips supply as only 410, 000 OVC accessed an average of 1or 2 services of support that were not comprehensive out of a total of 1, 600,000 who are in need. The aim of ZNASP II is to ensure that OVC receiving a minimum package of services increases from 410,000 in 2009 to 1,280,000 by 2015.

Priority Strategies

1. Expand access to child protection services for orphans and vulnerable children to enhance government capacity to effectively lead, coordinate, regulate and monitor child and family protection service delivery

This strategy entails the establishment of child sensitive social protection programs that deliver reliable, regular cash transfers to poor and labour constrained households. The strategy also requires the building of capacity of the ministries ICT system to aid in the coordination and regulation of child protection service delivery. The systems to be put in place will include databases at district and provincial levels that are linked to the national database as well as various ICT equipment.

2. Strengthen the capacity of the ministry of labour and social services to provide leadership in social protection for children

Capacity building and support services for the ministry will be enhanced to enable the ministry to take its leadership role in social protection for children. This will be achieved through various capacity building activities which include training of ministries staff in programme management, coordination, monitoring and evaluation and quality assurance monitoring.

3. Capacity development of communities in coordination, community targeting and monitoring of OVC interventions

Trainings for Village Focal Persons (VFP's) will be conducted to build the capacity of communities in coordination and targeting of OVC in their respective communities. This will in turn increase access to services by OVC.

Table 31: OVC receiving minimum package of service Output Indicator and Targets

Result no.	Indicator			Targets				
		Baseline	Source	2011	2012	2013	2014	2015
2.5.1	Number of OVCs receiving minimum package of services	410,000	Programme Data	800,000	960,000	960,000	1,120,000	1,280,000

4.2.3: Enabling Environment

<u>OUTCOME 3.1:</u> A conducive environment for effective HIV responses created and national policy index increased from 6.2 in 2010 to 9.0 in 2015

<u>Output 3.1.1:</u> Enabling policy, legal, regulatory and social environment for national HIV responses created and strengthened.

Third decade into the HIV and AIDS epidemic, policy and regulatory framework continues to impede progress in the implementation on the response. These need to be urgently attended to in order to create an enabling environment for an effective national response. Certain key aspects of the policy, legal and regulatory environment have been identified as barriers to effective response to the HIV epidemic. Therefore to address these fundamental barriers to the response, an enabling environment that ensures zero tolerance to stigma and discrimination and the policy and regulatory framework have to be addressed.

Table 32: Policy, Legal, Regulatory and Social Environment Output Indicator and Targets

Result No.	Indicator	Baseline		Target				
		Value	Source and Year	2011	2012	2013	2014	2015
3.1	National Composite Policy Index (NCPI) score	6.2	UNGASS report 2010	6.8	7.3	7.9	8.4	9.0

Priority Strategies

1. **Review and address key laws policies, guidelines and standards that impinge on effective and efficient implementation of the response**

The current evidence (A review of HIV and AIDS policies study NAC 2011) in Zimbabwe indicate that there are key laws, policies and regulations that impact negatively on the national response hence the need to be reviewed and harmonised them to be in line with new emerging

issues in the HIV and AIDS area. This strategy will continue to review and revise key laws, policies and regulations that impact effective responses to HIV and AIDS

2. **Strengthen the capacity of public sector and civil society champions to engage effectively in the policy, legislative and regulatory development, implementation, monitoring and evaluation process.**

The public sector and civil society are the major players in the national response to HIV and AIDS in Zimbabwe. They thus need the capacity to develop, implement, monitor and evaluate the policies, legislation and regulations that govern HIV and AIDS implementation in the country. The public and civil society will capacitated through training and provision of grants to implement this cause. This will enable to use evidence based approaches to programming and advocacy.

3. **Conduct commemorations and campaigns**

Historically Zimbabwe has managed to reduce HIV and AIDS prevalence through creating and strengthening HIV and AIDS awareness. This has been done through multi strategies which include commemorations and campaigns of major international, national and local events. These events are used as call for action to the community and policy makers in the national response to HIV and AIDS.

4. **Conduct HIV and AIDS exhibitions**

In order to increase awareness on HIV and AIDs in the general population and among policy makers exhibitions will be conducted. Information sharing is critical for community participation in HIV and AIDS programmes and for policy development and implementation as well as behaviour change.

<u>Output 3.1.2:</u> Capacity of organizations and institutions mainstreaming gender increased

Evidence shows that adult HIV prevalence is higher among women in the age group 15-49 (21%) than among men in the same age cohort (14.5%). This gap is also evident and even wider among young people: Females age 15-19 years have higher HIV prevalence rates than men among the same age group making HIV a gendered epidemic in Zimbabwe. Cultural and traditional practises have been identified as impediments in the HIV and AIDS response. Gender norms related to masculinity encourage men to have more sexual partners and older men to have sexual relations with much younger women putting women at greater risk. Secondly, many women (especially those who are married or who cohabit) do not personalize HIV risk, which leads to low rates of condom use, low uptake of voluntary counselling and testing services, and low levels of knowledge of HIV status. ZNASP II aims at cumulatively increasing the capacity of organisations and institutions in mainstreaming gender by 2015 to 675.

Table 33: Organizations and Institutions Mainstreaming Gender Output Indicator and Targets

Result No.	Indicator	Baseline		Targets				
		Cumulative value	Source and Year	2011	2012	2013	2014	2015
3.1.2	Number of organisations and institutions mainstreaming gender	250	NAC report 2010	135	135	135	135	135

Priority Strategy

1. **Capacity building training for HIV and AIDS implementers.**

Gender mainstreaming and operationalisation in HIV and AIDS interventions has been noted as a gap that needs to be filled. Whilst gender has been incorporated in the strategic plans as one of the guiding principles most implementers and programmers lack the skills of mainstreaming and operationalising gender into HIV and AIDS programmes. Under this strategy training of AIDS service organizations implementing HIV and AIDS programmes will be conducted to bridge this gap.

<u>OUTCOME 3.2:</u> Women and men expressing accepting attitudes towards PLHIV increased from 17% to 75% for women and men from 11% to 60% by 2015 for men

Stigma and discrimination has been identified in the MIPA baseline survey conducted in 2009 as one of the main barriers to both MIPA and access of HIV and AIDS services by PLHIV and uptake of preventative services. One of the biggest and critical impediments to MIPA implementation is HIV related stigma at three levels: social, institutional and personal. This is largely attributed to a non conducive environment caused by weak policies, gender disparities and stigma and discrimination. In this strategy stigma reduction interventions are aimed at addressing key drivers of stigma that include lack of knowledge and awareness, fear, cultural norms and a weak policy and regulatory framework that addresses stigma effectively. Cultural norms and practices exacerbate stigma through fear of labelling if one is indentified as a person living with HIV. Stigma has also been identified among health care providers in health care settings as well. In line with the national and global vision of zero tolerance to stigma and discrimination there is need to empower PLHIV through their networks and organizations to challenge stigma and discrimination in institutions and the general population with a view of increasing the number of men and women who express accepting attitudes towards PLHIV. This plan aims at increasing accepting attitudes among the general population from a baseline of 17% for women and 11% for men in 2005-6 to 75% for women and 60% for men

Table 34: Stigma and Discrimination Outcome Indicator and Targets

Result No.	Indicator	Baseline		Target	
		Value	Source and Year	2013	2015

3.2	% of population expressing accepting attitude toward PLHIV	17% women 11% men	ZDHS 2005/6	47% women 35% men	75% women 60% men

<u>Output 3.2.1:</u> Districts reached with anti-stigma and discrimination awareness campaigns

Current information shows that levels of stigma and discrimination are relatively high especially amongst men with only 11% of men expressing accepting attitudes towards PLHIV compared to 17% of women. In order to increase levels of acceptance to 75% and 60% for women and men respectively, this strategy aims at creating and strengthening HIV and AIDS awareness in the communities through multi-pronged awareness campaigns.

Priority Strategies

1. **Capacity building trainings for community and health service providers.**

Stigma and discrimination often manifest itself at community level and within institutions providing health services. Targeting these particular institutions for training is anticipated to assist in raising the targets for men and women expressing accepting attitudes towards PLHIV. A standardized anti stigma and discrimination tool kit will be used to train people in all the 85 districts of the country.

2. **Capacity building of organizations and networks for PLHIV through provision of grants.**

In the spirit of MIPA, organizations and networks for PLHIV will be given annual grants to champion anti stigma and discrimination campaigns at district level. Apart from reducing stigma the grants are also intended to empower these organizations and networks.

3. **Conduct print and electronic awareness campaigns**

Print and electronic media have proven to be effective and efficient channels of communicating HIV and AIDS information in Zimbabwe. These channels of communication will be used to fight stigma and discrimination. Weekly radio and television programmes targeted at the entire population will be aired and broadcasted whilst print material in the form of pamphlets, posters, news bulletin and bill boards will be used during the anti stigma and discrimination campaigns.

<u>Output 3.2.2:</u> PLHIV meaningfully involved in HIV coordination structures and programmes increased from 10% to 25% and 5% to 25% by 2015 respectively

The MIPA baseline survey conducted in 2009 revealed that participation and involvement of PLHIV is most significant at lower levels of implementation of the national response and MIPA structures have been created at district, ward and village level. The baseline survey revealed that although PLHIV are represented in key national governance structures such as the NAC and the CCM, effective engagement in both structures has been limited because PLHIV representatives in these structures lack the resources to regularly communicate with their constituencies and to solicit ideas and feedback. Their participation in formulation and implementation of key HIV policies and strategies, is also hampered by this lack of capacity to

exercise their voice and to participate effectively in national HIV and TB policy formulation, legislation, implementation and monitoring even though a national network of PLHIV (ZNNP+) has been in existence for several years, it is generally acknowledged that it lacks the technical and institutional capacity to enable it to effectively push the MIPA agenda. In order to address these disparities capacity strengthening initiatives targeted at networks and organizations of PLHIV will be undertaken at community level through training and provision of grants.

Table 35: MIPA Output Indicators and Targets

No.	Indicator	Baseline			Targets				
		Value	Source	Year	2011	2012	2013	2014	2015
3.2.1	Number of support groups with institutional capacity	95	ZNNP+ programme data	2010	150	300	600	800	1000
3.2.2a	% of PLHIV meaningfully involved PLHIV in HIV coordination structures as decision makers	10% estimate	NAC Report	2009	12%	15%	18%	22%	25%
3.2.2b	% of PLHIV meaningfully involved in HIV programme activities as implementers and experts	5% estimate	Observation NAC	2009	10%	12%	15%	20%	25%

Priority Strategies

1. **Strengthen the capacity of networks representing PLHIV to advocate, effectively engage in national decision making processes and governance of the national HIV and AIDS response in Zimbabwe.**

Networks and organizations of PLHIV provide avenues that enable support groups and PLHIV to engage with service providers and policy makers. These networks have structures that start at support group level and go up to national level. Capacity building in relation to advocacy and lobbying will be undertaken in all the 85 NAC administration districts in the country. A core team drawn from ten provincial PLHIV networks will undergo TOTs which will be cascaded to districts. Additionally selected organizations and networks of PLHIV will be provided with grants to strengthen their membership at grassroots level.

