Zimbabwe National HIV and AIDS Strategic Plan 2011-2015 [ZNASP II]

Revitalizing our commitment to zero infections, zero deaths and zero discrimination

21 November 2010

Contents

Acknowledgements 3

List of Acronyms 4

Section 1: Introduction 6

Section 2: The Epidemiology and Impact of HIV in Zimbabwe 8

Section 3: Zimbabwe's national response to HIV and AIDS 2006-2010 15

3.1 Prevention of new infections 15

3.2 Treatment and Care 25

3.3 Mitigation and Support 31

Section 4: ZNASP II Strategic framework 36

4.1 HIV prevention 36

4.2 Treatment, care and support 44

4.3 Enabling Environment 48

Section 5: Risks and mitigation strategies 49

Section 6: Monitoring and Evaluation 52

Section 7: Management and coordination of the national response 59

Section 8: Cost of Implementing ZNASP 2011-2015 60

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List of 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	Behavior Change Communication
BTSZ	Blood Transfusion Services Zimbabwe
CHBC	Community and Home Based Care
CHS	Casual Heterosexual Sex
CSO	Central Statistical Office
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
GFTAM	Global Fund for AIDS, Tuberculosis and Malaria
GoZ	Government of Zimbabwe
HBC	Home-based Care
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IDU	Injecting Drug Users
IEC	Information, Education and Communication
IPT	Isoniazid Preventive Therapy
KYE	Know Your Epidemic
KYR	Know Your Response
M&E	Monitoring and Evaluation
MARP	Most At Risk Population
MC	Male Circumcision
MDR-TB	Multi-Drug Resistance Tuberculosis
MER	More Efficacious Regimens
MIPA	Meaningful Involvement of People Living With HIV and AIDS
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
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 Counseling
PLHIV	People Living With HIV
PMTCT	Prevention of Mother to Child Transmission
PPT	Periodic Presumptive Treatment
PSI	Population Services International
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
VCT	Voluntary Counselling and Testing
WB	World Bank
YAS	Zimbabwe Young Adult Survey 2001-2002
ZAN	Zimbabwe AIDS Network
ZBCA	Zimbabwe Business Council on HIV/AIDS
ZDHS	Zimbabwe Demographic and Health Survey
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan 2006-2010
ZNFPC	Zimbabwe National Family Planning Council
ZNNP+	Zimbabwe National Network for People Living with HIV

Section 1: Introduction

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 (2006-2010) and aims to align the Millennium Development Goals (MDGs). The plan identifies a set of priorities and strategic actions tied to measurable results and provide a clear direction for moving forward. It is based on a rigorous analysis of epidemic trends, assessment of key gaps and challenges that hinder achievement of universal access, grounded in the best science and evidence and focuses on the areas of greatest need.

Development of the strategy

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 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 and December 2010. 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 analytical data 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 (September and October);
- Stakeholder consultation in October involving over 90 participants representing The Government of Zimbabwe, development and financing partners, civil society organizations and PLHIV networks to validate findings from the analyses undertaken by the core writing team;
- Strategy development workshops in October in which stakeholders defined key results and strategies to achieve them for inclusion in the new national strategic plan;
- Development of draft strategy by the lead consultant based on outputs from the strategy development workshops;
- A stakeholder consultation to review and validate the draft strategy and provide additional input for its finalization;
- Peer review of the draft strategy by ASAP; and
- Finalization of the strategy basis on the basis of the inputs described above by the lead consultant.

An oversight committee chaired by the CEO of the NAC secretariat was established to oversee the development of this strategy and comprised members from the AIDS and TB Unit within the Ministry of Health and Child Welfare, The United Nations Joint Programme on HIV and AIDS (UNAIDS), development partners, civil society organizations and networks of PLHIV. The wider public was engaged through the media.

Guiding Principles

The development of this new ZNASP 2011-2015 was informed by the following principles:

- Focusing on measurable results;
- Grounding proposed interventions in evidence and prioritizing what is most effective;
- Focusing investments where it is most needed and where it will have the greatest impact;
- Putting human rights at the centre of the national response to HIV and AIDS;
- Meaningful participation of those for whom HIV and AIDS interventions are planned;
- Efforts must seek to strengthen community and health systems to ensure sustainability
- Efforts must comply with national, regional and international declarations signed and ratified by the Government of Zimbabwe.

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

This document is organized into eight sections including this introductory section.

- **Section 2** provides a situational assessment based on the most up to date epidemiological analyses of HIV and AIDS in Zimbabwe.
- **Section 3** provides a description of the achievements, challenges and key gaps in the national response to HIV and AIDS from 2006-2010. It also considers the policy context to the national response to HIV and AIDS and identifies key policy related gaps and challenges that hinder or impede an effective response.
- **Section 4** Constitutes the core of ZNASP II. It describes Zimbabwe's strategies in the three thematic areas of Prevention, Treatment Care and Support and Enabling Environment. Under each thematic area specific priority programmes and operational strategies are described. Details on the impact and outcome level results are given; baselines and targets are stated for each of the thematic and intervention areas. A strategic direction and priority strategies for each of the interventions necessary for effective implementation are articulated immediately following the expected results.

- **Section 5** identifies key risks that may compromise the implementation of the strategic plan and strategies and articulates measures to mitigate those risks.

- **Section 6** describes how monitoring and evaluation of this strategy will be undertaken, as well as providing information on the impact, outcome and output level indicators that will be used to measure progress, the targets to be achieved and the systems that will be used to ensure data are collected

- **Section 7** provides a detailed description of how the national response will be managed and coordinated

- **Section 8** summarizes costing information and presents the overall budget of the plan

The Annexes includes operational details of the plan, including specific activities and costing details as well as responsibilities for institutions involved in implementing each activity.

Section 2: The Epidemiology and Impact of HIV in Zimbabwe

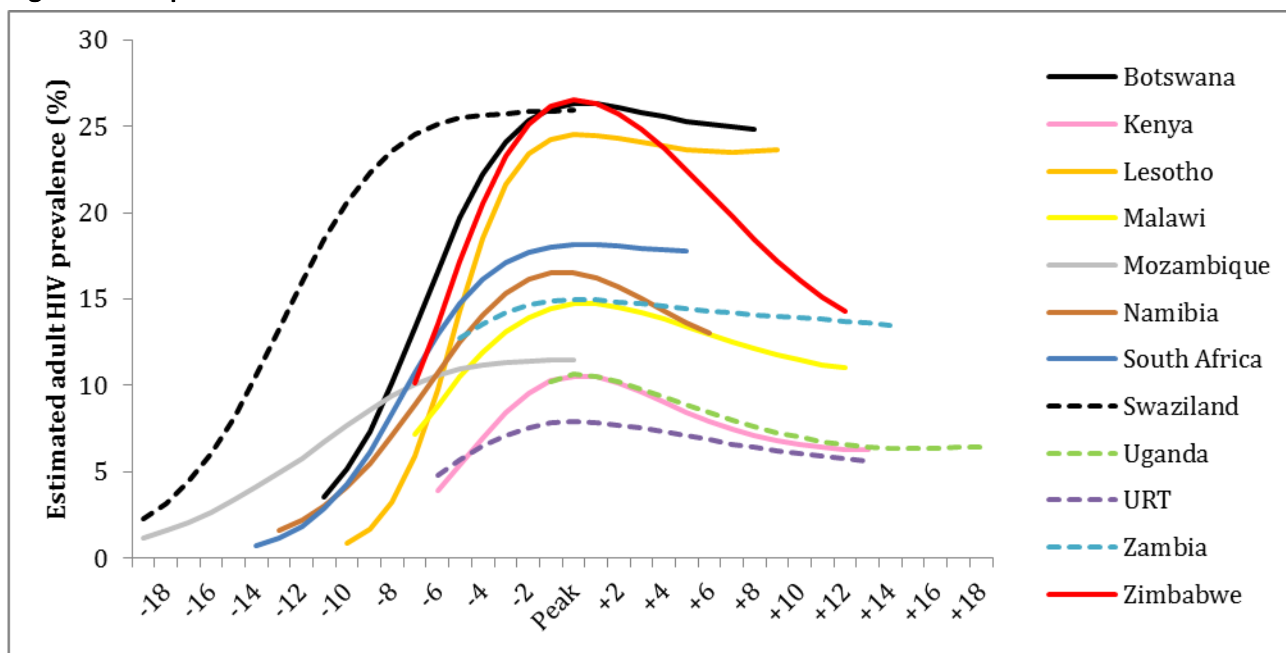
A clear understanding of the nature, dynamics, and characteristics of an epidemic is critical in informing strategies that can be reviewed and adapted to fit local conditions. The following section presents a characterisation of Zimbabwe's HIV epidemic. It is heavily informed by analytical work from the *Analysis of HIV epidemic, Response and Modes of Transmission Report.* [1]

A generalised epidemic with high levels of HIV prevalence in the past and significantly lower levels in the present

Zimbabwe has a generalized HIV epidemic, with exceptionally high level of HIV prevalence in the past and significantly lower levels at present. It is estimated that between 1998 and 2010, adult HIV prevalence has halved from 27.2% to 14.3%. The epidemic in Zimbabwe has contracted faster than any other HIV epidemic in Eastern and Southern Africa as *Figure 1* below illustrates:

[1] Fraser, N et al (2010) Zimbabwe: Analysis of HIV epidemic, Response and Modes of Transmission Report

Figure 1: HIV prevalence curves from East and Southern Africa



Source: xxx

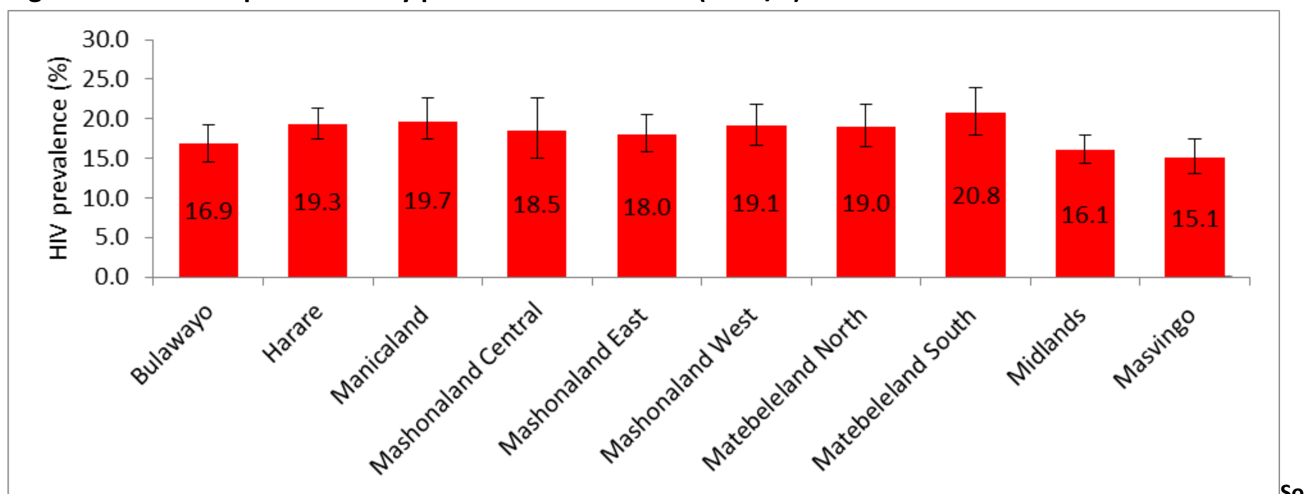
The contraction in HIV prevalence is attributed to very high mortality as well as significant changes in sexual behaviour. Existing available data from the PSI surveys conducted in 2001, 2003, 2005, 2006, and 2007 support this conclusion, especially with regard to partner reduction. For men 15-29, the proportion reporting non-regular partners fell from 32% in 2001 to 21% in 2003, and remained near that level through later PSI surveys. For women 15-29, the estimates were for a reduction from 17% to 8% in the same period.

A geographically homogenous HIV epidemic

In contrast to other countries in the region, the Zimbabwean HIV epidemic is geographically quite homogenous with similar HIV prevalence levels across provinces (*figure 2*). Geographical homogeneity also applies when HIV prevalence in rural and urban zones is compared: Rural and urban residents have similar odds of being HIV infected (17.6% in rural vs. 18.9% in urban areas). There may however be significant heterogeneity in HIV prevalence at a local level, as noted in very different levels of HIV prevalence among ANC clients, with particularly high HIV prevalence levels among those resident in resettlement farms and growth points[2].