2. **Strengthen the capacity of networks representing PLHIV to effectively engage in national decision making processes**

This strategy seeks to strengthen the capacity of PLHIV to participate effectively in governance of the national HIV and AIDS response in Zimbabwe through training in advocacy skills, mentoring and lesson sharing among the networks, regionally and internationally.

4.2.4: Coordination, Monitoring and Evaluation

OUTCOME 4.1: Effective strategic information available

In line with the "three ones" principle the national M & E system and that of the HMIS are not integrated and run in parallel resulting in dual reporting and increasing reporting burden among implementing partners and stakeholders. Therefore, there is need to harmonise these parallel systems to adhere to the "Three ones" principle. Effective strategic information will be derived from surveillance, surveys, routine programme monitoring, research and evaluation and HIV information system. It is the intention of the ZNASP II to move from data generation for performance reporting to data generation for policy, planning and programmatic decisions and actions to enhance performance in a continuous cycle. A robust Strategic Information system is therefore required for the ZNASP to guide policy, support programme planning and implementation, measure performance, identify gaps and emerging needs so as to develop solutions to address gaps and meet needs and continuously assess and refine actions to ensure accountability and an effective national HIV response.

Table 36: Strategic Information Outcome Indicators and Targets

Result No.	Indicator	Baseline	Year and Source	Target				
				2011	2012	2013	2014	2015
4.1	% of policy and management meetings based on strategic information	20%	2010, Minutes	30%	50%	70%	80%	90%

Output 4.1.1: HIV and AIDS implementers registered with National AIDS Reporting system

To ensure that all activities conducted in a given district are recorded and counted, every implementing partner operating in the district must register with the District AIDS Coordinator (DAC) by completing and submitting the *Organizational Details Form* (ODF). By the end of 2010, about 80% of the implementers were registered with a reporting coverage of 70%. Registration is expected to increase to 100% by 2015. On the other hand, the reporting rate is also expected to increase to 80% by end of 2011 and 100% by 2015.

Priority Strategies

1. **Facilitate the registration and reporting of implementing partners in all the districts**

NAC shall through its decentralized structures conduct organizational mapping at district level and ensure that all implementing organizations are registered and reporting on a monthly basis. Reporting shall be enforced at all levels through quarterly support visits and audits.

2. **Review and revise existing data collection tools, clarify cut-off dates and reporting timeframes and add a component appropriate to the private sector**

While the NARF was revised in 2010, the indicators are continuously updated hence the need to review and update the tools biennially. Currently the private sector is not reporting through the national M & E system, therefore there is need to establish and maintain a harmonized and comprehensive reporting system with clearly defined reporting timeframe. NAC shall therefore conduct stakeholders' consultation to fulfil the above.

3. **Disseminate the harmonized HIV and AIDS indicator guide**

HIV and AIDS indicators guide was developed, but has not been disseminated to lower level leading to inconsistence in interpretation and reporting. The dissemination will be achieved through printing and distribution of the guide to stakeholders followed by training of the focal persons

4. **Develop a standard operation procedure (SOP) for data collection for all implementers that can be applied to their setting**

Currently there is no SOP which guides data collection, quality control and transmission of information from point of collection to next levels. From the data audits conducted there were recommendations that there is need for SOP for data collection. NAC will spearhead the development and dissemination of the SOP.

<u>Output 4.1.2:</u> Human resources capacity for M&E at NAC and AIDS and TB Unit strengthened

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 prioritizes the capacity building of staff within the two institutions in order to bridge the gaps identified.

Priority Strategies

1. **Develop monitoring and evaluation training curricula.**

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. This 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, including the identification of funding partners.

2. **Training of data managers, implementers, M&E staff and Health Information Officers (HIOs) at all levels on monitoring and evaluation.**

There is no standard training on M&E offered. Using the adopted and customized UNAIDS curricula, training of M&E personnel will be conducted at various levels (community, district, province and national).

3. **Recruit additional M&E staff to strengthen the capacity of the NAC and AIDS and TB to effectively coordinate monitoring and evaluation of the national response.**

This strategy will prioritize the recruitment of personnel for the identified posts.

Output 4.1.3: M&E system established and functioning

In order to realize a functional M&E System in the country, an M&E assessment was carried out in 2010. The assessment utilized the 12 M&E components and identified some gaps and challenges. Among others, are insufficient human capacity for HIV M&E at all levels, weak surveillance and evidence based decision making as well as poor data dissemination and utilization.

Priority Strategies

1. **Strengthen the HIV M&E capacity of all implementers at all levels**

This strategy will identify implementers, assess their M&E capacity and capacitate them through training, provision of SOP, indicator guide and supervise the data collection. The strategy will also encourage the recruitment of qualified M&E personnel by implementing partners.

2. **Strengthen routine monitoring of the national response to HIV and AIDS**

This strategy will help to strengthen the reporting systems by providing guidelines on data collection, quality control and timely reporting to higher levels. Implementers will also be trained in report writing.

3. **Strengthen surveillance of the national response to HIV and AIDS**

Challenges have been noted in the current surveillance systems including limited funding and poor data flow. This strategy therefore seeks to increase funding support for surveillance systems.

4. **Strengthen support supervision and auditing systems**

Although NAC regularly conducts district support visits, there has been a major challenge of standardised assessment tools. This strategy will therefore help to develop and customise standardised support and supervisory and data quality assessment tools.

5. **Develop a plan for data analysis and utilisation**

This strategy will guide in synthesis of data from various levels by defining an objective oriented analytical and data dissemination plan. It will also assist in creating demand for effective utilization of M&E and research products among decision and policy maker**s.**

Output 4.1.4: Selected/ prioritised research and evaluations conducted

Assessment of the extent to which objectives of the strategic plan (ZNASP II) are met requires an array of periodic evaluations. These evaluations are critical to collection of specific outcome and impact indicators as well as evaluating some fundamental attributes of programs such as efficacy, equity, relevance, appropriateness etc. In a national program, whereas the monitoring

component of program's Monitoring and Evaluation plan can be integrated into implementation plans, evaluation cannot because of its cost. The Evaluation component therefore has to be strategically planned for utilizing national surveys and surveillances, project evaluations and other similar researches.

Priority Strategies

1. **Update research agenda**

The current HIV and Research Priorities expire in 2012. It is however noted that research issues change from time to time, hence the focus of this strategy to redefine the research and evaluation priorities/agenda for the period 2013-2015. NAC will spearhead a consultative process to develop, share and implement the priorities.

2. **Promote implementation of operations research at all levels**

There is limited capacity for as well as implementation of operations research at all levels of the national response. This strategy therefore seeks to promote operations research by training staff from NAC, MoHCW and other implementers in this area. This will include grant and mentorship arrangements as a follow up to trained staff.

3. **Provision of resources for research and evaluations**

NAC has established a small grants scheme to support research and programme evaluations. This grants scheme will need strengthening as part of this strategy by mobilising and allocating more resources.

<u>OUTCOME 4.2:</u> National response to HIV effectively coordinated and managed

Zimbabwe has already established the necessary coordination structures and systems for an effective response. The response analysis conducted even revealed that these management and coordination structures need to be strengthened in order to achieve the results proposed in this strategy.

Table 37: Coordination and Management Outcome Indicator and Targets

Result No.	Indicator	Baseline	Year and Source	Target				
				2011	2012	2013	2014	2015
4.2	Number of meetings successfully held at all structures	1613	2010, Meeting Reports	1,843	2,304	2,304	2,304	2,304

<u>Output 4.2.1:</u> Capacity to effectively manage the national response increased and maintained at 95%

The coordination framework for the national response shall be strengthened to ensure effective planning, implementation, M&E and reporting and accountability for the national response. Focus shall be on establishing and strengthening focal points for sector coordination and linkages between sectors and national level coordination mechanisms. This shall include maintenance of optimal staffing levels, equipping the coordination structures with required infrastructure to facilitate coordinated planning, implementation and M&E at the decentralised level.

Priority Strategies

1. **Strengthen national level partnerships**

The National AIDS Council has created various platforms for coordinating the national response. These include the National Partnership Forum and the various TWGs and their task forces. This strategy seeks to review the terms of reference of the National Partnership Forum and TWGs and streamline their work to effectively deliver on the coordination of the national response at all levels. NAC's capacity will also need strengthening to provide improved coordination for the Partnership Forum and the TWG by allocation of resources.

Strengthen sector level partnerships

Zimbabwe adopted national multi-sectoral response to HIV; however there is poor coordination of these sectors. This strategy will empower NAC to effectively coordinate sectoral partnerships. NAC will provide resources for regular meetings with these sectors.

2. **Strengthen decentralised coordination structures**

The PAACs, DAACs and WAACs are key coordination structures in the national response. Although the PAACs and DAACs have remained functional, the WAACs have had less attention from national level in organising and equipping them. At the same time, the DAACs' effectiveness has been affected by limited resources. This strategy will therefore ensure strengthening of these structures by allocating them more financial resources and equipment for them to perform their coordination activities effectively.

<u>OUTCOME 4.3:</u> Financial gap for ZNASP reduced to less than 20%

Coordinating the mobilisation and strategic allocation of financing to different areas of the national HIV and AIDS response has been difficult due to many parallel financing systems, hence the need to have a coordinated financing system.

Table 38: Financing Outcome Indicator and Targets

Result No.	Indicator	Baseline	Source and Year	Target				
				2011	2012	2013	2014	2015

1.1	% of ZNASP financial resources mobilized	58%	ZNASP I MTR 2009	60%	65%	80%	90%	100%

<u>Output 4.3.1:</u> Resource mobilisation strategy for ZNASP in place by December 2011

AIDS spending often falls below the budget amount while there has been absence of a resource mobilization strategy to bridge the gap. The NAC will establish and chair a multi-sectoral resource mobilization committee whose responsibility will be to mobilize the financial resources required to achieve the expected results proposed in this strategic plan. Efforts shall be made to reduce the funding gap of the national response. The ZNASP II operational plan should be properly costed and shared with the funders and provide financial reports according to agreed schedule. Accountability of financial resources mobilised need to be enhanced through financial audits.

Priority Strategies

1. **Strengthen capacity to mobilize adequate resources to support the implementation of ZNASP II**

Although there is a huge funding gap in the national response, the country is yet to develop a resource mobilization strategy. This strategy therefore seeks to ensure that NAC spearheads the development of a national resource mobilization strategy.

2. **Full and timely release of funds for annual operational plans**

The annual HIV and AIDS work plan should be properly costed and shared with the funders and provide financial reports according to agreed schedule. This strategy will ensure timely disbursement of financial resources according to the work plan.

3. **Establish effective accountability and oversight system for HIV funding**

NAC shall spearhead the development of common user-friendly financial accountability guidelines and measures as well as train implementing partners and grant recipient organisations on their use. This strategy will ensure that the financial and program reports should be submitted on time by all implementing partners. The audited accounts of the ZNASP should be widely disseminated by NAC. NASA will be carried out in order to enhance accountability.