[2] Zimbabwe ANC surveillance Report 2009

Figure 2: Adult HIV prevalence by province in Zimbabwe (2005/6)

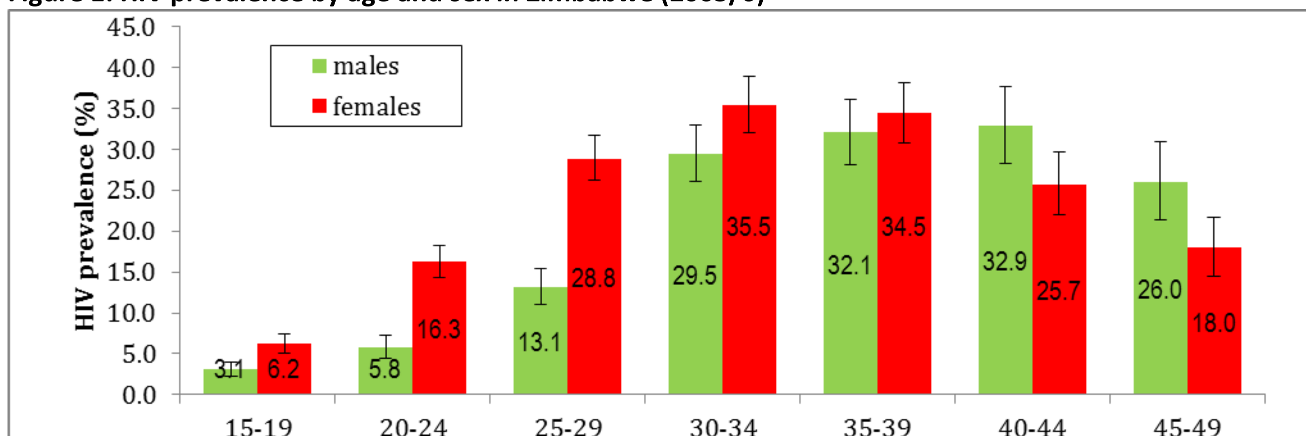


Source: 2005/6 ZDHS

A gendered HIV epidemic

As largely is the case elsewhere in Eastern and Southern Africa region, adult HIV prevalence is significantly higher among women aged 15-49 (21%) than among men in the same age cohort (14.5%)[3]. This gender gap is even wider among young people: Females aged 15-19 years have significantly higher HIV prevalence rates than men among the same age group (*Figure 3*).The differential between female and male prevalence is large also in the age groups 20-24, 25-29 and 30-34 years reflecting both historical transmission patterns and significant levels of age disparate sexual relationships. The peak age for HIV infection in women is 30-34 years while for men it is the 40-44 years age group.

Figure 1: HIV prevalence by age and sex in Zimbabwe (2005/6)



Source: 2005/6 ZDHS, Table 14.3

The annual number of newly infected is increasing after a steep decline in the 1990s and period of stability: It is estimated that 182 Zimbabweans were infected with HIV daily in 2009 compared to 173 in 2007

[3] 2005/6 ZDHS

In 2007, an estimated 63,247 adults acquired HIV: However, in 2009 it is estimated that this number rose to 66,156 (approximately 182 new HIV infections daily)[4]. HIV incidence is estimated at 0.85% in 2009. To put it simply, this means that, of every 100 HIV-negative persons in Zimbabwe, 1 person will become infected with HIV every year. Projections into the future, based on current HIV prevalence, population growth and ART utilization indicate that the number of newly infected adults will continue to grow.

Heterosexual sex within unions/regular partnerships accounts for the bulk of sources of new adult HIV infection in Zimbabwe: other sources of new infections include casual heterosexual sex and sex work

The UNAIDS Modes of Transmission (MoT) model was used to model sources of new infections, and overall incidence. The MoT 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 1* below:

Table 1: Sources of new adult infections in Zimbabwe [To be verified]

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

Nationally, the model estimates that the majority of new infections occur among people in the general community who are not engaging in high risk sexual activities. Individuals in this risk category are in discordant, monogamous relationships of at least a year's duration but often longer[5]. This finding is consistent with data from the ZDHS (2005- 2006), where 2000 cohabiting couples were tested for HIV. Among 72% of the couples, both partners tested negative for HIV. In 15% both partners were HIV positive. 13% of the couples were discordant. In 8% of the couples it was the male partner that was infected and the women was not. In the remaining 5% of couples the woman was infected and the man was not. Transmission of HIV among those engaged in low risk heterosexual sex occurs either within couples with long-term discordancy or among couples where HIV has been introduced into the relationship by occasional extra-marital sexual intercourse.

People involved in casual sexual relationships (more than 1 partner a year) and their partners contribute about 23.92% of new HIV cases. This is an expected finding given that the ZDHS (2005-2006) data show that multiple sexual partnerships in Zimbabwe are directly associated with risk of

[4] Spectrum/EPP estimates for Zimbabwe (June 2010)
[5]Colvin, M(2010) Zimbabwe Modes of Transmission Study

being HIV positive. Individuals engaged in concurrent sexual relationships would also fall into this category.

This modelling study also appears to show that sex workers and their clients contribute substantially to HIV incidence accounting for 14% of new HIV cases. In other words of the 66,156 new infections in 2009, sex workers and their clients accounted for 9,261 of these.

There is a scarcity of local HIV prevalence data among MSM in Zimbabwe and no systematic size estimations of MSM have been conducted in Zimbabwe. As such it has not been possible to accurately model the potential contribution of MSM to new infections in the country.

Key drivers of Zimbabwe's epidemic include multiple concurrent partnerships, low and inconsistent levels of condom use among married couples or those in long term relationships, low rates of male circumcision and age disparate sexual relationships

Key drivers described below put people at risk of HIV infection:

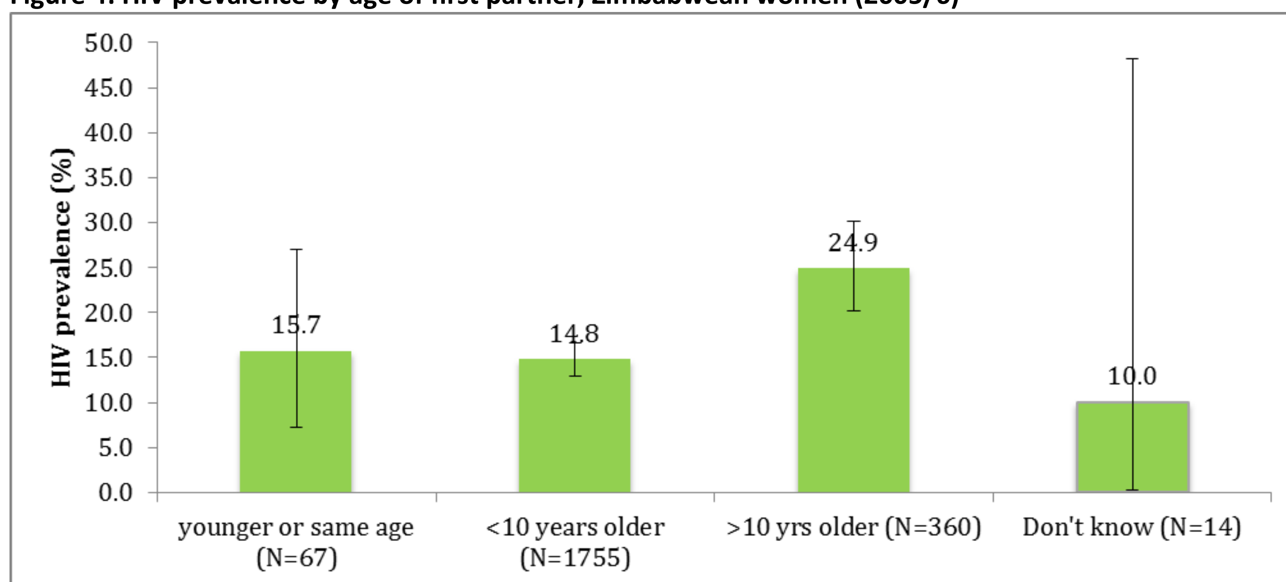
- Multiple Concurrent Partners (MCP) is generally defined as a sexual behaviour characterised by having more than one sexual partner in the same time period. Zimbabwean men are more likely to have multiple partners than women. According to the ZDHS (2005-6), 1 in 10 women and 1 in 3 men aged 15-49 years who had sex in the 12 months preceding the survey had sex with two or more partners.

- Low and inconsistent levels of condom use, especially among married couples**:** There is generally a low level of condom use in Zimbabwe, although the more casual the sexual encounter, the more likely that a condom is used due to increased risk perception. According to the ZDHS (2005-6), condom use is lowest amongst married couples and those with long-term partners with only 3.6% of married women and 7.7% of men reporting using condoms the last time they had sex with a spouse or cohabiting partner.

- Low Levels of Male Circumcision: Randomised controlled trials on male circumcision (MC) in South Africa, Kenya and Uganda showed the potential for MC to reduce HIV infection by almost 60%. However male circumcision in Zimbabwe remains low with 10.5% of men aged 15-54 reporting being circumcised in the 2005/6 DHS. Such a low level is unlikely to affect overall HIV transmission to any important degree.

- Age disparate sexual relationships: Studies indicate that relationships between young women and older men are common and tolerated in Zimbabwe as in many parts of sub-Saharan Africa and are associated with unsafe sexual behaviour and increased HIV risk as data from the 2005-6 ZDHS indicate(*Figure 4*). Gregson et al (2002) note that in such relationships condoms tend to used selectively and strategically and such utilization increases HIV risk.

Figure 4: HIV prevalence by age of first partner, Zimbabwean women (2005/6)

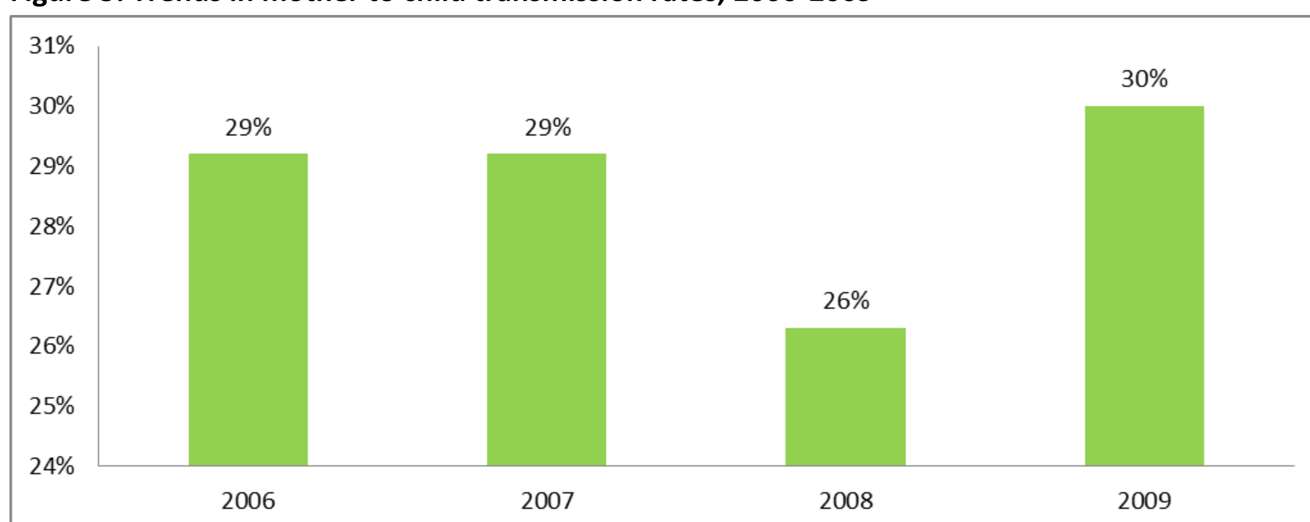


Source: ZDHS 2005/6

Mother to child transmission (MTCT) continues to remain a significant source of new infections among infants: Approximately 1 in 3 infants born to HIV infected mothers are infected

HIV infection from an HIV-positive mother to her child during pregnancy, labour, delivery or breastfeeding is called mother-to-child transmission (MTCT). The percentage of infants born to HIV infected mothers who are HIV infected has remained high averaging 28.5% between 2006 and 2009 (*figure 5*). An estimated 15,000 children were newly infected with HIV in 2009[6], the vast majority of them through MTCT.