Table 39: Coordination and M & E Output Indicators and Targets

Result No.	Indicator	Baseline	Year and Source	Target				
				2011	2012	2013	2014	2015
4.1.1	Number of implementers registered and reporting	70%	2010, NAC Report	80%	85%	90%	95%	100%

4.1.2	% of established posts filled	90%	2010, HR Report	90%	95%	100%	100%	100%
4.1.3	Functional M & E System (12 components)	44%	2010, M&E Assessment Report	65%	80%	80%	90%	100%
4.1.4	Number of researches conducted	4	2010, Research Database	4	6	6	8	8
4.2.1	% of ZNASP activities implemented	60%	2009, ZNASP I MTR	10%	50%	70%	90%	100%
4.3.1	Resource mobilisation strategy for ZNASP in place and disseminated to donors	0	2010, Source N/A	1	1	1	1	1

Mid and End-of-Term Reviews

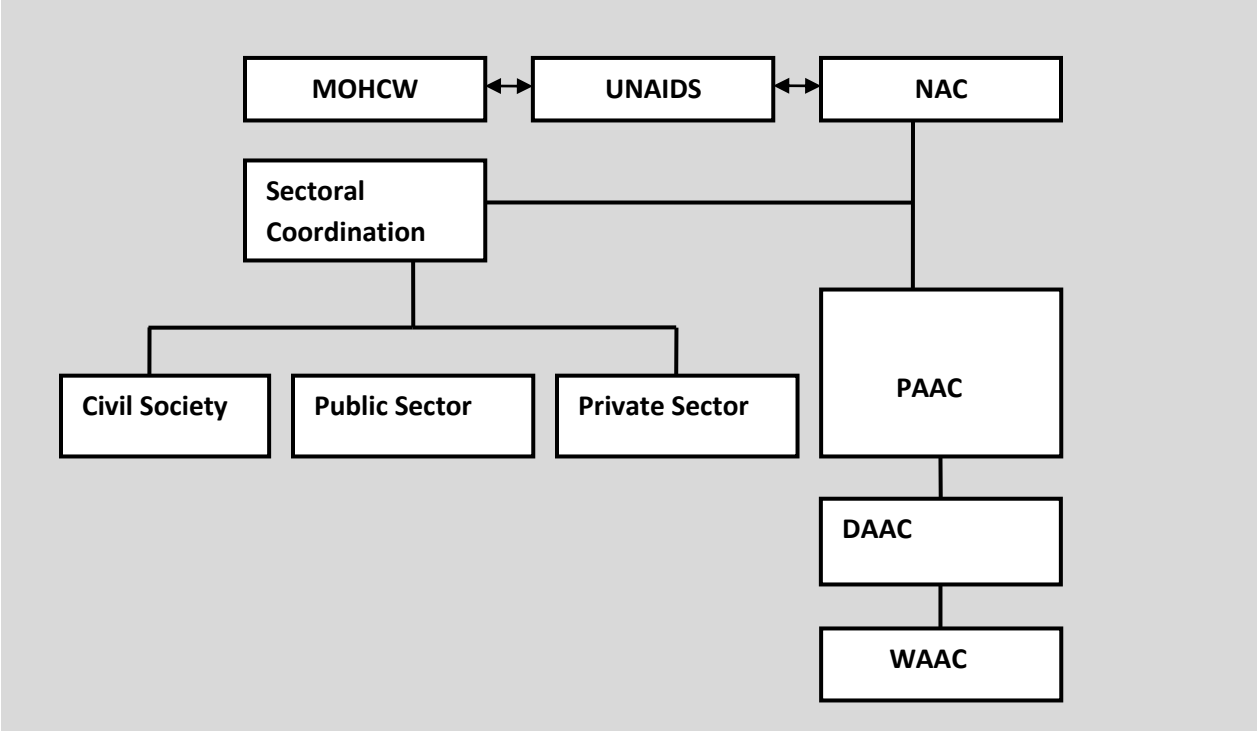
The implementation of the ZNASP II will be reviewed in 2013 to assess progress being made in reaching set targets and providing an opportunity to rethink national strategies for scaling up the national HIV and AIDS response. The assessment will involve a desk review including M&E data generated by the 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. The priorities and strategies of ZNASP II will be modified as necessary based on the outcome of the review.

By mid 2015, the end-of-term evaluation of the ZNASP II will be undertaken with the possibility of ushering in a new strategy to address HIV and AIDS issues from 2016 and beyond.

Institutional Framework for Coordinating the HIV and AIDS response

As already highlighted in previous sections coordination of the response has been a key challenge. It is envisaged that ZNASP II will improve and strengthen the coordination, monitoring and evaluation of the national HIV and AIDS response. The diagram below is an outline of the coordination structures from National level down to the grassroots.

Figure 7: Institutional Framework for Coordinating the HIV and AIDS response



To ensure that NAC carries out its mandate, on-going capacity development for members of the NAC board and the NAC secretariat in the matters of corporate governance will be undertaken to enable them to represent their respective constituencies effectively and efficiently. Mechanisms to ensure effective partnership, participation and coordination will be established and operationalised within key sectors, including civil society; PLHIV associations, networks and organizations; the private sector; financing partners and the public sector. NAC will provide the necessary administrative, technical and financial support in the establishment and operationalisation of these mechanisms.

The UN family's support to the national HIV response will continue to be coordinated through the Joint UN Team on AIDS. The Technical Working Groups and the National Partnership Forum will continue to partner NAC to review progress in the national response to HIV and agree on

the key actions to strengthen service delivery, coordination and management of the responses at different levels.

SECTION 5: HEALTH SYSTEMS STRENGTHENING (HSS)

Human, material, equipment and infrastructural gaps identified during the situational analysis will need to be addressed for ZNASP II to meet set targets, specific outcomes and outputs by 2015. Strategies and activities identified in the strategy are directly linked to the results framework.

Rationale for including HSS in ZNASP II

Implementation of the HIV response will be impossible without inclusion of the health delivery system in this strategy because of the interaction between HIV and AIDS with the HSS. The interaction of HSS and planned interventions is critical in indentifying and addressing system level factors and obstacles likely to impinge on achievement and sustainability of the overall response. Furthermore, the attention given to the scale up of the response might shift attention from overall achievement of health outcomes for the country. Therefore, it is critical that proposed strategies and inputs for HIV and AIDS are an integrated part of HSS to enhance overall efficiencies. In addition the increased attention given to HIV and AIDS presents an opportunity to leverage human, financial and technical resources under the framework of ZNASP II, for broader impact on health outcomes and other priorities through health systems strengthening.

The WHO HSS Building Blocks

In its National Health Strategy, 2009-2013, Zimbabwe has clearly articulated the ultimate goal of the health sector which is "equity and quality in health: a people's right". The Policy puts emphasis on quality of health care and equity in access as a human right. The HSS strategy is informed by WHO's 6 building blocks which focus on: a) Leadership and Governance, b) Health Services Delivery, c) Human Resources and Health Infrastructure, d) HMIS, e) Health Technologies, and f) Health Financing. The HSS outcomes from the building blocks include system responsiveness and efficiency leading to social and financial risks protection and ultimately resulting in improved HIV and health outcomes.

B1: Leadership and Governance

To give direction and guidance in the provision of health care, leadership and governance systems were prioritized in the NHSP 2009-13. Strengthening of the sector especially at the decentralized level will be necessary to support plans to scale-up HIV services during the ZNASP II period. The health delivery system has faced many challenges in the past decade due to the unstable macro-economic conditions. The challenges impacted negatively on delivery of quality health care and the response. In this regard ZNASP II aims to address the gaps identified in order to meet targets and outcomes of the strategy.

<u>OUTCOME 5.1:</u> Strong leadership and governance structures exist at all levels of the health sector

Weak leadership and governances structures result in lack of accountability and a fragmented approach to addressing the HIV epidemic. Additionally centralised decision making power affects lower levels of care because red tape affects timely decision making that is critical to service provision.

Output 5.1.1: The leadership and governance capacity at all levels of the health sector built

Leadership and governance are weak at all levels of care. While health services have been decentralized, decision making and resource allocation within the health sector remains skewed with the centre retaining most of decision power which ultimately affects timely decision making lower levels. Yet the implementation of the response is more pronounced at the district level of care. Inadequate planning and performance reviews which led to weak coordination including support and supervision of lower levels of care. Furthermore, it has been observed that there is limited use of available data to inform decision making. Hence it is important to build district level leadership capacity in their core functions of sector oversight, coordination and regulation as well as in accountability and partnership building. Leaders need to have a clear understanding of the national health sector policies and plans so that they are better able to harmonize and align district level interventions with national policies.

Priority Strategies

1. Strengthen leadership training at all levels during the ZNASP II

Leadership development at all levels will be commenced and this should be extended to the multisectoral District AIDS Action Committees (DAACs). There will be need to develop clear guidelines for oversight, coordination and partnership at decentralised levels to form a basis for training of DAACs.

2. Strengthen governance of the national HIV response at all levels

There is need to strengthen and review current systems for monitoring and supervision and oversight of the national HIV response at all levels. This strategy, therefore, aims at establishing a governance system that ensures effective monitoring and supervision of the response, decision making processes that guarantee transparency and accountability of key actors and focus on involvement of a wide range of partners in the decision making processes.

B2: Human Resources for Health (HRH) and Physical Infrastructure

Adequate Human resources and physical infrastructure are critical in the implementation of ZNASP II interventions and have an overall impact of the proposed outcomes and strategies. High vacancy rates among the different health cadres pertinent to the delivery of the response will affect reach and quality of interventions.

OUTCOME 5.2: Adequate Human Resources for Health available and equitably deployed

To ensure ZNASP II achieves its outcomes the high vacancy rate within the health delivery system has to be addressed across all levels of care to ensure equity in provision of and access to preventative, treatment, care and support of interventions.

Output 5.2.1: Training of health workers scaled-up

To increase the number of health workers needed to efficiently and effectively implement the response, ZNASP II seeks to improve the human resource base by reducing vacancy rate to 50% by 2013 through the following strategy:

Priority Strategy:

Training of health workers scaled-up
Refurbishment of training schools and building new ones where feasible needs to be undertaken to accommodate the increased numbers of trainees. Training curricula for the different cadres will need to be reviewed to be in line with the country's health needs and review for requisite admission criteria. Support and supervision of trainees should be strengthened. The training and deployment of adequate numbers of mid-level health professionals (especially midwives and medical/physician assistants) is critical for Zimbabwe to meet its commitment to MDGs 4, 5, and 6.

Output 5.2.2: Staffing norms for healthcare services developed

To guide staffing norms, an assessment to identify staffing gaps relative to needs at different levels of care is essential to inform policy formulation and a strategy that spells out how the human resource base will be strengthened. In ZNASP II the following strategy will be utilised.

Priority Strategy

Develop and operationalize appropriate staffing norms
In order to recruit and deploy staff equitably across all levels of care, a policy framework that is based on output related staffing norms has to be developed. The following key activities for development of appropriate staffing norms are proposed: conduct workload and job analyses, job evaluation and develop job description, and develop and apply staffing norms for recruitment and placement of health staff. Scaling up cadetship programme and decentralizing specialised medical personnel and internship to selected provincial and other hospitals with resources capacity will boost the much needed mentoring at this level of care.

Output 5.2.3: Health workers retention policy developed and implemented

Retention of health workers is critical for the overall implementation of the response. The following interventions are proposed in this strategy to enhance staff retention.

Priority Strategies

1. Institute a staff retention strategy

It is critical to create conducive conditions and incentives to retain and motivate staff to perform their duties to the best of their ability. Staff retention allowances should be put in place and rural based workers have to be given rural allowances to attract staff to work in rural settings. Important incentives include adequate staff housing with access to transport. Improved salary levels commensurate with experience and qualifications should inform part of the retention scheme package. Working conditions and other non-monetary incentives should be comparable to other SADC countries. To boost the much needed human resources base, attempts at securing specialist training places for training that is not offered locally, and external recruitment of key specialist skills should be pursued.

2. Scale-up the provision of functioning health facilities in rural and hard to reach communities

In line with the primary health care concept of health delivery premised on the three 'A's *(availability, accessibility and affordability*) of health care it is prudent to ensure that rural areas and resettled populations have easy access to a functioning health facility. Need therefore arises for scaling-up functional health facilities to meet the demand for health services. The scale-up will involve rehabilitating, constructing and equipping health facilities as well as providing incentives to motivate staff to operate the health facilities. Outreach programming has to be resuscitated.

3. Meet HIV programme staffing and health facility requirements

Some of the challenges impacting on implementation of HIV and AIDS interventions and general health delivery include: inadequate number of trained personnel at all levels of the health care delivery system, high attrition rate for trained personnel from both the public and private sectors, burn out and low motivation among health workers. Therefore, ZNASP II proposes the refurbishment of old and construction of new additional health facilities and training of adequate numbers of health workers especially midwives and primary health care nurses. Staffing establishments across the different cadres have to be revised to meet the current staffing needs in order to respond to the needs for HIV prevention, treatment, care and support envisaged in period 2011-2015. The following interventions are recommended to ensure health staff plays a meaningful and significant role in the response:

- Inclusion of HIV in the pre-service training of all health workers to ensure adequate numbers of trained staff is available in the long term.
- In-service training for existing staff.
- Innovative task shifting and task sharing arrangements will provide short-term relief for this long term challenge.

B3: Health Services Delivery

The mandate of the HSS is to ensure an effective Health Services Delivery that guarantees safe, quality prevention, promotion, curative, and rehabilitative health interventions when and where they are needed, with minimum waste of resources. Effective health services are

informed by science and reliably follow evidence-based guidelines including an organized program for measuring and improving quality. Challenges facing the health delivery system and gaps that impact quality management of patients and equity in health provision and access have been highlighted. These include shortage of human, resources, poor working conditions, aged equipment, lack of supplies and commodities essential for health delivery, aged and dilapidated infrastructure. Consumers especially the poor and marginalised subgroups of the population also face a raft of challenges when they want to access health services such transportation due to poor roads, broad socio-cultural barriers including gender and user fees. High levels of stigma and discrimination within institutions and health delivery systems are some of the key reasons that reduce access to and uptake of HIV prevention, treatment and care services. To achieve health outcome targets stipulated in ZNASP II all these barriers will have to be significantly reduced.

OUTCOME 5.3: Healthcare consumers are accessing quality health services at all levels of care

Healthcare provision should strive to ensure that the concept of equity in access is adhered to and consumers are accessing quality health services across all levels of care.

Output 5.3.1: Demand for health services created and health systems strengthened at all levels to meet increasing demand for services

Demand for health services has to be created through awareness and knowledge about what services are offered by the health system. ZNASP II seeks to create this demand by utilising the following strategies.

Priority Strategies

1. Create demand for and increase access to healthcare services

This will be accomplished by the development of service delivery models that consumer needs driven provision of integrated comprehensive service delivery packages, and improving patient safety and providing quality care will contribute to effective demand creation for healthcare services at the district and community levels. Define and publish a health service package that will be provided for free including the clearly defining the beneficiaries and a hospital client services charter which should be widely disseminated to raise awareness on health.

2. Improve the systems supporting the delivery of health services

Tenets of good supporting systems include leadership, management and infrastructure and logistics as well as the critical issue of HRH: health workforce development, recruitment, deployment and retention. These are critical for efficient and effective delivery of the response.

B4: Health Management Information Systems (HMIS)

HMIS provides health services data, which are augmented by population-based surveys that provide information on HIV and AIDS including the Demographic and Health Surveys and Integrated Bio-Behavioural Sentinel Surveys (IBBSS). Robust interventions should be informed by evidence. This is dependent on collection of quality timely information that is authentic, and dependable. This is necessary as to track, monitor and evaluate progress against set targets. Identified challenges include lack of capacity and progress in measurement and analysis of health information that hamper national policy making and resource allocation; data tends to move to higher levels in the system for compilation and analysis, use of the data for management at the district, facility, and community level is critical including management and dissemination of health information to inform programming. Therefore, the success of ZNASP II is dependent on the improvement of HMIS by addressing identified gaps and harmonising the various HIV M&E systems existing in the health sector and ensuring alignment with the national HIV M&E Plan.

OUTCOME 5.4: The HMIS improved

To track and monitor progress towards implementation of the response, is imperative to put in place an HMIS that is coordinated.

Output 5.4.1: All health management information systems harmonized and migrated to a single platform

Ensuring that HMIS are harmonised will lead to better assessment of outcomes of ZNASP II and avoid fragmented and double reporting.

Priority Strategy

1. Consultation and consensus building for a harmonised HMIS

It is critical for the various stakeholders to buy into the idea of a harmonised HMIS, hence the need for intensive consultation. Activities will include consensus building meeting on the concept, design and strategic direction for the common HMIS platform, establishment of a TWG to review and document detailed information system requirement for health information in the health sector, solicit Technical Assistance, procure corporate utility tools and antivirus software and train staff at the Centre for Health Information Management (CHIM) to manage the software.

Output 5.4.2: Data flow from facility to district, provincial and national level using web-based software facilitated

To enhance timely use of information from the point of capture, data flow at all levels of care using web based software should be facilitated.

Priority Strategy

Install ICT infrastructure and train managers on web-based M&E system

To ensure easy retrieval and flow of data, a web-based system will be deployed through reviewing and revising primary data capture forms, training of regional teams on the use of the software, procurement and installation and maintenance of ICT infrastructure at all levels of care.

Output 5.4.3: The capacity of staff to effectively monitor health and HIV programmes built

Priority Strategies

1. Provide training and supervision

Short term training will be provided to managers in systems operation, data validation, data generation and analysis. Quarterly supervision and hands on training to staff at data sites in the districts and provinces to check on data quality will be conducted.

2. Provide tools for data management

Facilitation of data use in decision making and improvement in programming will be aided by generation of quality data and analysis at the point of data capture and facilitating the transmission of the data between the different levels of health sector. Programme managers will be trained on the use of the dashboard and be provided with the software manuals and guides.

Output 5.4.4: All key health information systems are computerized and in use

Computerisation of all key health information will enhance easy data entry, retrieval and usage.

Priority Strategies

1. Computerize medical records, HRIS, and LMIS in health facilities where feasible

Timely data use is enhanced by computer-based systems that allow for easy data entry and retrieval, fast data manipulation and analysis, and enables rapid data and information sharing. The following key activities within the health delivery system should be computerised: medical records system, Human Resource Information System (HRIS) and Logistics Management Information System (LMIS). Training will be provided in the use of electronic medical records, HRIS, and LMIS software in health facilities that are feasible and appropriate. Computers and other related software and consumables will be provided and solar power will be provided as standby power source for the electronic equipment.

2. Provide improved communication systems

Fast and reliable communication is essential for an effective HMIS. IP based telephone systems will be provided to inter-connect all for relevant areas of health facilities and departments. In areas where IP network is not feasible, two way radio (voice) communication systems will be provided.

B5: Health Technologies

Availability, affordability and access to essential medicines and supplies should be the hallmark of good performance of a health care delivery system. Procurement of medicines and supplies including antiretroviral drugs for the public sector is currently undertaken by the MoHCW and NATPHARM. Forecasting and managing appropriate stocks of essential medicines and supplies needs a coordinated supply chain management system that does not create interruptions in the delivery of medicines & other supplies. LMIS challenges include poor road infrastructure, lack of supervision at decentralized level, and poor quality service data needed for forecasting and quantification. Storage capacity is currently inadequate particularly at the district health departments and drug regulatory and quality assurance mechanisms need strengthening. The Medicines Control Authority of Zimbabwe (MCAZ) is responsible for the regulation of medicines, vaccines and traditional medicines. Its role is to ensure quality control, drug and food safety and post marketing pharmacovigilance. Due to financial constraints, quality control and pharmacovigilance activities are not adequately decentralized to the implementation level. The system for undertaking appropriate studies for monitoring the emergence of anti-microbial drug resistance including resistance to ARV drugs and for addressing substandard drug production, and distribution and use of counterfeit medicines is weak. The LMIS is one of the weak systems in the health sector and needs immediate attention so as not to endanger the services provided by the HIV programme during the ZNASP II period to improve the procurement and supply management system.

OUTCOME 5.5: Health commodity security is assured at all levels at all times

It is critical to ensure the safety and security of all commodities and supplies at all levels of care and at all times

Output 5.5.1: The procurement and supply chain management system is strengthened

To ensure that health commodities and supplies are secure, the supply chain management will be strengthened at all levels through the following strategies:

Priority Strategies

1. Build the technical and managerial capacity

Technical and managerial capacity is essential to ensuring health commodity security. There is therefore the need to build capacity for M&E at all levels and improve skills in forecasting and quantifications for health commodities to avoid drug stock outs and treatment interruptions. In current storage facilities for the health facilities will have to be rehabilitated to meet standards for warehousing and framework agreements have to be developed and their use promoted to assure quality and economies of scale. A scheduled delivery system will be employed and equipment and transport secured to support the delivery of health commodities. Laboratories will have to be refurbished, equipment bought and maintained and reagents supplied in sufficient quantities.

2. Improve governance and policy issues

To avoid misunderstanding and corrupt practices associated with health commodities and supplies, good governance and clear policies have to be put in place. Need therefore arises for guidelines to be put in place to support the selection of medicines and other health commodities and reviewing of quality assurance systems to support commodity security. Capacity building to ensure rationale and proper use of medicines will be undertaken. Stakeholder information sharing meetings will be held regularly to discuss health commodity security issues.

3. Strengthen supervision and M&E systems

Plan and review meetings with stakeholders are crucial and so is the scale-up of harmonized monitoring and evaluation tool to all levels. Strengthened M&E systems coupled with facilitative supervision will ensure accountability in service delivery as well as quality of services and of health commodities.

B6: Health financing:

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. An additional investment of 700 million USD over 3 years or around 19 USD per capita is required to achieve a reduction in under- 5 and maternal mortality of 38% and 17% respectively. The need to resource mobilize becomes apparent to bridge the gap in funding.

OUTCOME 5.6: Increased levels of sustainable and predictable financial resource base to ensure provision of high quality services to the population

Successful implementation of ZNASP II is dependent on provision of sustainable and predictable financial resource base and accountability of resources mobilized.

Output 5.6.1: Financial Management system at all levels is strengthened and improved use of existing resources.

To enhance accountability of resources mobilized for the response, ZNASP II seeks to strengthen financial management systems at all levels of the response.