Figure 5: Trends in mother to child transmission rates, 2006-2009



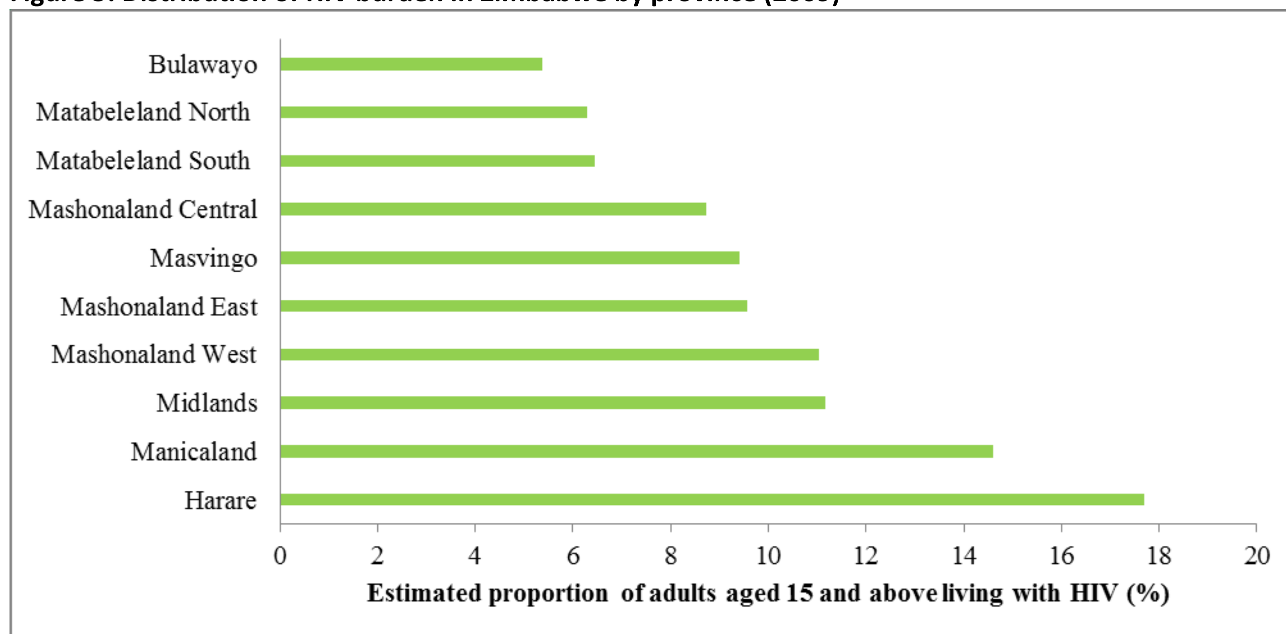
Source: MOHSW database

An estimated 1 million adults and 150,000 children are living with HIV Zimbabwe: the third Largest HIV burden in Southern Africa:

[6] Spectrum/EPP estimates for Zimbabwe (June 2010)

Zimbabwe has the third largest HIV burden in Southern Africa with an estimated 1 million adults aged 15 and above and 150,000 children under 15 living with HIV[7]. Disaggregation of adult HIV burden by province (*Figure 5*), reveals that 6 provinces account for 73.15% of PLHIV in the country with Harare, the province in which the capital is located, accounting for largest proportion of PLHIV in the country (just under 20%) and Bulawayo, the country's second largest city accounting for the smallest proportion of PLHIV (just over 5%).

Figure 5: Distribution of HIV burden in Zimbabwe by province (2009)



Source: Spectrum/EPP estimates for Zimbabwe, Government of Zimbabwe 2009/ZDHS 2005/6.

AIDS is a leading cause of mortality in Zimbabwe: 230 adults and children died from AIDS every day in 2009

Zimbabwe has one of the highest rates of premature adult mortality in the world, largely due to AIDS. It is estimated that over 84,000 adults and children died from AIDS in 2009[8]. A maternal and perinatal mortality study conducted in 2007 by the Ministry of Health and Child Welfare found that HIV and AIDS is the leading cause of death among mothers and infants accounting for over 27% of all deaths[9]. However, AIDS-related mortality is following a decreasing trend as result of increased availability and access to life-prolonging antiretroviral treatment (ART) in the country.

TB co-infection is high and contributes to mortality among PLHIV: 7 out of 10 adult TB patients tested HIV positive in 2008

Tuberculosis (TB) is a major public health problem: Zimbabwe has the fourth highest incidence of TB in the world[10]. Unlike most other high-burden countries, which have been steadily improving their rates of diagnosing and successfully treating TB, Zimbabwe's have been declining. As a consequence, TB-HIV co-infection rate is high: according to the World Health Organization (WHO),

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[7] HIV Estimates (June 2010)-Zimbabwe
[8] HIV Estimates (June 2010)-Zimbabwe
[9] Munjanga, S.P et al (2007) Zimbabwe maternal and perinatal mortality report
[10] WHO Global Tuberculosis Report 2010

nearly 68% of new adult TB patients tested HIV positive. National data suggest the actual estimate is slightly higher, around 80%[11]. Globally, WHO estimates that in 2008[12], 1 in 4 deaths of HIV-positive patients was caused by TB infection and although no data is available on TB-HIV related mortality in Zimbabwe, it is likely that it is similar if not higher.

AIDS deaths have left in their wake large numbers of orphans and vulnerable children: It is estimated that 25% of all children in Zimbabwe have lost one or both parents to AIDS

Over the past two decades, the large number of deaths from HIV and AIDS has left in their wake large numbers of orphans and vulnerable children. It is estimated that 25% of all children – 1.6 million – have lost one or both parents due to HIV and AIDS and related causes[13].

People with a history of STIs, especially genital ulcer disease, are more likely to be HIV infected

The 2009 ANC Sentinel Surveillance Report showed that women with current or past genital ulcer disease (GUD) had nearly three times the HIV prevalence of women without a history of GUD. Among young ANCs aged 15-24, those with GUD had a HIV prevalence of 31%. This is corroborated by ZDHS 2005-6 that found that men and women who reported a recent STI were significantly more likely to be HIV positive, according to the 2005/6 DHS. 40% of women who reported having had an STI or STI symptoms in the previous 12 months were HIV-infected, compared to 24% who did not report an STI or STI symptom. For men, the corresponding HIV prevalence figures were 32% and 18%.

Section 3: Zimbabwe's national response to HIV and AIDS 2006-2010

The 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*. The following section presents a summary of the results achieved, key challenges and gaps in the response to date. The section also articulates the policy and legal environment in which the national response is currently being implemented and managed.

3.1 Prevention of new infections

3.1.1 Social and Behaviour Change Communication (SBCC)

HIV incidence is the gold standard 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 they has been a decline in annual HIV incidence from 1.14 in 2006 to 0.85 in 2009(see *table 2*).

Table 2: Trends in annual HIV incidence, 2006-2009

Year	Estimated annual incidence	Range (low and high estimates)
2006	1.14	0.86 - 1.46

[11] MOHSW AIDS and TB Unit
[12] WHO Global Tuberculosis Report 2010
[13] ZDHS (2005-6)

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

This decline in new infections is supported by ANC HIV prevalence data among young women aged 15-24 (a generally accepted proxy indicator for incidence) in which HIV prevalence declined from 12.5% in 2006 to 11.6% in 2009 ($p<0.001$)[14]. 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 ($p <0.001$).

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[15] reported:

- More people had comprehensive knowledge of HIV (36% during the survey versus 23% at baseline in 2007);
- An increase in condom use with non-regular partners (39% during the survey versus 29% at baseline);
- An increase in the number of people ever tested from 36% to 50% and couples tested together from 12% to 25%; and
- HIV prevalence among young pregnant women in sites in SBCC focus districts declined from 14.8% to 12%

There survey also reported improvements in community norms about partner concurrency between the baseline and interim survey. In 2009 compared to 2007, more people disagreed that in their communities most men (21% vs. 14%) and women (24% vs. 20%) have multiple sexual partners even while married and that most women belong to a 'small house' (39% vs. 34%).

Key gaps and challenges in SBCC

- Generally with all SBCC interventions in Zimbabwe, there has not been insufficient integration with biomedical and structural interventions;
- Approximately 25% of infected couples in Zimbabwe are serodiscordant yet there is no evidence of SBCC interventions that target serodiscordant couples;
- Low coverage of the NBC programme: In 35 of 61 districts, interventions were only introduced in early 2010 and is still in the first stage of its implementation;
- Interventions been implemented under the NBCP are not appropriately targeted and segmented for all populations in the communities in which they operate and thus they do not reach all of their intended audiences with appropriate messaging. This is supported by findings

[14] Source: 2009 ANC Surveillance Report
[15] UNFPA/NAC. 2009. National Behaviour Change Strategy Interim Survey

from the interim evaluation that reported that more adults compared to young people participated in activities implemented under the NBCP programme;

- There are no social and behaviour change communication interventions targeting men who have sex with men (MSM). 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;
- Interventions focused on sex workers have not been of sufficient coverage or intensity;
- All schools must provide life skills based HIV and AIDS education to pupils, however the quality of life skills education provide is poor: To illustrate, an assessment by SACMEQ[16] on HIV knowledge concluded that only 1 in 20 grade six students in the country had desirable HIV and AIDS knowledge levels against 9 out of 10 teachers who reportedly had desirable knowledge. In addition, the current curriculum in use promotes abstinence only and the teaching of contraceptive use including condoms is prohibited.
- Similarly interventions focused on young people out of school have not been of sufficient coverage, intensity or duration and coverage of existing interventions has continued to decline;
- There is no evidence of SBCC interventions targeting PLHIV within support groups or those on Pre-ART and ART presenting missed opportunities for prevention with positives (PwP);
- There is no evidence that stigma and discrimination is adequately addressed in the NBCP. HIV related stigma deters many Zimbabweans from utilizing prevention services or from being tested for HIV, severely limiting the efficacy of the programme;
- There is evidence to suggest that the coverage of people reached through workplace based HIV and AIDS education has declined sign over the period in which ZNASP has been implemented.

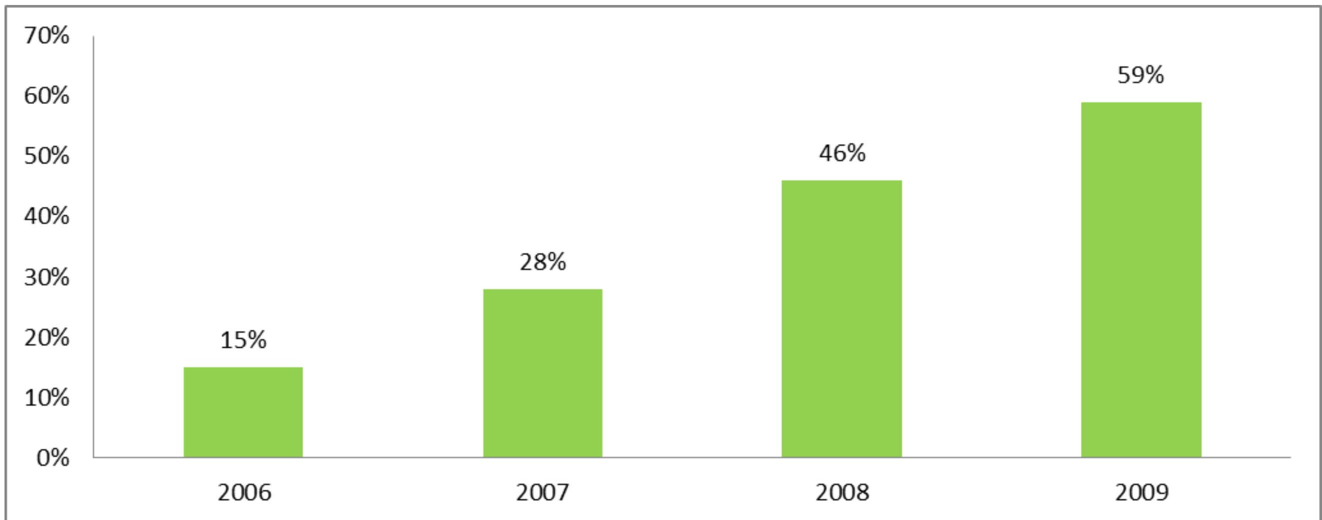
3.1.2 Prevention of Mother to Child Transmission (PMTCT)

Coverage of services for PMTCT has increased steadily. At the end of October 2010, 1 560 facilities provided ANC services, of which 60% offered both on-site HIV testing and ARVs for prophylaxis while the remaining 520 offered ARVs for PMTCT but do not yet offer on-site HIV testing. A new counseling cadre called primary care counselor was introduced in 20076 and supported the introduction and roll out of Provider Initiated Testing and Counseling (PITC) at Maternal and Child Health (MCH) sites. As a result, 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 6*).