Priority Strategy

Strengthen National Health Care Financing

To strengthen national health care financing, a national health care financing policy and strategy will have to be developed; and updating of central government funding policy for local government and other public health providers. Improvement in the implementation of the Public Finance Management System (PFMS) at all levels of care through training of health

workers in financial management and skills and institutionalise implementation of the Results Based Management (RBM) Concept.

OUTCOME 5.7: People are accessing the health services they want at a cost they can afford

One of the constraints to accessing health services especially among the poor is the issue of user fees.

Output 5.7.1: All poor people who need health care are supported by the government to access care

Priority Strategy

Undertake a review of user fees policy

To ensure equity in access to health services by all who need the service the user fees policy has to be revisited as this can be a barrier to uptake of preventative, treatment care and support. The possibility of pro-poor policy that exempts the very poor from paying for health services should be explored to ensure that poor people have access to health care. The government should also consider wavering the fee on treatment of opportunistic infections.

SECTION 6: COMMUNITY SYSTEMS STRENGTHENING

This section looks at mechanisms aimed at strengthening community structures to enable them to be more efficient and effective in responding to the HIV and AIDS epidemic

OUTCOME 6.1: Key CBOs, FBOs NGOs, networks of PLHIV, community level leadership and social structures contribute to the achievement of HIV and AIDS response outcomes

To create an enabling environment that is conducive to effective participation in the response at community level, community based organisations, community level leadership and community structures need to be strengthened. This strategic plan aims at community systems strengthening by ensuring an effective system for delivering HIV services through coordinated community level linkages and processes. In this strategy capacity development of communities will be based on services that enable NGOs operating at national and local level, FBOs, CBOs and community social and leadership structures to be effective. Community systems strengthening is premised on six building blocks, discussed under 'A' to 'F' below.

A. Strengthening the enabling environment and advocacy

Output 6.1.1: Improved enabling environment for and advocacy capacity of CBOs, FBOs and local and national level NGOs

Given the key vintage advantage of community organisations in turning around the tide of the epidemic, it is critical that these structures are equipped with requisite skills and resources to enable them to be effective through: participation in decision making and policy dialogue at local and national levels, monitoring implementation of HIV policies and advocating for improved access to HIV services at the community level, creating an enabling environment for communities' voice to be heard and needs to be met. Currently, CBOs, FBOs and NGOs are more involved in service delivery; involvement in advocacy is limited to issue driven initiatives. The capacity of CBOs, FBOs and NGOs will be built to enable them to undertake monitoring of advocacy activities in a sustained and coordinated approach.

Priority Strategies

1. **Strengthening of key community leaders and players**

To equip communities to be more effective and efficient in the response, community based organisations (CBOs), localised NGOs, as well as local leaders such as traditional leaders, local Councillors, leadership of community groups and church leadership will be targeted.

The following interventions are prioritised in this plan

- Develop the capacity of CBOs, networks of PLHIV and support groups, FBOs and NGOs to adequately articulate and lobby for effective service delivery, monitoring and document HIV service provision and policy implementation. Civil society groups at provincial and

district levels will be supported to improve capacity and leadership for effective advocacy and implementation of HIV initiatives.

- Training, supervision and provision of standardised data collection to ensure that overall reporting is strengthened will enable more efficient planning and distribution of resources. Computer equipment will be procured and communication systems improved to facilitate more effective capturing of information.

- Strengthen access to treatment, case and psycho-social services for PLHIV
- Protection of Human Rights and social services for persons infected and affected by HIV
- Universal access to HIV prevention and treatment.

2. Advocacy, communication and social mobilisation

Key players with linkages at community level such as CBOs, and NGOs will be supported to engage government and other institutions at local, provincial and national levels in policy dialogue in order to improve HIV policy environment in both formulation and implementation. Documented lessons on policy implementation and HIV service provision will inform their advocacy. 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. Support will be provided for the development of advocacy plans and communication materials and engagement skills with partners, government institutions and the media. This strategy aims at providing support to CBOs, FBOs and NGOs efforts in advocating for improved legal and policy environment with emphasis decriminalisation of social behaviours or addressing needs of marginalised groups that have limited avenues for their voice to be heard.

Prioritised interventions will include:

i. Identifying lessons, documenting experiences of communities and key affected persons in order to develop national programmes and policy guidelines in prevention; treatment, care and support and social mitigation of the impact of HIV that are relevant.
ii. Establishing mechanisms supported by CBOs, FBOs and NGOs, for channelling community experiences and needs to the policy makers through participation of community actors in local, provincial and national consultative and partnerships forums.
iii. Holding community consultative meetings to mobilise communities to communicate and advocate for change in an enabling environment at local level
iv. Engaging in advocacy efforts at regional and national level, using information generated at local level
v. Strengthening political commitment for affective action by leaders at all levels.

B. Community networks, linkages, partnerships and coordination

<u>Output 6.1.2:</u> Community networks, linkages, partnerships and coordination mechanisms established and functioning

Organisational development, civil society organisations skills on accountability, proposal writing and financial management will be addressed to encourage greater sustainability of local organisations. Larger civil society groups at national, provincial and district level such as ZNNP+ will be supported to improve capacity and leadership for effective advocacy and implementation of HIV initiatives. ZNASP II will promote the strengthening of partnerships at the local level to improve coordination of initiatives to enhance impact and avoid duplication. Linkages and coordination systems between the formal health systems and community based initiatives will also be enhanced. Information exchange will be enhanced through support of advocacy work by creating linkages. In order to scale up access to HIV services and advocacy issues, CBOs and NGOs will be supported to create these networks and linkages at community level. Partnerships will be created at local level, to encourage exchange of information, consolidate lessons and participate in policy dialogue. The partnerships will also seek to develop common agendas, and joint programme planning, monitoring and evaluation.

Priority Strategies

1. Build community networks, linkages and partnerships

Key CBOs, FBOs and NGOs will be funded and supported to facilitate establishment of networks of key populations at community level. These networks will include those of PLHIV, Women, Youth, and MARPs. To promote local level information exchange and advocacy on access to HIV services, stigma and discrimination, change of harmful cultural practices and overall HIV prevention networks with common interests and needs will be encouraged to form linkages. CBOs, FBOs and NGOs involved in this initiative will establish partnerships at regional and national level to promote joint programming and advocacy.

2. 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. Coordination at both district and community level will assist to strengthen flows of information from bottom up and top down. Planning and coordination mechanisms of CBOs and NGOs interventions at the district, provincial and national levels will be strengthened. This will be done by working with umbrella or membership organisations with leadership from the PACS, and DACs to improve on harmonization and alignment of national and local priorities and accountability for results for the investments being made at all levels. Recognising that monitoring systems in civil society remain weak, activities have been planned to strengthen capacity to effectively monitor programme achievements.

C. Resources and capacity building

<u>Output 6.1.3:</u> Adequate resources provided and capacity building of CBOs and NGOs undertaken

One of the key challenges facing community systems in Zimbabwe is lack of sustainable funding for the activities of these organisations and lack of resources to undertake work at community level. Hence, the main elements of resources required by CBOs, FBOs and NGOs such skills mix, technical expertise and organisational capacity to manage and implement programmes, and financial and physical resources to delivery of HIV services will be improved. This strategy aims at provision of support to CBOs, FBOs and NGOs involved in community systems response to improve their skills, organisational capacity and access to financial resources.

Priority Strategies

1. Build skills of CBOs, FBOs **and NGOs on service delivery, advocacy and leadership**
Skills building for these organisations will focus on organisational management and leadership and delivery of HIV services. The organisations will be trained in technical skills required to undertake informed advocacy; support HIV prevention, HIV related stigma and discrimination; treatment, care and support; implement initiatives such as HTC, Condom Promotion, Change of Harmful cultural practices, Home and Community Base Care and understanding of health service delivery, linkages with health facilities, analysis of health policies and implementation (related to HIV) as well as programme planning and M&E.

2. Develop mechanisms for funding CBOs and NGOs to implement community level activities
The capacity of the CBOs, FBOs and NGOs to access and manage finances effectively will also be built. This includes developing internal governance and accountability systems, strengthening financial management and accounting and establishing a transparent system for accessing funding by CBOs, FBOs and NGOs. This system will ensure that organisations supported have the capacity to implement the initiatives.

D. Community activity and service delivery

<u>Output 6.1.4:</u> CBOs, FBOs and NGOs supported to provide community based HIV services

Community based HIV services are meant to complement the health facility based HIV services; and they are an extension of the health services from the health facility to community and to household level to ensure continuity of care beyond the health care system. Recognising the critical role played by communities in provision of care, and the weak linkages that are evident between these systems, the aim of this strategic plan is to strengthen and improve linkage between health facilities and community level services in order to improve HIV prevention,

treatment follow up and provision of care to both infected and affected people. A system to improve referrals between the community and the health facility, and monitoring and reporting the quality of community based services will be put in place.

Priority Strategies

1. Improve community based HIV services availability, use and quality

To ensure standardisation and set criteria for measuring of impact of interventions need arises to develop national guidelines for community based HIV services for various interventions such as awareness and education interventions, HIV testing and counselling, Home and Community Based Care, Peer Education, Orphans and Vulnerable Children Care, Care and Support to People Affected and Infected by HIV and Condom Promotion and Distribution among others. Organisations working at community level will be trained to provide services according to these guidelines and support will be provided for planning, implementing monitoring and evaluating programmes providing these services. Health facility personnel will provide technical back up to the CBOs and NGOs. Key principles to guide community based HIV services will be access, equity and quality.

2. Improve monitoring and reporting on community based HIV services

To ensure monitoring and quality of services provided 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. The Health Facility personnel with support at the district while national level NGO networks will monitor the community based HIV services.

E. Organizational leadership and strengthening

<u>Output 6.1.5:</u> Organisational management and leadership of CBOs, FBOs **and NGOs strengthened**

To enable CBOs, FBOs and NGOs and other community actors manage HIV programmes effectively organisational management and leadership will be strengthened. Evidence shows that currently, the organisational capacity of most CBOs and NGOs is weak – with weak governance systems that are inadequate for effective accountability and management of programmes. Capacity building of these organisations to enable them to be accountable to their communities, stakeholders and partners and provide leadership in improving the enabling environment at the local level will be conducted. Hence capacity building will focus on leadership building, development of accountability systems and participatory decision making arrangements (especially for CBOs), human resources management and financial management in order to strengthen the credibility of the CBOs and NGOs to work with and advocate on behalf of communities and specific populations.

Priority Strategy

Management, accountability and leadership of CBOs and NGOs strengthened

Capacity building will include strategic planning, proposal development and writing, organisational management and systems, monitoring and evaluation and information management. Capacitating organisations in these areas will lead to improved leadership and strengthen their accountability to the community.

This capacity building will be undertaken through:

i. A comprehensive capacity assessment
ii. Conducting training for key staff from the organisations management and boards
iii. Establishing a mentorship programme to sustain capacity development
iv. Provide information to organisations to support on the job training
v. Lesson sharing
vi. Linking capacity development to delivering of specific programme outputs

F. Planning, monitoring and evaluation

<u>Output 6.1.6:</u> Capacity of CBOs, FBOs and NGOs in planning, monitoring and evaluation strengthened

To encourage community led planning monitoring and evaluation, a participatory will be established to ensure that interventions implemented by CBOs, FBOs and NGOs are community needs driven and relevant. Accountability of the CBOs and NGOs to the community will be enhanced. As a result communities often do not own the programmes being implemented and they are often not involved in monitoring and evaluation of these programmes. This strategic plan uses a bottom up approach in planning and M&E in order to enhance community ownership of programmes and commitment.