Figure 6: Trends in percentage of pregnant women with HIV receiving antiretrovirals for preventing mother to child transmission of HIV, 2006-2009

[16] Southern and Eastern Africa Consortium for Monitoring Educational Quality (SACMEQ) 2010. How Effective are HIV-AIDS Prevention Education Programmes?



Source: MOHSW PMTCT program

The coverage of infant antiretroviral prophylaxis also increased in accordance with the increasing uptake of antiretrovirals 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[17].

Key gaps and challenges in PMTCT

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

- The majority of the investments in the PMTCT have been focused on MTCT. In contrast, preventing unintended pregnancies by increasing the voluntary use of contraception has been undervalued and little used. This is of concern in light of studies 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. Similarly primary prevention of HIV for pregnant women found to be uninfected when they access the PMTCT programme is limited and is of concern in light of findings from Mbizvo et al (2001) of high sero conversion incidence among women during pregnancy and following delivery. Finally, Although PMTCT accounts for approximately 40% of all testing in the country, relatively few eligible pregnant women are being initiated on ART for their own health;
- Coverage of PMTCT prophylaxis among HIV pregnant women at 59% remains sub-optimal;
- Coverage of Virologic testing for HIV exposed infant's remains unacceptability low at 13% resulting in many HIV positive infants unidentified in the postnatal period, thereby missing out on critical interventions;
- Testing male partners in the context of PMTCT remains a challenge. Involvement of men PMTCT is limited and very few participate in testing with their partners;
- ANC user fees 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 use ANC services where PMTCT services are situated;

[17] MOHSW data base

- Very few of the facilities offering PMTCT services are implementing the more efficacious regimen which is more effective in averting infections- only 8 out 62 districts offer the MER;
- Only 12% of the estimated HIV infected pregnant women were assessed for their eligibility to receive ART for their own health in 2009;
- There is evidence to suggest that HIV related stigma impedes the utilization of PMTCT services in Zimbabwe[18].
- Coverage of Cotrimoxozole prophylaxis remains alarmingly low: only 34% of all expected HIV-exposed infants received Cotrimoxozole in 2009; and
- Services to support mothers living with HIV in making safer infant feeding decisions at MCH clinics remain inadequate due to a lack of capacity by health workers to provide support.

3.1.3 Male Circumcision (MC)

The ZNASP recommended that male circumcision be included as an intervention to reduce the risk of heterosexual transmission of HIV to men and proposed that the feasibility and acceptability of its implementation at larger scale be investigated and pilot initiatives be established during the implementation period of the strategy. No specific MC targets were set in the ZNASP. An MC situation analysis was conducted and results disseminated 2008.

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[19].

Key gaps and challenges related to scaling up male circumcision

The national MC strategy has set an ambitious target of circumcising 1.2 million HIV negative young men aged 15-29 between 2011 and 2015 to reach 80% coverage, 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:

- Traditionally low rates of uptake of HIV testing and counselling among Zimbabwean men: given HIV prevalence rates of 13% among the target population, this would mean that a minimum of 1,356,000 in this age group would need to be counselled and tested over the next 5 years;
- Community awareness on male circumcision as well as its benefits remains low; and
- Presently only doctors are allowed to undertake circumcisions: At the time of writing no decision had been made on task sharing to allow nurses to undertake circumcisions. Given

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

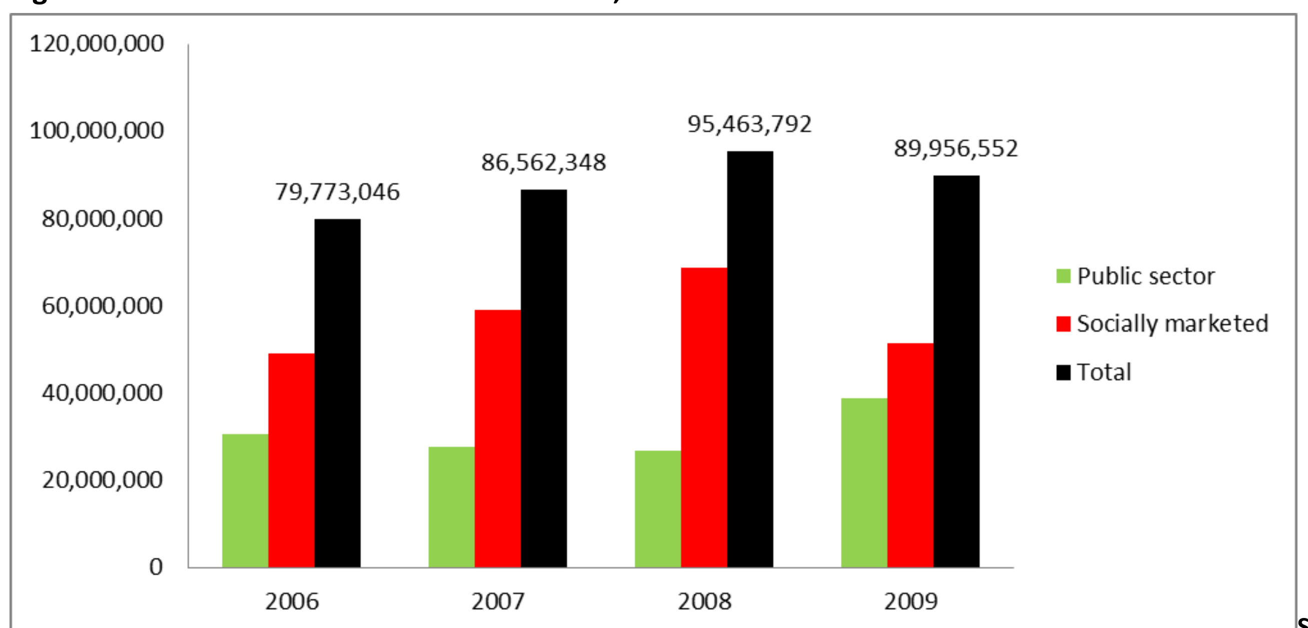
[19] MOHSW data base

the shortage of doctors, it would be impossible to achieve the proposed targets with this cadre alone;

3.1.4 Condom programming

In Zimbabwe, condom promotion and distribution is spearheaded by the MoHCW, the Zimbabwe National Family Planning Council (ZNFPC) and Population Services International (PSI). The main objective of the ZNASP (2006-2010) was to make both public sector and socially marketed condoms more widely available through the annual distribution of 150 million condoms annually by 2010. *Figure 7* below shows male condom distribution from 2006 to 2009.

Figure 7: Trends in male condom distribution, 2006-2009



Source: MOHSW AIDS and TB Unit

Zimbabwe managed to distribute 351,755,738 male condoms, 59% of the 600 million condoms the ZNASP had targeted to be distributed between 2006 and 2009. The number of male condoms distributed per person of reproductive age was 14 in 2006, 16 in 2007, 17 in 2008 and 16 in 2009[20]. 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.

Key gaps and challenges relating to condom promotion and distribution

[20] Persons of reproductive age are defined as those between the ages 15-49 (estimated population in this age group in is 5,514,830- source census)

- The quantities of male condoms distributed per person of reproductive age at 16 pieces per annum is insufficient;
- There are no approaches for promoting condom use in PLHIV especially in the context of sero-discordance;
- Further increases in condom use among casual partners and commercial partners appear difficult;
- Myths, misconceptions and negative perception by many of the public sector distributed condoms persist – there are insufficient marketing efforts for public sector condoms and unattractive packaging of public sector condoms;
- Service providers lack the technical capacity and confidence to promote the use of the female condom;
- There are social norms that create barriers to communication on sex and negotiating safe sex, in particular within marriage; and
- 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.

3.1.5 STI prevention, treatment and management

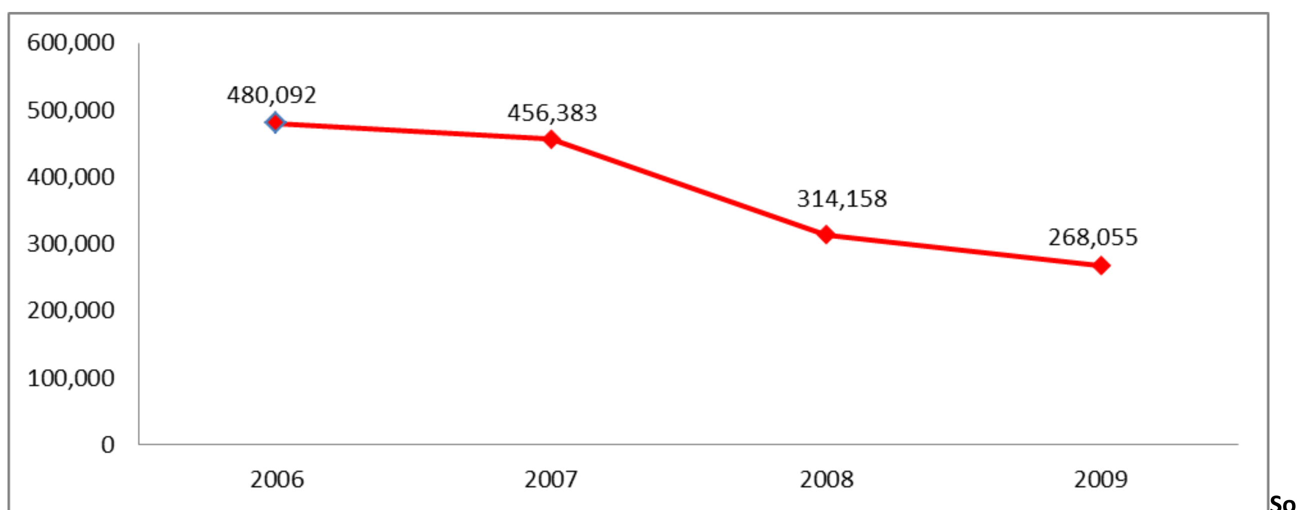
A review of the sexually transmitted infections programme in Zimbabwe was conducted in 2007[21]. The review reported that all provinces conduct health education and promotion programmes on STIs. Key approaches for STI prevention and management include condom distribution and promotion, as well as encouraging early treatment of STIs. The review also noted that strong referrals and linkages to the HTC, TB, PMTCT and ART services exist.

Policy and case management guidelines have been developed and disseminated throughout the country[22]. STI guidelines were revised in 2007; STI flowcharts have been printed and distributed; and the STI curricula was reviewed and expanded to include other HIV prevention.

The annual total number of STIs treated has declined by approximately 55% from just over 480,000 in 2006 to 268,000 in 2009 (*figure 8*).

Figure 8: Trends in cases of Sexually Transmitted Infections, 2006-2009

[21] Ministry of Health and Child Welfare 2007 Review of the Sexually Transmitted Infections Programme in Zimbabwe
[22] Ministry of Health and Child Welfare : The Zimbabwe Health Sector HIV Prevention Strategic Framework 2007-2010



Source: MOHSW AIDS and TB Unit

This decline in STI prevalence is attributed to concerted STI programming efforts centered 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;
- Although annual cases of STIs have been declining the number of cases remains high and disaggregated data for 2009 shows that there are some geographic areas which cases of STIs are on the rise. For instance Some 24,000 people were treated for STIs in 2009 in Harare, an increase of more than 150 percent from the 2008 figures of a total of 8 500 cases.

Post-Exposure Prophylaxis (PEP)

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. Pilots were undertaken at a number of learning sites. In 2008, 66% of health workers who reported a work related injury received PEP, while 69% of them completed treatment.

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

- PEP is not widely available in all health facilities;
- Insufficient capacity to provide PEP inside and outside of health facilities;
- 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

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[23].

Key gaps and challenges related to Blood safety

- Uptake of post donation counseling has been low: In 2008, only 15% of donors came back to obtain their results and post donation counseling in 2008[24];
- 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 ZNASP 2006-10 identifies HIV Testing and Counselling (HTC) as an important component of the national prevention response. The Zimbabwe National HIV Testing and Counseling 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.

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.

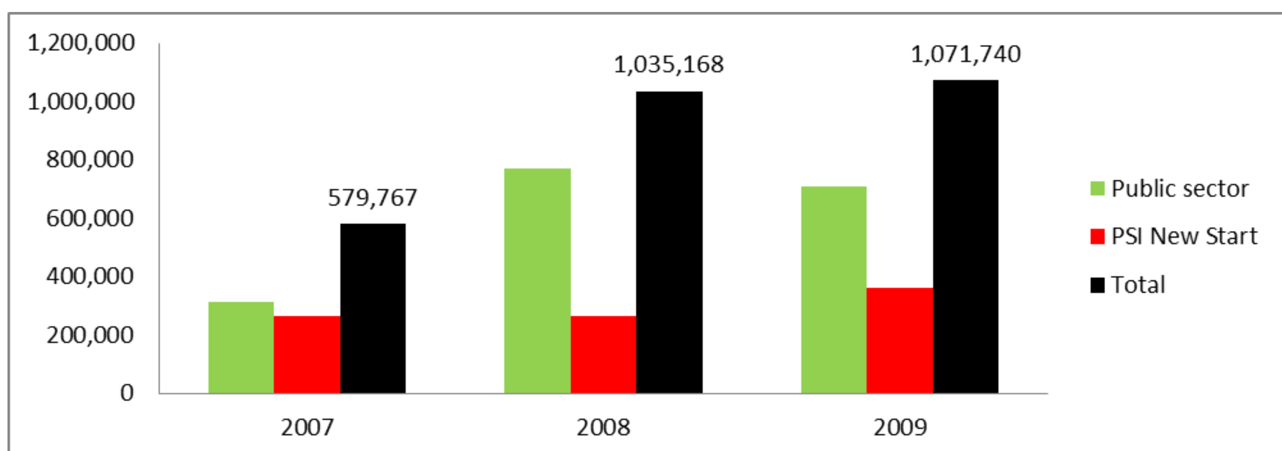
Figure 8 shows data on annual uptake of HIV testing and counselling public sector facilities as well as at PSI's New Start centres between 2007 and 2009[25]. The data show that there number of individuals counselled and tested almost doubled between 2007 and 2008 and has remained stable at just over one million individuals been tested annually. 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. PITC gives all patients who register at a health centre the option to be counselled and tested for HIV.

Figure 8: Trends in number of individuals counselled and tested for HIV, 2007-2009

[23] It also attained ISO certification in 2006 and retained the certification since.

[24] National Blood Service Zimbabwe 2008 Annual Report

[25] These data must be interpreted carefully because they may include individuals re-testing for HIV during the reporting period



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ource: MOHSW AIDS and TB Unit

Knowledge of HIV status seems to have increased as results from the NBCP interim survey showed that the percentage of people ever tested for increased from 36% at baseline to 50% at the interim survey. There were also significant increases in couple counselling from 12% in 2007 to 25% in 2009[26].

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

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

- Too many people living with HIV are unaware of their HIV status: approximately three in five of the estimated 1 million adults aged >15 living with HIV are unaware of their status, placing them at greater risk for spreading the virus to others[27];
- Couple counselling rates remain low especially in light of discordancy data highlighted earlier: CITC data indicate that only 20% of individuals accessed HTC as couples in 2009;
- PITC is not offered in all health facilities: 1 in 3 public health facilities do not have the capacity to offer PITC;
- Disaggregated HTC data indicate that the majority of individuals tested and counselled are females with limited participation by men;
- Although primary care counsellors have been recruited to support HTC, they are only able to offer pre and post-test counselling and are prohibited from undertaking rapid testing limiting, the efficiency of the HTC process;
- HTC services are insufficiently integrated with other services including MC and Family Planning;
- Insufficient coverage of HTC in rural areas;
- Insufficient coverage of HTC services in 6 high burden provinces;
- Due perhaps to deficiencies in policy, very few children aged <15 are being counselled and tested;
- HIV related stigma and discrimination acts as a significant impediment to utilization of HTC services[28].

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[26] UNFPA/NAC. 2009. National Behaviour Change Strategy Interim Survey
[27] MOHSW ART/HTC data base and EPP/Spectrum estimates (June 2010)
[28] Sambisa, W (2008) AIDS Stigma and Uptake of HIV Testing in Zimbabwe. DHS working papers

- Civil society and community responses have been limited by weak technical and organizational systems to enable them to effectively respond.

3.2 Treatment and Care

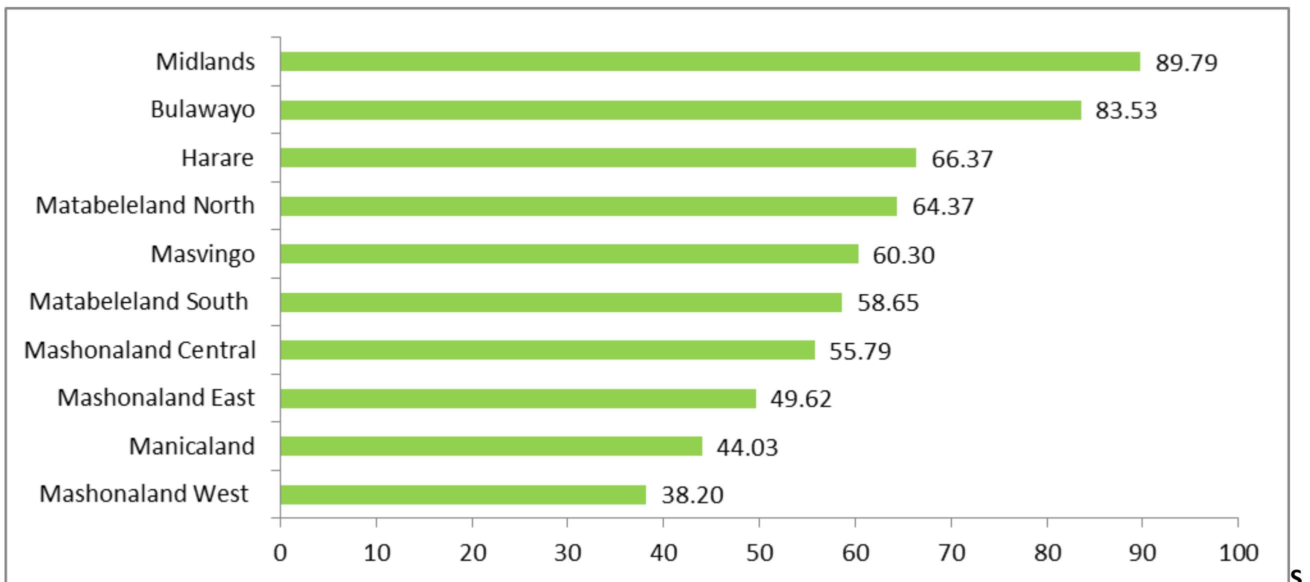
3.2.1 Provision of Antiretroviral Therapy (ART)

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. Due to high HIV related mortality at the time of the development of the strategy (annual deaths were estimated at 123,065 in 2006), the ZNASP 2006-2010 set ambitious targets of significantly increasing coverage of both adult and child ART. The ZNASP proposed to ensure that by 2010 at least 75% of adults with advanced HIV infection received ART and that *all* children with advanced HIV infection received ART.

At the end of June 2010, 314,927[29] adults with advanced HIV infection were on ART (60% of whom were female) representing coverage of 54% based on the recently revised WHO guidelines, up from 39% in 2009, 17.5% in 2006 and just 8.3% in 2005[30]when the ZNASP was been developed representing significant progress.

Zimbabwe would have surpassed the ZNASP target had the WHO guidelines on eligibility for ART not been revised. *Figure 9* shows adult ART coverage by province as at June 2010.

Figure 9: Percentage of adults with advanced HIV infection on ART, by province 2010[31]



Source: MOHSW ART database and EPP/Spectrum estimates on PLHIV, June 2010

As the table shows, ART coverage is highest in Bulawayo and Midlands (over 80%) and lowest in Mashonaland West, Manicaland and Mashonaland East (under 50%).

[29] MOHSW ART database
[30] Zimbabwe Country progress report (2009)
[31] As at June 2010, based on current WHO guidelines

The number of eligible HIV infected children on ART was 8 627 (24.8%) in 2007, 13 287 (38.7%) in 2008 and 20 003 (57.1%) in 2009 based on the old (2006) WHO recommendations for initiating ART in children. However, there were 33 424 children on ART by June 2010, representing coverage of 37% based on the revised (2010) WHO recommendations for initiating ART in children.[14] The upward trend in coverage noticed between 2007 and 2009 is primarily attributed to the scale up and decentralization of the ART programme which was linked to an increase in coverage of public health facilities offering comprehensive ART services (i.e. both initiating treatment and follow up) from just 4.36% of facilities in 2006 to 7.82% by June 2010. The number of facilities providing follow up ART services also increased from just 32 in 2006 to 387 by June 2010.

Retention rates of HIV infected individuals are also commendable: Cohort analysis undertaken by the National AIDS Commission reported retention at 12 and 24 months after initiation of treatment as 75% and 64% respectively[32 33].

The expansion of ART coverage is also attributed with helping to keep more people alive and reduce HIV related mortality. It is estimated that annual AIDS death decreased from 123,000 in 2006 to 84,000 at the end of 2009[34.]

At the end of 2009, the ART Programme began to undertake HIVDR prevention surveys that focus on consecutively selected cohort of eligible patients starting ART in each of the selected representative sentinel sites and evaluates HIVDR outcomes 12 months after ART begins[35]. Besides collecting data on outcome factors like viral load, information on adherence, mortality and loss to follow up is also being documented. The first results from the surveys are expected at the end of 2010.

Key gaps and challenges relating to the provision of ART

Although substantial progress has been made towards to achieving universal access to ART for both adults and children, nearly half of all eligible adults and two thirds of children are still not receiving treatment. In addition, the number of adults, infants and children newly paced on ART is still not keeping pace with the number of those newly infected as a result of failure to prevent new infections. Key gaps include:

- Current estimates on HIV disease burden reveal that 6 provinces account for approximately 73.2% of the HIV disease burden in Zimbabwe. However, the ART program equitable distribution of ART services countrywide without due regard to data on HIV disease burden per province or district as resulted in ART treatment gaps in areas where it is needed most;
- Physicians are currently the only cadre allowed to initiate ART in Zimbabwe. As a result of their severe shortage, expansion of ART services has been limited. Given that this shortage is expected to continue in the short to medium term, it has been acknowledged that tasks customarily performed by physicians will have to be shared and involve other health-care

[32] ART Data Verification & Cohort Analysis in 22 districts, Global Fund Round 5 Zimbabwe (1-6 November, 2009)
[33] Cohort Analysis of ART patients 24 Months after ART Initiation, NAC, Jan 2010.
[34] EPP/Spectrum estimates, June 2010.
[35] Report on the National HIV Drug Resistance Prevention and Assessment Strategy2006-2008, MOHCW

providers such as clinical officers and nurses, of whom there are greater numbers. Although the MoHCW has adopted the IMAI guidelines, hence allowing ART initiation at first level (task shifting) by nurses. However, the policy and regulatory framework has not been changed to allow task shifting or sharing to be implemented in Zimbabwe;

- All HIV infected individuals currently on a Stavudine based regimen have to be switched according to the WHO 2009 recommendations from 2011 onwards. Stavudine will be substituted by Tenofovir (adults) or Zidovudine (children). Due, to the large number of clients involved and the financial implications of the new drug regimens, this switch presents a significant challenge to the current programme;
- An analysis conducted as part of the development of this strategy shows that on average each comprehensive ART facility manages 2,756 patients and this has severely compromised the quality of treatment and care provided to patients not to mention the high burnout and stress reported by health workers working in these facilities during supervisions. As a direct consequence, there is often no opportunity for appropriate monitoring of patients to ensure that Pre-ART clients are followed up according to the National ART Guidelines or for clients on ART, there is limited quality follow up to ensure medication adherence ;
- Furthermore, the quality of care is compromised by inadequate laboratory services (especially CD4) to monitor clients on OI/ART;
- Moreover, viral load testing is not routinely available in the public health sector
- The ART data that is currently being collected using a paper based system monthly is cumulative or program based. Hence, undertaking cohort analysis with this this data set is impossible and presents a considerable challenge with regard to timely data analysis and use for the national ART programme;
- There is limited relevant operational research undertaken within the ART programme to inform decision making and policy formulation; and
- Civil society and community responses have been limited by weak technical and organizational systems to enable them to effectively respond

3.2.2 Prevention, care and management of TB/HIV coinfection

Although gaps in routine surveillance of HIV among TB patients, TB is highly associated with HIV infection in Zimbabwe and it is estimated that approximately 80% of TB cases are co-infected with HIV[36]. 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.