Priority Strategies

1. Strategic and operational planning at community level strengthened

To ensure evidence based strategic and operational planning CBOs, FBOs and NGOs will be supported to carry out local gap analysis and identification of needs for various target populations at the community level to inform effective resource allocation based on priorities of needs identified.

2. Develop the capacity of CBOs , FBOs and NGOs in community led M&E

To strengthen community led planning and M&E skills credible linkages will be established with large NGOs to facilitate skills transfer and complement each other to implement community led planning and M&E. Training CBOs, FBOs and NGOs will be conducted.

SECTION 7: PUBLIC SECTOR ESPONSE IN ZNASP II (2011-2015)

7.1: Key line ministries and their role in the response

The public sector plays a major role in the response through provision of an enabling policy environment for achieving the nation's development goals and objectives. Without public sector involvement the HIV and AIDS control efforts will be futile because the public sector contribution to the national response is at various levels. The MoHCW contribution to the national response is high; and that of other ministries significant. Challenges within the public sector such as human, financial, social, political and legal continue to hinder effective performance of the sector in the national HIV response and affect the realisation of nationally determined HIV impacts and outcomes.

The public service commission approved the Public Service HIV and AIDS Strategic Plan in 2006 which informed sector plans for individual ministries (2006-2010). Every ministry has a unique response to make in achieving the outcome and impact targets determined by the ZNASP II; however, some public sector ministries and departments are recognised as critical for and key to improving public sector contribution to the national HIV response. The key 15 line ministries include:

1. ***Ministry of Health and Child Welfare (MoHCW):*** The Ministry of Health and Child Welfare plays a regulatory role for matters relating to both public health and primary health care. It is the lead technical agency responsible for the provision of HIV prevention, treatment and care services in the country. The health sector has effectively mainstreamed HIV into its core business. The National AIDS and TB Control Programme in the MoHCW effectively coordinates the national HIV response within the public, private, and NGO/FBO health sectors.

2. ***Ministry of Education, Sport and Culture (MoESC):*** It is the ministry responsible for primary and secondary education, sport and culture in the country. The MoESC's sector HIV activities were guided by a strategy plan from the period 2006-2010. MoESC is a critical ministry in the response to the epidemic because reduction of HIV incidence is largely dependent on targeting young people both in and out of school by catching them young through provision of education, values, norms and behaviours that are amenable to changing the course of the epidemic.

3. ***Ministry of Tourism:*** As the ministry responsible for the hospitality and tourism industry the sector's potential as a source of HIV transmission is widely acknowledged and hence has a critical role to play in the response.

4. ***Ministry of Finance (MoF):*** The ministry can steer the course of poverty through initiating pro-poor policies aimed at poverty reduction that can benefit vulnerable populations including people living with AIDS (PLHIV) and OVC.
5. ***Ministry of Information Media, Information and Publicity (MoMIP):*** The ministry is the core agency responsible for disseminating and transmitting critical information on government priorities to the general public. The sector's role and engagement in ZNASP II will be dissemination of HIV prevention education, behaviour change communication and in linking people-in-need to critical HIV and AIDS services. ZNASP II seeks to strengthen HIV mainstreaming, hence the ministry's role needs significant improvement.

6. ***Ministry of Local Government, Rural and Urban Development***: This ministry responsible for local government and oversees administration of municipalities, districts and provinces of Zimbabwe. ZNASP II aims at ensuring that the response is conducted in a coordinated way and aims at strengthening the functions of PACS and DACs to efficiently and effectively carry their mandate in the response.

7. ***Ministry of Labour and Social Services (MoLSS):*** The ministry's core business is to monitor child related activities both within the school and home environment. Its other core mandate is to ensure that employees and employers observe and abide by the labour regulations act. ZNASP II recognises the critical role played by the MoLSS in mitigating the impact of HIV and AIDS on OVC through various partnerships i.e. UNICEF.

8. ***Ministry of Industry and International Trade:*** The core function of the ministry is to promote the development of vibrant, sustainable and globally competitive industrial and commercial enterprises, and fair trade practices through the provision of conducive policy and regulatory frameworks. In ZNASP II the role of the ministry is to promote comprehensive workplace HIV programmes including families of workforces in industry.

9. ***Ministry of Gender and Women Empowerment:*** Available evidence indicates that women bore the brunt of the epidemic and also constitute the larger population in the country. Hence the ministry is a core partner in the response to the epidemic in ensuring that the policy and regulatory framework that heightens women and girls risk vulnerability to HIV infection is addressed.

10. ***Ministry of Youth, Development and Employment Creation:*** Youth are the backbone of the society in terms of reproductive and economic productivity yet their livelihoods are threatened by the HIV epidemic. ZNASP II seeks to strengthen youth interventions to reduce HIV incidence among the youth.

11. ***Ministry of Agriculture:*** With its widely dispersed country-wide network of extension field workers, the ministry provides the closest presence and link with the most remote, hardest-to-reach populations within the country's local communities and therefore has great

potential to provide HIV prevention information and education to their constituents. Nutrition plays a pivotal role in the management of HIV disease.

12. ***Ministry of Defence:*** The country's security is dependent on a healthy defence force. In ZNASP II this ministry will play an important role in ensuring interventions targeted at the defence forces are implemented in line with the strategy for overall impact.

13. ***Ministry of Small and Medium Enterprise Development:*** This sector has grown in the past decade due to structural adjustment programme. The sector employs more than 50% of the working population. In ZNASP II interventions targeting this work force will be implemented in line with the labour laws.

7.2: Mainstreaming HIV into key line ministries

Thirteen (13) line ministries are identified as critical for successful mainstreaming of HIV in the public sector. Incorporating HIV into the core businesses of the 13 line ministries is at different levels of mainstreaming with the MoHCW arguably the most advanced. Policy, structural, technical and financial issues are important challenges impeding mainstreaming of HIV into the core businesses of key line ministries. During the ZNASP II period, concerted efforts will be made to strengthen the mainstreaming of HIV into all key line ministries by addressing the key challenges encountered by the various ministries.

<u>OUTCOME 7.1:</u> Mainstreaming of HIV into core business of key line ministries strengthened

<u>Output 7.1.1:</u> All key MDAs have incorporated and are implementing HIV interventions as part of their core business

Strategies

1. **Review and implement the policy and guidelines for HIV mainstreaming in key line ministries**
   The existing policy and guidelines on mainstreaming HIV in public sector should be reviewed with a focus on relevance, effectiveness, and efficiency. HIV interventions should benefit employees in the public sector. Technical assistance for mainstreaming HIV into line ministries will be facilitated by NAC in collaboration with government and development partners.

2. **Establish divisions/units or focal persons to coordinate for HIV and AIDS mainstreaming**
   All key line ministries will establish divisions/units or a focal person at the minimum to be responsible for the coordination of HIV work. The capacity of the divisions/units or focal persons should be built to effectively undertake their coordination functions

7.3: HIV Workplace Programmes in the Public Sector

This section addresses HIV and AIDS issues affecting line ministries staff and employees. A public sector HIV Workplace Programme strategy exists which has informed the implementation in all HIV interventions in the public sector.

<u>OUTCOME 7.2:</u> HIV related institutional and infrastructural capacity of line Ministries, **strengthened**

<u>Output 7.2.1:</u> HIV Workplace Programmes established and functional in departments of all line ministries

Priority Strategies

1. **Review policies and guidelines for HIV Workplace Programmes**

HIV workplace programmes will reviewed to ensure they are in line with the strategy relevant and appropriate to the continued dynamic change of the epidemic.. This is particularly important for the human resources management policies prevent stigma and discrimination against staff that are living with HIV. Where Employees Health and Wellness Programmes exist, the interest of staff living with HIV will be incorporated. Ministries which do not have HIV Workplace Programmes will be assisted to initiate and sustain them.

2. Strengthen HIV Workplace Programmes in all ministries

NAC will provide support to all ministerial departments to establish functioning HIV Workplace Programmes. Capacity building for focal persons will be appointed to coordinate the programmes. They will be provided with material resources to effectively carry out their functions.

SECTION 8: POLICY AND ADVOCACY FOR ZNASP 2011-205

The outcomes and outputs set in this strategy cannot be achieved without a supportive policy environment. This section outlines the key interventions to be implemented to strengthen the policy and advocacy environments for the national HIV response.

National policies need to keep in tandem with the ever changing epidemiology of the HIV and AIDS epidemic. The National HIV Policy last reviewed in 1999. This is the key document guiding the national HIV response. Many sector level and workplace programme policies that have been established over the last 15 years to guide stakeholders implementing HIV interventions are derived from the National HIV policy. These policies are often clear in their intentions but full implementation remains problematic.

Important challenges and gaps of the National HIV Policy include limited involvement of key bodies such as the traditional and religious leaders who provide guidance and have stewardship for the norms, cultures and beliefs that govern behaviours in society and inadequate dissemination, implementation, monitoring and evaluation of HIV policies and guidelines at the sector and workplace programme levels.

The absence of an explicit national policy on private sector involvement in the national HIV response significantly reduces systematic private sector engagement and relegates meaningful corporate social responsibility to sporadic relief activities.

Creating and strengthening policy environments that will contribute to achieving the plan impacts of halving the number of new HIV infections by 2015 relative to that in 2010 and improving the survival of PLHIV on ART as articulated ZNASP 2011-2015. Therefore, the strategy calls for the review and strengthening of the National HIV Policy and associated sector and programme level policies with a focus on relevance, effectiveness and efficiency and creating new policies that will enhance the national HIV response.

<u>OUTCOME 8.1:</u> The National HIV Response operates within enabling policy environments

Creating and/or strengthening policy environments that will contribute to achieving the articulated impacts of halving the number of new HIV infections by 2015 relative to that in 2010 and improving the survival of PLHIV on ART as articulated in the ZNSAP 2011-2015 is of paramount importance. Hence thuis strategy calling for the review and strengthening of the National HIV Policy and associated sector and programme level policies with a focus on relevance, effectiveness and efficiency and creating new policies that will enhance the national HIV response.

<u>Output 8.1.1:</u> The National HIV and AIDS Policy reviewed and fully operationalized

The National HIV Policy was last reviewed in 1999. Hence urgent need arises to review the policy to ensure it is relevant to the ever changing dynamics of the epidemic. The policy should re-enforce the Three-Ones Principles (One National Strategic Plan, One National HIV Coordinating Authority, and One National M&E System for the response) as the three pillars of the national HIV response. The key challenge in the implementation of the current National HIV and AIDS Policy is the inadequacy in fully operationalizing the multisectoral and decentralised approaches of the current policy. For example private sector involvement is weak, civil Society Organisations involvement is not well coordinated, harmonized and aligned to the response.