Zimbabwe adopted the WHO interim policy on TB/HIV collaboration in 2007. A national TB/HIV collaborative committee was established in 2008, followed by the establishment of decentralized collaborative structures at provincial and district level[37]. At national level the two programmes have started joint planning and there are work plans for the implementation of the collaborative activities. Both programmes have focal points responsible for the collaborative activities.

[36] National TB Control Programme Database, MOHCW, 2009
[37] TB/HIV Planning Reports 2008 -2010, MoHCW

The ART and NTP programmes worked closely in the development of the 2009-2013 NTP Strategic plan and the guidelines for co-management of TB/HIV, including development of strategies for intensified case finding and infection control in healthcare settings. Table 3 shows progress in TB/HIV programming

Table 3: Progress in prevention, care and management of TB/HIV coinfection

	2007	**2008**	**2009**
% (number) of TB cases tested for HIV	26 (10,762)	45(18,310)	83 (38,424)
% (number) HIV positive	69 (7,426)	76 (18,310)	77 (29,586)
% (number) of HIV positive TB cases put on CPT	78 (5,824)	79 (12,402)	Data not available
% (number) of HIV positive TB cases put on ART	23 (1,727)	33 (4,630)	Data not available

As the table indicates, there has been substantial progress in expanding HIV testing and counselling for people with TB since 2007. The percentage of people with TB that were tested for HIV increased from just 26% in 2007 to 83% in 2009. This rapid increase in the uptake of HTC was mainly attributed to training of health workers and the revision of the TB M&E tools to capture HIV activities.

ART is a high priority life-saving intervention for PLHIV. Studies and modeling efforts suggest that early initiation of ART for PLHIV who develop TB may lead to reduced mortality and incidence of TB[38]. The percentage of PLHIV and TB who received ART increased from 23% in 2007 to 33% in 2008.

Co-trimoxazole preventive therapy (CPT) has been proven to reduce morbidity and mortality among PLHIV and TB. The total number of PLHIV and TB who were treated with CPT increased by 100% from 5,824 in 2007 to nearly 12,500 in 2008.

Key gaps and challenges relating to the prevention, care and management of TB/HIV coinfection

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 coinfection remains far from the goal of universal access. Key gaps and challenges include:

- Non availability of TB drugs due to stock outs are frequent
- Low uptake of ART service due to limited capacity and competence among health workers in TB/HIV co-management as well as limited ART initiation capacity the challenge of which has been described in earlier section;
- WHO recommended isoniazid preventive therapy (IPT) for people living with HIV in early 2008. However, no policy on IPT has been developed or implemented to date;
- TB infection control measures are equally important in settings providing health services, particularly to people living with HIV, but this critical TB intervention has been largely

[38] Lawn SD, Churchyard G. Epidemiology of HIV-associated tuberculosis. Curr Opin HIV AIDS. 2009 Jul; 4(4):325-33.

overlooked and the expansion of HIV services without these measures in placed has created optimal conditions for hospital related TB transmission among vulnerable patients, their families and health care workers;

- The limited number of diagnostic services for TB (sputum examination and CXR) in some health facilities has led to a delay in treatment of TB and initiation of ART;
- Regarding DRTB diagnostic services; there were often shortages of reagents for DRTB culture and drug susceptibility testing (DST);
- There are no regular DRTB Surveys in order to establish the burden of DRTB among TB cases in Zimbabwe;
- The data also draw attention to the urgent need to strengthen integrated monitoring and evaluation systems to assess the progress and outcomes of collaborative HIV/TB interventions; and
- Civil society and community responses have been limited by weak technical and organizational systems to enable them to effectively respond

3.2.3 Diagnostic services for treatment and care

Diagnostic services play a vital role in the success of the national HIV/AIDS response. Laboratories play an essential role in diagnosing HIV infection, assessing the immune status of people living with HIV, formulation of treatment plans and in monitoring treatment outcomes such as adverse events and treatment failure.

Key progress in diagnostic services includes the procurement, distribution and utilization of 71 CD4, 69 haematology and 45 biochemistry machines in the public health facilities. In order to expand HR capacity for diagnostic service provision, the MoHCW reintroduced the State Certified Medical Laboratory Technician (SCMLT) training programme in 2007 and also created 2 posts for this cadre at district laboratories in response to the increase in demand of services created by the HIV services and exodus of laboratory scientists to other countries. 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 and viral load testing has recently been launched.

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

- The exodus of laboratory scientists out of the country negatively affected the laboratory services: of the 430 posts, only 43% are filled;
- Laboratory monitoring for Pre-ART and ART is largely centralized – technicians and diagnostic services at the peripheral levels (particularly rural and remote areas) are severely lacking;
- The current laboratory infrastructure in place is inadequate to respond to the diagnostic needs of patients on Pre-ART and ART;
- Laboratory information and management systems (including stock management) are weak;
- Frequent stock outs of reagents for monitoring Pre-ART and ART patients;
- Electricity backup systems are inadequate;

- Support and supervision systems are inadequate; and
- Logistic systems are weak;
- Civil society and community responses have been limited by weak technical and organizational systems to enable them to effectively respond;

3.2.4 Community home based care (CHBC)

Community home based care (CHBC) and support services provided in Zimbabwe over the past 5 years have comprised a broad range of activities, exclusive of ARV treatment, that are available to HIV-infected and affected individuals. These activities, including palliative, psychological, social, spiritual and preventive services, seek to increase retention in care, maximize functional ability, and minimize morbidity. In rural areas and places where clinics are overcrowded, home-based care and community health workers provide essential services and strengthen the reach of a health system.

CHBC is well established in Zimbabwe. A national CHBC strategy has guided CHBC activities in Zimbabwe. National CHBC policy and guidelines have been developed and a harmonized national training programme for CHBC has been developed and is in use. This is supported by a caregiver policy that guides the management of care givers working in the area.

Significant numbers of chronically ill have accessed CHBC over the past five years. The number of chronically ill individuals receiving care increased from 453,957 in 2007 to 489,320 in 2008 and 697,647 at the end of 2009.

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

- Although all districts have an implementer of CHBC, the geographical coverage is limited to less than a third. In addition, interventions are largely concentrated in urban and peri-urban areas leaving outlying areas without coverage;
- Involvement of men as care givers and volunteers is an clear and ever present challenge;
- Supply and replenishment of CHBC kits is inadequate to meet client needs and has been inconsistent compromising the quality of care and support provided;
- Weak integration and linkages of the CHBC activities with HTC, ART, PMTCT, STI and TB interventions severely limiting effectiveness and efficiency of interventions;
- High rates of turnover of caregivers and volunteers due to burnout and stress;
- Quality of support and supervision provided to care givers is limited;
- Weak monitoring and evaluation systems for CHBC; and
- Although ART coverage has increased significantly, the CHBC programme has yet to be reoriented to responding to the evolving care and support needs of individuals infected by HIV and AIDS

3.2.5 Nutrition Programming for children and adults living with HIV

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) [39].

The Government has to date provided guidance on nutrition programming for children and adults living with HIV[40], including nutritional assessment and counseling of those with HIV and AIDS, multi micronutrient supplementation and managing the dietary implications of taking anti-retroviral (ARV) drugs. 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

- Coverage of therapeutic and supplementary feeding is low;
- Although guidance on nutrition programming has been developed, it has yet to be disseminated;
- Only 33% of health facilities have capacity to manage acute malnutrition among children and adults living with HIV[41].
- Reflecting challenges related to quality of care of PLHIV on Pre-ART and ART mentioned earlier, nutrition counselling and assessment has been inadequate[49] ;
- Zimbabwe is yet to adapt the revised WHO Infant and Young Child Feeding Guidelines;
- The majority of the foods utilized to support therapeutic and supplementary feeding of children and adults living with HIV who are suffering from severe and moderate acute malnutrition is imported and is not sustainable in the long term; and
- There is weak collaboration between the Nutrition and HIV Programmes; and
- The lack of data also draw attention to the urgent need to strengthen monitoring and evaluation systems related to nutrition programming

3.3 Mitigation and Support

3.3.1 Care and support for orphans and other vulnerable children (OVC)

Deaths from AIDS have left in their wake a growing number of orphans and vulnerable children and Zimbabwe. The country has the unenviable record of having 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[42].

The ZNASP 2006-2010 recognized the urgency of addressing the growing needs of children orphaned or made vulnerable by HIV and AIDS with compassionate care and support. A National Action Plan for OVC (NAP) for 2006-2010 was developed during the same time as the ZNASP and aimed to reach 25% of OVC by 2010 with appropriate care and support. To implement NAP, an $86 million multi-donor Programme of Support (PoS) administered by UNICEF was established.

[39] Greenaway K, 2009, No 2: Food by Prescription: A Landscape Paper, GAIN working paper series.
[40] MOHCW (2010) Guidelines on Dietary Management for PLHIV (2010) and MOHSW Policy Statement on Infant Feeding and HIV as well as Infant Feeding Guidelines for Health Workers were developed in 1999.
[41] National Nutrition Programme Database, National Nutrition Unit, MOHCW, October 2010.
[42] ZDHS 2006-2010 and EPP/Spectrum estimates (June 2010)

To date, more than 410,000 children have been reached with appropriate care and support through the PoS. Given that national estimates suggest that there may be as many as 1.6 million OVC, the PoS managed to achieve the 25% target set in the NAP. In addition, an independent outcome assessment of the NAP activities funded through PoS in 201043 concluded that the programme was found to be relevant to the needs of the OVC, efficient and effectively implemented.

Key gaps and challenges relating to care and support for OVC

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[44]:

- Unclear targeting due to different definitions of OVC in the NAP, PoS and the BEAM programme;
- OVC suffer many types of deprivation, but the majority of interventions have only provided an average of 1 or 2 types of support and were not comprehensive;
- Interventions have overly focused on reach (number of children served) to the detriment of the quality and standard of the care and support services provided to OVC;
- 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;
- Child poverty was not considered as a key cause of vulnerability in the original NAP yet household poverty is a major cause of child vulnerability in Zimbabwe, resulting in a lack of access to social services and increased protection risks for the poorest children yet targeting vulnerable children together with their households is likely to be more effective than focusing on OVC alone as the numerous social cash transfers interventions initiated in the east and southern to support families that care for orphans and other children affected by AIDS has shown[45].
- Interventions to address child abuse are limited;
- Monitoring and evaluation systems related to care and support for OVC are weak;
- Civil society and community responses have been limited by weak technical and organizational systems to enable them to effectively respond

3.3.2 Meaningful Involvement of PLHIV (MIPA)

Zimbabwe like the rest of the world adopted GIPA now MIPA as articulated in the outgoing. A key strategic action of ZNASP 2006-2010 was to fully operationalize (mainstream) MIPA throughout the thematic areas of the national response. PLHIV are represented and participate in key national

[43] Jimat Development Consultants (2010*) Programme of Support for the National Action Plan for Orphans and Other Vulnerable Children: Outcome Assessment*, Harare. (Report prepared for the OECD-OVC Group, the Ministry of Labour and Social Services and UNICEF).
[44] *Programme of Support for the National Action Plan for Orphans and Other Vulnerable Children: Outcome Assessment*, Harare. and MTR of the ZNASP (2009).
[45]Stewart, S and Handa, S (2008) Reaching OVC through Cash Transfers in Sub-Saharan Africa :Simulation Results from Alternative Targeting Schemes- UNICEF working paper

governance structures such the National AIDS Council (NAC) and the country coordinating mechanism (CCM) and they have made important contributions to the functions of both structures. They also sit and participate in decentralized coordination structures of both the NAC and the Zimbabwe AIDS Network. 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

- The MIPA baseline study undertaken by ZNNP+ reveals that one of the biggest barriers to MIPA is HIV related stigma at three levels: social, institutional and personal;
- Although PLHV are represented in key national governance structures such as the NAC and the CCM, effective engagement in both structures has been limited by the fact that PLHIV representatives in these structures lack the resources to regularly communicate to their constituencies and to solicit ideas and feedback;
- Although PLHIV have participated and participate in formulation and implementation of key HIV policies and strategies, they often lack the capacity to exercise their voice and to participate effectively in national HIV and TB policy formulation, legislation, implementation and monitoring;
- Although 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

3.4 Effective management and coordination of the national HIV and AIDS response

Zimbabwe's multisectoral response to HIV and AIDS is managed and coordinated by the National AIDS Council (NAC), a statutory body established by an Act of Parliament in 2000. The NAC has an executive secretariat, responsible for coordinating the response with particular focus on national policy development, partnerships and resource mobilization, monitoring and evaluation and administration of the National AIDS Trust Fund (NATF). Zimbabwe's health sector response is coordinated by the MOCHW HIV and AIDS and TB unit. Zimbabwe adheres to the "Three Ones" principles: the existence of one national coordinating body, one strategic national plan of action and one national monitoring and evaluation framework. Decentralized coordination structures of the NAC include Provincial AIDS Action Committees (PACs), District AIDS Action Committees (DACs), Ward AIDS Action Committees (WACs) and Village AIDS Action Committees (VACs).

A number of 'de facto' coordinating entities involved in the national response in Zimbabwe and these include: (1) The Zimbabwe Business Coalition on HIV and AIDS (ZBCA) which coordinates the private sector response to HIV and AIDS; (2)The Zimbabwe AIDS Network (ZAN) which coordinates civil society responses to HIV and AIDS; (3)The Zimbabwe Network of PLHIV (ZNNP+) which coordinates associations of PLHIV in Zimbabwe; (4) The UN Joint Team on HIV and AIDS (UNJT) which coordinates the UN family's response to HIV and AIDS and (5)The Country Coordinating Mechanism (CCM) which coordinates resource mobilization to the GFATM and provides oversight over the implementation of Global Fund HIV related grants in the country.

A multi-sectoral national partnership forum was established and meets quarterly at national level to strengthen the national response to HIV and AIDS through effective coordination among key stakeholders. One of its main tasks is to coordinate information sharing and analysis of trends, identify and address resource gaps in order to scale up and sustain comprehensive HIV and AIDS interventions.

Numerous Technical Working Groups (TWG) have been established to coordinate intervention specific activities including TWGs for HTC, treatment and care, condoms, MC, youth, CHBC, PMTCT, TB/HIV, BCC, nutrition, M & E and OVC.

Key gaps and challenges relating to management and coordination of the national response to HIV and AIDS

Key gaps and challenges that hinder the effective management and coordination of the national response to HIV and AIDS include:

- There are no joint annual planning and review process for the national response to HIV and AIDS;
- There is inadequate capacity and experience in operational planning;
- Donors and financing partners to the national response to HIV and AIDS do not have a specific coordination mechanism and as a result the NAC reports that it finds it difficult to effectively interact with them in a unified manner;
- The Ward AIDS Action Committees (WACs) and Village AIDS Action Committees (VACs) are dysfunctional and even when they were functional have proven expensive to manage and run;
- No specific mandate to coordinate their respective mandates for a number of ' de facto' coordinating agencies was provided in the last ZNASP and many of these agencies are often perceived as representing their own interests undermining their authority and credibility;
- A number of TWG are dysfunctional, duplicate coordination and have not met regularly and consistently and a significant majority lack clear terms of reference;
- Although ZNASP 2006-10 was costed, no accompanying resource mobilization strategy was developed to support its implementation and as such as resource mobilization has been a challenge;
- 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;
- There exists no subsidiary legislation to the NAC Act in the form of statutory instruments to operationalize the act and this has hindered the ability of the NAC to effectively undertake its mandate. For instance it has been noted that there is no legal requirement for all stakeholders in the national response to report their HIV and AIDS activities ;
- Coordinating the mobilisation and strategic allocation of financing to different areas of the national HIV and AIDS response has been difficult. Many parallel financing systems exist;

3.5. Policy Context to the national response to HIV and AIDS

Zimbabwe has a large number of policy instruments relevant to HIV and AIDS at national and sectoral level. Zimbabwe is also committed to fulfilling its international obligations as party to the UNGASS Declaration of Commitment on HIV and AIDS (UNGASS 2001), The Abuja Declaration and Plan of Action (2001), the Maseru Declaration on HIV and AIDS, The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) and the UN Convention of the Rights of the Child and the Universal Human Rights Declaration, and aiming to attain the Millennium Development Goals.

However despite the plethora of policy instruments, there are certain key aspects of the legal and regulatory environment that impede effective implementation of the national response:

- *Operationalization of the NAC Act*: as mentioned earlier in section 3 above there exists no subsidiary legislation to the Act and this has hindered the ability of the NAC to effectively undertake its mandate, particularly as it relates to effective monitoring and evaluation of the national response
- *National HIV and AIDS policy*: There has been no significant, formal, overall policy development since the national HIV policy published in 1999. Although the paper has provided excellent guidance for overall policy, it needs to be reviewed and updated in light of new evidence and the evolving epidemic;
- *The law and MARPS:* A series of difficult legal issues arise from attempts to programme more directly for the MARPs (sex workers and MSM), and to take these programmes to scale: Sex work and homosexuality are all illegal in Zimbabwe. Programmes have been working with all these groups for many years, but under severe constraints;
- *School based HIV and AIDS education:* Government policy prohibits teaching of condom use in the schools based HIV and AIDS education programme and adversely affects prevention efforts among sexually active young people;
- *HIV testing and counselling for children:* there is no explicit policy guidance on how HIV testing and counselling services should be provided to infants and children, regardless of their legal status;
- *Infant feeding in the context of HIV and AIDS*: The policy Statement on Infant Feeding and HIV as well as Infant Feeding Guidelines for Health Workers were developed in 1999 and have yet to be revised in light of current evidence and recently issued guidance from WHO;
- *Isoniazid Preventive Therapy (IPT):* There is currently no national policy on IPT despite evidence that has shown that IPT dramatically reduces the incidence of TB among PLHIV; and
- *Task sharing and task shifting:* Zimbabwe does not have national policy that regulates task sharing and task shifting. Lack of such a framework hinders collaboration, information sharing, and allocation of specific funds or resources for task shifting or task sharing.

Section 4: ZNASP II Strategic framework

The ZNASP 2006-2010 provided a sound framework within which sectoral and civil society-led strategies, plans and budgets could be formulated, implemented and monitored. However, a key weakness of ZNASP 2006-2010 was that it was not prioritized nor was it results focused as reflected in the lack of a results framework or clearly articulated targets and results to be achieved.

A key feature of the Zimbabwe National Strategic Framework for HIV and AIDS 2011-2015 (ZNASP II) is a results framework that starts with evidence and baselines and articulates specific measurable results. Secondly, interventions proposed in ZNASP are prioritized. Consequently, the following six criteria were used to prioritize proposed interventions and strategic actions: (1) Strength of current national and global evidence on the effectiveness of proposed interventions (2) whether or the intervention proposed will affect the course of the epidemic and/or significantly affect the lives of those infected of affected; (3) whether the proposed intervention will achieve maximum impact with the least amount of resources; (4) Whether the proposed intervention warrants public subsidy, (5) Whether proposed interventions address drivers of the epidemic noted in section 1 above and finally, (6) whether the proposed interventions have adequate political support.

Reflecting a commitment to achieving an impact within the population, the ZNASP II is structured around achieving the following expected **impact level results**:

- The estimated annual number of new infections is reduced from 66,155 in 2009 to 46,308 by 2015;
- The percentage of HIV infected infants born to HIV positive mothers is reduced from 30% in 2009 to less than 5% by 2015;
- The percentage of pregnant women aged 15-19 who are HIV infected is reduced from 6.8% in 2009 to 6% in 2011, 5% in 2013 and 4.5% by 2015;
- The percentage of young people aged 15-19 who are HIV infected is reduced from 3.1% among women in 2006 to 2.17 in 2015 and from 6.2% among men to 4.3% in 2015; and
- The estimated annual number of deaths to AIDS is reduced from 84,000 in 2009 to 58,800 by 2015.

The Zimbabwe National HIV and AIDS Strategic Plan 2011-2015 (ZNASP II) consists of four thematic areas: (i) HIV prevention, (ii) HIV and AIDS treatment, care and support (iii) Enabling environment and (iv) management and coordination of the national response. Each of the thematic areas consists of prioritized intervention areas. The specific prioritised interventions under each thematic area, the expected outcome results as well as the strategies to achieve those results are described in the pages that follow.

4.1 HIV prevention

The past decade has brought some remarkable successes in HIV prevention in Zimbabwe, with the country witnessing significant contractions in HIV prevalence and incidence. However, despite these successes, prevention remains the greatest challenge of the HIV epidemic in Zimbabwe. For every two Zimbabweans who began antiretroviral treatment in 2009, another 1 individual got infected with HIV. The life time cost of treating HIV is estimated to be approximately $14,000.

Unless this trend is reversed and the number of new infections sharply reduced, efforts to expand access to HIV treatment will falter and countless numbers of Zimbabwean will die as a result of unavoidable infections.

Zimbabwe can reduce HIV transmission: There are effective means to prevent every mode of transmission. However, while attention to the epidemic, particularly for treatment access has increased significantly in recent years, the effort to reduce HIV incidence is faltering. As the analysis presented in section 3 above has shown, the country has not yet reached individuals and communities with the level of prevention coverage needed to have major impact. To realize the promise of available HIV prevention tools, they must be brought to scale: To illustrate, modelling clearly shows that if MTCT was virtually eliminated and 80% coverage of male circumcision among 15-29 was achieved over the next 5 years, half of the infections projected to occur by 2025 could be averted and the annual number of new HIV infections would plummet by nearly a third to fewer than 46,000 infections by 2015.

The Modes of Transmission (MOT) study also shows us that not every person or group has an equal chance of becoming infected with HIV. Yet for many years, too much of the country's response has been conducted as though everyone is equally at risk for HIV infection. It is evident that reducing HIV transmission requires a more nuanced and sophisticated focus on populations and communities where the most new infections are occurring. At a time of limited resources, efforts must be re-oriented towards giving much more attention and resources to populations at the highest risk of HIV infection.

One of the hardest lessons of the HIV and AIDS epidemic is that there is no single 'magic bullet' that will stem the tide of new HIV infections: combination approaches are necessary. A second lesson learnt is that for prevention efforts to succeed, prevention programming must be tailored to the specific characteristics of the epidemic that is unfolding in the area to be targeted.

Building on these lessons and findings, the ZNASP 2010-2015 interventions (in combination) are prioritised to achieve the following impact level results

Prevention Impact level results	*Less Zimbabweans are infected with HIV:* The estimated annual number of new infections is reduced from 66,155 in 2009 to 46,308 by 2015
	Mother to Child transmission of HIV is eliminated: The percentage of HIV infected infants born to HIV positive mothers is reduced from 30% in 2009 to less than 5% by 2015
	Less pregnant women are infected with HIV: The percentage of pregnant women aged 15-19 who are HIV infected is reduced from 6.8% in 2009 to 6% in 2011, 5% in 2013 and 4.5% by 2015
	Less young men and are women are infected with HIV: The percentage of young people aged 15-19 who are HIV infected is reduced from 3.1% among women in 2006 to 2.17 in 2015 and from 6.2% among men to 4.3% in 2015

Prevention interventions have been prioritised into two categories. Highest priority interventions are those which evidence clearly shows that their implementation will have the most potential to achieve the impact level results noted above. Highest priority interventions include the following:

- Prevention of Mother to Child Transmission (PMTCT)
- Male Circumcision (MC)
- HIV Testing and Counselling (HTC)
- Condom promotion and distribution
- Social and Behaviour Change Communication (SBCC)

If Zimbabwe can eliminate MTCT during the life of the ZNASP 2011-2015, it can reduce annual infections by 10,000 (representing 16% of total annual infections)[46]. Circumcising approximately 240,000 HIV negative men aged 15-29 annually between 2011 and 2015 will reduce new infections by approximately 6,857 per annum[47]. It is also estimated that with expanded HIV testing and counselling and condom promotion and distribution anchored within targeted social and behaviour change communication interventions an additional 1-2,000 infections could be reduced annually. These five interventions thus have the potential to contribute to ensuring that significantly less Zimbabweans are infected with HIV annually.

High priority interventions are those that need to continue because of their importance in sustaining the gains already achieved in prevention. High priority interventions include the following:

- Blood Safety
- Post Exposure Prophylaxis (PEP)
- Treatment of sexually transmitted infections (STIs)

The key outcome and output level results that need to be achieved in order to impact level targets as well as the strategies to achieve those results are articulated under each intervention area in the pages to follow.