NAC is mandated to provide leadership and stewardship for the national HIV response. Under this strategic plan, focus will be on establishing mechanism(s) within which NAC will spearhead and facilitate full and effective operationalisation of the National HIV and AIDS Policy and related sector and workplace programme policies.

Strategies

1. **In-depth review of the National HIV and AIDS Policy**

An urgent review of the policy needs to be conducted with effective involvement of public, private and civil society sectors in HIV and AIDS in order to identify policy bottlenecks in implementation and recommending remedies to improve its implementation. The reviewed policy should include a costed plan for its implementation and monitoring framework.

2. **Establish mechanisms within NAC to effectively implement the National HIV and AIDS Policy**

Dissemination of the revised National HIV and AIDS policy at all levels (national, decentralised and community levels) should be disseminated by NAC. Dissemination of the policy to other key that include: media, traditional and religious leaders, civil society, and public and private sectors should be undertaken. NAC should set up a steering to ensure a mechanism of implementing and monitoring the policy is put in place enhance accountability. Human and financial resources for implementation of the policy should be allocated.

3. **Establish an environment for enhancing the engagement of PLHIV in the national response**

Given the vintage advantage of PLHIV in the response, the revised national HIV and AIDS policy should explicitly recognise the role of PLHIV in implementation of the national response to HIV. As already highlighted current involvement of PLHIV is limited at decision making level but more pronounced at lower levels of the response. This could be attributed to fear of being stigmatised and discriminated. However, PLHIV have a vital role to play in health education and promotion within their communities but in a safe environment hence the revised policy should make provisions for creation of this environment.

<u>Output 8.1.2:</u> SBCC, PMTCT, Condom Promotion, MC, C**HBC and provision of HIV services to MARPs policies developed and operationalized**

Key interventions rooted in clear policies have a better chance of yielding positive results. Policies currently in place include SBCC, PMTCT, Condom Promotion and CHBC interventions. SBCC is at the heart of generating demand for, utilisation of and adherence to HIV prevention, treatment, care and support information and services. In the absence of an SBCC policy to direct operations, stakeholders have developed their own SBCC strategies that may send different and conflicting messages to the target audience on similar issues, and use varied channels of communication to get messages across. With no common platform, the quality, consistency, and effectiveness of BCC interventions are therefore difficult to ascertain. There is a need for policies to address the gaps in identification of age and gender appropriate SBCC strategies including IEC materials.

Implementing the 4 prongs of comprehensive PMTCT is the primary mechanism for achieving the national commitment to the virtual elimination of MTCT of HIV by 2015. The four prong approach should be informed by a National policy and should be the basis for PMTCT services.

Community Home Based Care is part of the continuum of care which facilitates family and community participation and ownership of the national response; it also relieves health facility-based resources for other more intensive intervention services. Skills transfer to elderly family members caring for PLHIV and OVCs, is important, so that they can provide appropriate nursing care, hygiene, encourage positive living; provide nutritional and emotional support and support in prevention and treatment of HIV.

Condom use is critical in ensuring safe sex. Condom promotion and distribution is currently being implemented by the public sector. The private sector is involved in condom promotion through social marketing.

The criminalisation of sex among MARPS hinders provision of HIV services because they are hard to reach. These groups operate underground for fear of arrest and victimisation. There is need for a policy to be developed on provision of HIV services to these MARPs given that they contribute a significant proportion of new HIV infections.

Priority Strategy

Strengthen technical working groups to coordinate and monitor policy implementation

National technical working groups, comprising of experts in the various policy areas, will be established to coordinate policy review and development in the areas outlined in strategy 1 above. The TWGs will be mandated with monitoring the implementation of these policies and review their effectiveness by midterm of this strategic plan. To enable the TWGs to effectively monitor implementation of the policies, the M&E Technical Working Group will develop and integrate appropriate indicators into the national M&E framework and develop a reporting system for each policy area. Information generated from monitoring and evaluation of these policies will inform future refinement or adjustment in policy implementation.

<u>Output 8.1.3:</u> All HIV and AIDS interventions effectively mainstream gender

Key gender-related characteristics that impact on men and young boys, and women and girls' risk of HIV infection and mitigating its impact on women and girls in Zimbabwe that need to be prioritised and addressed during ZNASP II period include:

i. Women generally lack the leverage to self-actualize in view of pervasive male control over household economic resources and decision making because they are dependent on financial and decision men for financial support and permission to obtain HIV services including accessing HTC services. Older women, often bear much of the burden of care for OVC and PLHIV hence should be targeted for psychosocial, economic and other social support to support them in their vital role.

ii. Fear of negative consequences such as violence, abandonment or divorce and related economic hardship, as well as women's adherence to religious beliefs makes it hard for women to demand fidelity and condom use from partners engaging in high sexual risk behaviours for HIV infection, these factors put women in long term relationships at risk of HIV infection. Women are biologically more susceptible to HIV compared to men.

iii. Trans-generational sex between older men who are in concurrent multiple partnerships and younger women resulting from arranged marriages or as a mechanism used by younger women to secure financial gains and other favours from older men increases younger women's risk of HIV infection. Gender based violence such as rape also exposes women to HIV infection. Need for age appropriate prevention, treatment, care and support messaging and HIV & AIDS service provision.

iv. Women bear a disproportionate burden of the HIV and AIDS epidemic at several levels: (1) Biologically, male-to-female transmission is much easier than female-to-male; (2) Socio-culturally, older women are in the forefront of providing care in families dealing with HIV, as well as other medical conditions; women are frequently blamed even though each HIV-positive woman has been infected by a man, are more likely to be presented as vectors of the virus - to their children and sexual partners - rather than getting protection from it, particularly if they are surviving through commercial sex work. Women are vulnerable to a number of cultural practices that place them at risk of HIV infection including wife inheritance.

v. Impact of the HIV epidemic on men: Young boys and men are known to be lured into human trafficking and the sex industry for survival making them become a bridging population spreading HIV into the general population. Such boys and men engage in high risk (unprotected) sex with their customers and female sex workers.

ZNASP II is designed to be responsive to and address gender inequality and provide appropriate indicators to measure comprehensive integration of gender dimensions into the national HIV and AIDS response.

Priority Strategies

1. **Develop and implement a gender mainstreaming framework for ZNASP interventions**

The framework will guide gender mainstreaming at programming, implementation, M&E and reporting stages of the NSP. This framework should include a costed implementation plan to facilitate resource allocation and implementation of gender mainstreaming in all interventions. NAC will work closely with stakeholders to establish a mechanism for coordinating and monitoring gender mainstreaming in the NSP.

2. **Develop the capacity of all key stakeholders on gender mainstreaming in the national response to HIV and AIDS**

Capacity development should target stakeholders at national and local levels. This should include advocating and sensitizing stakeholders including implementing partners, policy makers and decision takers at all levels on gender mainstreaming in all HIV and AIDS programmes and activities; production of a tool kit for gender mainstreaming with gender-sensitive results indicators; and provision of appropriate training and orientation on gender and HIV and AIDS.

3. **Monitor and evaluate gender mainstreaming in HIV interventions**

To monitor the extent of gender mainstreaming in HIV interventions, a framework for monitoring gender mainstreaming will be developed and integrated into the overall M&E framework for the ZNASP II. The mechanisms put in place coordinate gender mainstreaming will provide technical expertise on to the M&E technical working group on monitoring of gender mainstreaming, review strategic information to advise improvement on gender mainstreaming.

8.1 Advocacy Environment

Advocacy and lobbying through media campaigns, public speaking, or commissioning and publishing research or poll has influenced decisions made by authorities to be in favour of HIV prevention, treatment, care and support interventions. **In** Zimbabwe influence around public-policy and resource allocation decisions within political, economic, and social systems and institutions in favour of HIV have been informed by advocacy. HIV advocacy in Zimbabwe contributes to improving the condition of people living or affected by HIV and AIDS in many ways: they assist in the development of better public policy on HIV and AIDS; ensure governments' accountability for the HIV epidemic; give a voice to citizen interests on HIV and AIDS and mobilize citizens to participate in the fight against HIV and AIDS including support for a culture of accepting PLHIV that leads to reduction of stigma and discrimination and ultimately to increased utilization of HIV prevention, treatment, care and support services by PLHIV.

Priority advocacy activities to be undertaken during the duration of ZNASP II will include the following:

1. Advocacy for Mainstreaming HIV in line Ministries

The public sector employs many people and hence is a very critical strategic partner in the national HIV response. The key line Ministries include Health, Education, Women's affairs and Genders, labour and Social Welfare, Youth, Sports and Culture, Information and Technology, Local Government and Rural Development and Agriculture. The extent to which line ministries have mainstreamed HIV and AIDS is unknown. NAC in collaboration with concerned stakeholders will advocate and lobby that all line ministries facilitate the establishment of functioning HIV Workplace Programmes and strengthening HIV mainstreaming in their core business mid-term of ZNASP II in 2013. NAC will continue to provide technical assistance in establishing and strengthening HIV Workplace programmes and support access to resources by key line ministries to mainstream HIV into their core businesses. A key indicator of mainstreaming HIV into the key business of the line ministries is the inclusion of HIV in their Medium Term Expenditure Framework.

2. Advocacy for demand generation and utilization of quality HIV information and services at the district and community levels

Targets set out in ZNASP II are premised on the intent of the strategy to generate increased demand for services at the district and community levels throughout the country. In anticipation of the increased demand for and utilization of HIV services, MoHCW and NAC are improving and refurbishing healthcare facilities and improving the logistics and supply chain management and health management information systems. Using multimedia approaches, NAC and its partners will mount intensive and sustained advocacy, sensitization, and awareness creation activities at the national, provincial, district and community levels to generate demand for the HIV services. At the district and community levels, traditional and religious leaders, community-based organizations, faith-based organizations, associations of people living with HIV and youth groups will spearhead advocacy through the electronic and print media, campaign events, drama and community dialogues, peer education, and interpersonal communication. These activities are planned to take place throughout the duration of ZNASP. The general population will be targeted with SBCC messages to improve both comprehensive knowledge of HIV and reduce stigma and discrimination against PLHIV. The multi-media strategy is meant to encourage uptake of interventions such as HTC. Efforts will also be made to reach MARPs and youths, improve male uptake in HIV interventions, and encourage pregnant women to book for antenatal care where they will receive PMTCT services. People on HIV treatment will be encouraged to honour their review appointments and adherence to ART.

3. Advocacy for harmonization and alignment of HIV M&E systems

Based on the three ones principles ZNASP II, NAC will support the development of the national HIV M&E Plan and an M&E Manual. All implementing and development partners will work together to develop an appropriate system that can be understood and applied by all. NAC will disseminate the Plan and Manual and offer training in its use and undertake advocacy activities to sensitise implementing and development partners on the national HIV M&E Plan and Manual and request that M&E systems of implementing and development partners are harmonised and aligned with the national HIV M&E Plan.

4. Strengthening partnership with the media to increase advocacy, communication and accurate information sharing

The media has played a substantial role in raising awareness and knowledge on HIV and AIDS especially during the World AIDS Day. NAC shall strengthen its partnership with the media so as to improve accurate reporting on HIV and AIDS issues in the press as well as employ the media as an advocacy tool to reach targeted groups and the wider population with HIV information, education and communication. In this respect, NAC shall work closely with the Zimbabwe Journalists Association to improve media reporting on HIV, support training of media personnel on HIV and AIDS and provide press briefs on key HIV issues.

5. Advocacy to strengthen private sector participation in the national HIV response

Two categories of the private sector are recognized in the national HIV response: private sector not-for-profit and for-profit private sector. The combined contribution of the private sector to the national HIV response is substantial and covers all areas of the national response continuum from HIV prevention efforts to treatment and care services for PLHIV and support to reduce the socio-economic impact of HIV on PLHIV and OVC and their households and communities. ZNASP seeks to create an enabling environment to actualize an even greater private sector participation in the national HIV response.

a) Private sector not-for-profit organizations

The Zimbabwe Church Affiliated Hospitals (ZACH) and Zimbabwe Business Coalition against AIDS (ZBCA) are among the most active of providers of HIV services among the not-for-profit organizations. The MoHCW has a long and remarkable collaboration with ZACH in the provision of health services including HIV & AIDS at district level of care. The MoHCW will continue its partnership with and support to ZACH to further increase and strengthen participation in the national HIV response. ZBCA spearheads and coordinates the formal business sector response to HIV through HIV Workplace Programmes implementation.

b) Private-for-profit organizations

For the purpose of the ZNASP II, public-private- partnership (PPP) for the national HIV response is described as a government service or private business venture which is funded and operated through a partnership of government for example, parastatals.

i. **Private hospitals, clinics and medical laboratories:** Many Zimbabweans especially in urban set ups make use of these facilities hence their involvement in the national HIV response is crucial. Maternity homes have a great potential to increase access to PMTCT services. Efforts will be directed at finding *mutually* acceptable arrangements for the national HIV response to support training and skills improvement and the provision of HIV related medical diagnostic laboratory equipment and consumables in return for reporting results and accounting for the resources by beneficiary facilities.

ii. **Broadcasting stations:** During the implementation of ZNASP II TV and radio stations will be approached to support the national HIV response.

iii. **Mobile Telephone Service Providers:** Econet, and Telecel, are the major providers of mobile telephone services in the country; they provide mobile telephony nationwide coverage between them. ZNASP II will explore partnership opportunities with both service providers that will allow appropriate information and education on HIV prevention and other services through short message service (SMS) format with a potential to reach thousands if not millions of people. The option of telephone "hotlines" will also be explored and mutually acceptable arrangements for engaging mobile telephone service providers in the national HIV response shall be explored and if found feasible, will be implemented during ZNASP II.

SECTION 9: RESOURCE MOBILISATION AND MANAGEMENT FOR THE ZNASP II

Ensuring adequate financial and technical resources for the national HIV response has been prioritised by the Government of Zimbabwe already in the early days of the AIDS response. A number of steps were taken to ensure human resource development and sustainable financing, including the establishment of the National AIDS Trust Fund collecting the AIDS levy (3% of taxable income of all institutions and individuals) to fund the HIV responses at different levels.

Adequate and sustainable funding for HIV and AIDS programmes remain at the core of the national response. Since the establishment of the NAC, funding mechanism of the national response has undergone a number of changes including the development of home-grown funding solutions. These changes are as a result of rapid expansion in priority areas for the prevention programmes, care and treatment and Mitigation and coordination of response activities. In order to sustain this process, requisite funding is needed as well as the enhancement of structures to absorb this additional funding needed for other key identified areas.

However, during the past decade Zimbabwe's economy took serious knocks, with the hyper-inflationary environment rendering the local currency worthless and the indeterminate exchange rate making it difficult to get value for money for the HIV responses. External financial support, which was made available by bilateral and multi-lateral partners in the times of the crisis, had allowed sustaining and further expanding the HIV responses.

At the moment, the country is on the path of a steady recovery from the crisis. The economy has been showing the signs of improvement, and collections from the AIDS levy have increased significantly over the past two years, to reach USD5.7 million in 2009 and USD15.9 million in 2010. At the same time, given Zimbabwe's post-crisis resource constraints and the heavy burden of the disease, effective management of the available internal and external resources and mobilisation of external financial support remains a priority of the national HIV response.

In order to address this priority, a capacity development and resource mobilisation strategy will be developed, aligned to the Zimbabwe National AIDS Strategic Plan. The NAC will facilitate and ensure broad stakeholder participation in the development and implementation of the strategy. It is foreseen that the strategy will guide the development and refinement of mechanisms for mobilisation of the technical and financial resources; facilitate the generation and utilization of evidence for decisions related to resource mobilization, allocation and utilization; ensure strengthened monitoring, evaluation and reporting on resource mobilization, allocation and utilization; direct capacity development of sub-national level structures to ensure optimal utilization of, tracking of and reporting on resources that are mobilized at the national level; and will work to enhance timely disbursement of funds to sub-national levels and implementing partners. Zimbabwe's large pool of skilled and experienced personnel will be engaged in the implementation of the resource mobilization and management strategy.

The top three areas of spending from 2007 are HIV prevention services at 25%, HIV treatment care and support 50% and HIV impact mitigation including social protection services received the least funding at 15% of the budget. Recent analysis shows resources committed to the national HIV response was around US$80 million annually between 2006 and 2009 resulting in significant shortfalls in achieving universal access targets during the ZNASP I period.

With the current decentralised approach to implementation, the success of the national response will depend on the capacity to mobilise additional funding as much as the capacity to undertake improved financial management including allocation, use, accountability and reporting in all organisations involved in implementation activities. Overreliance on external funding remains a major challenge to the long term sustainability of the national response as the proportion of government contribution to the total resource pool for the national response remains low.

The private sector has an important role to play in responding to the challenge of HIV epidemic. A strong collaboration with captains of industry and private sector is visibly missing as businesses seemingly fail to realise the enormity of the impact of HIV infection on their businesses. Strong collaboration and coordination is needed especially with work place HIV programmes.

The ZNASP II focuses priority on mobilising adequate funding through increased contribution from GoZ and diversifying funding sources to complement funding from existing donors and prudent management of all funds for the NSP. The following are important tenets of the funding strategy to support the implementation of the ZNASP II.

<u>OUTCOME 9.1:</u> Resource mobilisation, tracking and use of funds for the ZNASP II improved

Table 40: Resource Mobilisation and Management Outcome Indicator and Targets

Result No.	Indicator		Targets				
		Baseline	2011	2012	2013	2014	2015
9.1	Increase in GoZ funding for the national HIV response increased 20% in 2010 to 75% in 2015	20% (NAC)		30%	45%	60%	75%

<u>Output 9.1.1:</u> Resource mobilization policy developed and operationalized and tracking of resource strengthened

Priority Strategies

1. Develop and operationalize resource mobilization strategy

A resource mobilisation strategy for ZNASP I did not exist. All stakeholders under the leadership of NAC and MoHCW should jointly develop the resource mobilisation strategy. The strategy should include approaches to diversify the sources of funding from both domestic and external sources. Domestic resource mobilization strategy should explore the possibility of an HIV and AIDS Fund.

2. Mobilize funding for the ZNASP II

A Resource Mobilisation Committee should be constituted to mobilise resources from both internal and external sources. Approaches should be made to GoZ to progressively increase its funding for the ZNASP II from 20% in 2010 to 75% in 2015 and to all funders for full and timely release of funds.

3. Strengthen resource tracking

Tools for tracking the resources for the national HIV response do not exist and these tools should be developed and strengthened to track resource allocation to specific aspects of the national HIV response.

Table 41: Resource Mobilisation and Management Output Indicators and Targets

Result No.	Indicator		Target				
		Baseline	2011	2012	2013	2014	2015
9.1a	Resource Mobilisation Strategy developed and operationalized			x	x	x	x
9.1b	Accountability guidelines for financial resources developed and in use			x	x	x	x

SECTION 10: RISKS AND MITIGATION STRATEGIES

A number of risks that may affect implementation of the strategy were identified during the development of ZNASP II and risk codes were assigned. These potential risks and proposed risk mitigation strategies are described in Table 38 below. The following risk rating codes are used: **H** (high risk), **S** (substantial risk), **M** (Medium Risk), **L** (Low risk) and **N** (negligible risk).

Table 42: Risks and Mitigation Strategies

Risks	Risk rating	Proposed Mitigation	Residual risk rating
Policy, regulatory and legislative constraints may impede the achievement of key results	**M**	The strategy proposes legislative, policy and regulatory reforms in key areas	**L**
Future funding proposals to support the implementation of this strategy to the Global Fund for HIV/AIDS TB and Malaria may be rejected and severely challenge the ability of ZNASP II to achieve outcomes.	**H**	The development of this strategy has been informed by the validation attributes required by the GFATM for an NSA application	**L**
This strategy takes into account Phase II grant resources been available to contribute to the achievement of the results stipulated in this plan. Phase II funding for existing GFATM grants may not be approved due to failure to achieve agreed targets.	**M**	The capacity of the CCM to provide appropriate oversight to the implementation of existing grants will be strengthened. Technical assistance will also be provided to principal recipients and sub-recipients to ensure that grant implementation is not impeded	**L**
Limited health sector experience in enabling service delivery to Most at Risk Populations such as CSW and MSM	**M**	Sharing of experiences and or approaches from other national programmes	**L**
Weak health system may limit the measurable effectiveness of proposed health sector interventions	**H**	Resources have been committed to support health systems strengthening initiatives. Current financing partners have expressed interest in supporting the implementation of the health sector investment case	**M**
Implementing partners (Government of Zimbabwe, private sector and communities) lack capacity to implement interventions proposed	**H**	Capacity building of all implementing partners will be scaled up	**L**
If the NAC fails in its key role, coordinating and holding partners accountable for the implementation of ZNASP II 2011-2015, especially as it relates to reporting, implementation will suffer	**M**	Amendments will be made to the NAC Act to enable the NAC to acquire regulatory powers to enable it to undertake its coordination functions effectively	**N**
Weak capacity to develop operational plans for the ZNASP II that will guide results-oriented actions will may limit ability to achieve proposed results	**H**	Technical support will be sourced to build national capacity in action planning	**N**
The social cash transfers programme causes social and political tensions	**H**	Transparent targeting with rigorous verification and community participation and strong IEC component	**N**

ANNEX 1: Zimbabwe National Operational Plan for HIV and AIDS Response

Annual operational plans will be developed on the basis of the ZNASP II 2011 - 2015 providing a framework indicating the activities to be undertaken and the allocation of responsibilities. These action plans comprise of a narrative and matrices containing the following information:

- **OUTPUTS:** What are the expected deliverables, and are they relevant to the programme?
- **ACTIVITIES AND RESULTS:** Are the steps to be taken in each intervention and an indication of where/what they lead to.
- **RESPONSIBLE INSTITUTION:** This is an attempt to indicate sector and agency responsibilities, where various players find their niche in the fight against HIV and AIDS.
- **TIME-FRAME:** Indicates the general anticipated duration of each intervention over the 12-month planning period.
- **INDICATORS:** Indicate, generally, evidence of implementation and/or accomplishment either in terms of process or outcomes or both.

The process of monitoring and evaluation of the national response will be greatly facilitated by the annual work or operational plan.

ANNEX 2: Costing of the Zimbabwe National Operational Plan for HIV and AIDS Response