4.1.1 Prevention of Mother to Child Transmission (PMTCT)

Expected outcome and output level results	*Unintended pregnancies among HIV positive women are reduced*: The proportion of HIV-infected women of reproductive age attending HIV care and treatment services with unmet need for family planning is reduced by 30% by 2015 from the 2011 baseline
	More women of reproductive age using contraception: Contraceptive prevalence rate is increased from 60% in 2006 to 80% by 2010
	More HIV positive pregnant women receive ARVs to reduce risk of transmission to their children: The percentage of HIV positive pregnant women who received antiretrovirals to reduce the risk of MTCT is increased from X% in 2009 to 85% by 2015

[46] Modelling using CDC PMTCT calculator
[47] DMPPT modelling estimates that on average 7.1 circumcisions are required to avert one infection when analysed for the period 2011 to 2025

	More pregnant women know their HIV status: The percentage of pregnant women counselled and tested for HIV is increased from X% in 2009 to 100% by 2015
	HIV status of all HIV exposed infants is known: The percentage of infants born to HIV women who received a virologic testing within 6 weeks of birth is increased from X% in 2009 to 100% by 2015
	All HIV positive pregnant women have been assessed for ART eligibility: The percentage of HIV positive pregnant women assessed for ART eligibility through CD4 testing is increased from X% in 2009 to 100% by 2015
	Increased availability of PMTCT services for pregnant women: The percentage of health facilities providing ANC services that provide both HIV testing and ARVs for PMTCT on site is increased from 66% in 2010, 75% in 2011, 80% in 2012, 85% in 2013, 95% in 2014 and 100% by 2015

Strategic directions: ZNASP 2006-10 aims to reduce primary infection of HIV among women attending ANC services, reduce unintended pregnancies among HIV positive women, reduce transmission of HIV during pregnancy, child birth and breast feeding and to ensure that all eligible HIV infected pregnant women and mothers receive ART.

Priority populations: Women of reproductive age with known HIV positive status; HIV positive women on the Pre-ART and ART programme, pregnant women attending ANC services and HIV exposed infants

Priority strategies:

- Integrate HIV prevention into all ANC services;
- Intergrate family planning into HTC services;
- Integrate family planning into PMTCT services;
- Integrate family planning to Pre-ART and ART services;
- Integrate HIV services into facility and community based FP services;
- Expand the availability of comprehensive PMTCT services for pregnant women;
- Strengthen and expand Early Infant Diagnosis (EIDS);
- Expand coverage of ART to facilities that offer comprehensive PMTCT services;
- Strengthen retention of mother-infant pairs in PMTCT programme;
- Strengthen monitoring and evaluation systems for PMTCT;
- Strengthen participation of men in PMTCT services;

4.1.2 Male Circumcision (MC)

Expected output level results	*More HIV negative young men aged 15-29 are circumcised*: The number circumcisions performed among HIV negative young men aged 15-29 is increased from 11, 102 in 2010 to 1,200,000 by 2015

Strategic directions: ZNASP 2010-15 aims to reduce the probability of transmission from HIV positive females to HIV negative males through the rapid expansion of adult MC services

Priority populations: Young men aged 15-29 with a particular focus on those in high HIV burden provinces

Priority strategies:

- Strengthen capacity within MOHCHW to provide leadership for MC at national, provincial and district levels;
- Strengthen linkages and referral between HTC and MC services;
- Scale up MC services through use of mixed service delivery models;
- Develop and implement communication plan to address barriers to uptake of MC services, generate timely demand for services and address potential risk compensation;
- Develop and implement effective procurement and supply chain management systems for MC;
- Strengthen human resource development for MC in the context of overall health workforce development;
- Strengthen mechanisms for quality assurance of MC services; and
- Pilot neonatal circumcision

4.1.3 HIV testing and counselling (HTC)

Expected outcome level results	*More PLHIV know their status*: Increase from 37% in 2010 to 80% by 2015 the percentage of people living with HIV who know their serostatus
	More individuals in formal and informal unions know their HIV status: Increase from 6.4% among women and 6.9% among men in 2006 to 50% by 2015, the percentage of individuals who are married or living together who received HIV test in the last 12 months and who know their results
	More Zimbabweans know their HIV status: Increase from 6.6% among women and 6.7% among men in 2006 to 50% by 2015, the percentage of individuals aged 15-49 who received HIV test in the last 12 months and who know their results

Strategic direction: ZNASP 2011-2015 aims to ensure that all PLHIV who are unaware of their HIV status know their HIV, with a particular focus on ensuring in particular that those PLHIV in sero-discordant relationships know their HIV status to ensure that they do not unintentionally expose their HIV negative partners to HIV. The aim is also to ensure that young men aged 15-29 in particular are also aware of the HIV status in order to ensure that the expected results for MC are achieved.

Priority populations: 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. Geographic priorities would be the six largest high HIV burden provinces.

Priority strategies:

- Strengthen capacity of the MOHCW to provide leadership for HTC at national, provincial and district levels

- Expand Provider initiated testing and counselling (PITC) to all health facilities;
- Expand community and home based counselling and testing;
- Expand blood donor programme;
- Strengthen human resource development for HTC in the context of overall health workforce development;
- Develop and implement communication plan to address barriers to uptake of HTC services among couples in formal and informal unions as well as among men and generate demand for services ;
- Develop and implement effective procurement and supply chain management systems for HIV testing and counselling;
- Strengthen mechanisms for quality assurance of HTC services; and
- Strengthen monitoring and evaluation systems for HTC;
- Strengthen linkages and referral between HTC and MC, FP, PMTCT,TB/HIV, CHBC and nutrition services

4.1.4 Condom promotion and distribution

Expected outcome level results	*Sexually active Zimbabweans have access to condoms*: Total number of male condoms available for distribution nationwide annually per person aged 15-49 is increased from 16 in 2009 to 32 by 2015
	More men and women involved in extramarital relationships use condoms: Percent of married women and men aged 15–49 who have had more than one sexual partner in the last 12 months reporting the use of a condom their last sexual intercourse.
	More men who have sex with sex workers use condoms: Percent of men aged 15-49 reporting sex with a sex worker in the last 12 months who used a condom during last paid intercourse (73.6 in 2005/6)
	More men and women report favourable attitudes towards the education of children on condom use: Percentage of women (41.4) and men (48) aged 18-49 who agree that children age12-14 years should be taught about using a condom to avoid HIV
	More young men and women use condoms the first time they have sex: Percentage of never married young women (42.2) and young men (46.8) age 15-24 who used a condom the first time they had sexual intercourse
	More young men and women engaged in risky six use condoms: Percentage of never married young women (43.8) and men(67.8) aged 15-24 who reported using a condom at last higher-risk intercourse
	More young men and women who engage in risky sex are aware of where to find condoms: Percentage of young women (17.8) and men (69.5) aged 15-24 who had higher risk sex in the last 12 month who report they know where they could get condoms

Strategic direction: ZNASP 2011-2015 aims 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 populations: sexually active adolescent 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

Priority strategies:

- Strengthen capacity of the MOHCW to provide leadership for condom promotion and distribution
- Review and revise current education sector policies that hinder access to knowledge on correct and consistent use of condoms amongst learners;
- Increase availability of both public and socially marketed male and female condoms;
- Develop and implement communication plan to address barriers to condom use among priority populations and generate demand for public and socially marketed male and female condoms
- Strengthen condom management systems and distribution logistics at all levels
- Strengthen mechanisms for quality assurance of male and female condoms

4.1.5 Social and Behaviour Change Communication (SBCC)

Expected outcome level results	*Young men and women have the knowledge to prevent sexual transmission of HIV:* Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
	Fewer men and women have multiple sexual partners: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
	Fewer married men and women have multiple sexual partners: Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
	Fewer young women have fewer older sexual partners: Percentage of women aged 15-19 who have had non-marital sex with a man 10 years or more older than themselves in the last 12 months, of all those who have had non-marital sex in the last 12 months
	More enterprises and companies provide work placed based prevention interventions: Percent of large enterprises/companies that have HIV/AIDS workplace policies and programme is increased by 30% by 2015 from baseline

Strategic direction: ZNASP 2011-2015 aims to implemented targeted Social and Behaviour Change Communication interventions (in which other prevention interventions are integrated within it) in order to support adoption of key preventive behaviours (including correct and consistent condom use) and change specific risk behaviours among the general population. Geographic priorities include high HIV burden provinces, towns and cities along transport corridors, growth points and resettlement farms.

Priority populations: couples who are married or live together, young men and women (both in and out of school), PHIV enrolled in Pre-ART and ART programmes, Sex workers and their clients and men who have sex with men (MSM)

Priority strategies:

- Strengthen and expand National Behaviour Change Programme (NBCP)
- Strengthen and expand school based HIV and AIDS education
- Strengthen and expand out of school based HIV and AIDS education for young people
- Strengthen and expand targeted SBCC interventions for Sex workers and their clients
- Develop and implement targeted SBCC interventions for MSM
- Expand Prevention with Positives (PwP)
- Strengthen and expand workplace based HIV and AIDS education

4.1.6 Blood safety

Expected outcome level results	*Universal screening of donated blood for HIV is maintained :* Percentage of donated blood units screened for HIV in a quality assured manner is maintained at 100% annually from 2011 to 2015

Strategic direction: ZNASP 2011-2015 aims to ensure universal screening for all blood units for HIV and other transfusion-transmissible infections is maintained and that the NBSZ is able to provide adequate quantities of blood units to meet the needs of all patients in a sustainable manner

Priority strategies:

- Strengthen and expand voluntary blood donation programme
- Strengthen and expand capacity of NSBZ to screen blood and blood products to ensure 100% blood safety.

4.1.7 Post Exposure Prophylaxis (PEP)

Expected outcome level results	*All men and women that require PEP have access to it when they need it :* The percentage of health facilities with HIV post-exposure prophylaxis (PEP) available is increased from X% in 2010 to X% by 2015

Strategic direction: ZNASP 2011-2015 aims to ensure that all men and women who qualify for PEP are able to access it.

Priority populations: health workers and those sexually abused and violated

Priority strategies:

- Strengthen and expand provision of PEP to all health facilities
- Develop and implement communication plan to generate awareness of PEP among the general population

4.1.8 Treatment of Sexually Transmitted Infections (STIs)

Expected outcome level results	*Less pregnant women are infected with Sexually transmitted infections :* The percentage of pregnant women infected with a Sexually Transmitted Infection is reduced from 0.80% in 2009 to 0.20% by the end of 2015

Strategic direction: ZNASP 2011-2015 aims to prevent and reduce the prevalence of sexually transmitted infections

Priority strategies:

- Strengthen capacity of service providers to treatment and manage STI according to national guidelines;
- Develop and implement effective procurement and supply chain management systems for STI drugs;
- Strengthen STI surveillance

4.2 Treatment, care and support

The impact of AIDS on mortality, morbidity and vulnerability of children has been severe: it is the leading cause of mortality among both adults and children accounting for over an estimated 84,000 deaths annually. AIDS is estimated to account for over 27% of maternal mortality. TB is highly associated with HIV[48] and it is estimated that approximately 80% of TB cases are co-infected with HIV. As a consequence of that association, TB is a leading cause of mortality among PLHIV in the country.

Furthermore, because HIV and AIDS predominantly attack people of childbearing age, the impact this has had on children, extended families, and communities in Zimbabwe has been devastating. Deaths from AIDS in the past decade have left in the wake hundreds of thousands of orphans and vulnerable children. Expanding access to a continuum of treatment care and support for PLHIV and enhancing social protection for children and other people affected by AIDS is crucial to reducing mortality, morbidity and vulnerability due to HIV and AIDS.

Reflecting a commitment to achieving an impact within the population in relation to treatment, care and support, the ZNASP II is structured around achieving the following expected **impact level result**:

- The estimated annual number of deaths to AIDS is reduced from 84,000 in 2009 to 58,800 by 2015

The priority focus for the ZNASP 2011-2015 is therefore to reduce HIV related mortality and morbidity by expanding access to treatment, care and support for PLHIV and enhancing social protection for children affected by HIV

[48] Global TB report for 2010 reports that 'People living with HIV are 20 to 37 times more likely to develop TB disease during their lifetimes than people who are HIV-negative'(page 47)

The following interventions will be implemented to achieve the above stated outcome impact result:

- Antiretroviral Therapy (ART)
- HIV and TB co-infection management
- Nutritional support for adults and children living with HIV
- Community home based care
- Social protection for orphans and vulnerable children

4.2.1 ART

Expected outcome level results	*More PLHIV survive for long on ART*: Percent of adults and children known to be alive and on treatment 12 and 24 months after initiation of antiretroviral therapy is increased from 75% and 64% respectively in 2009 to 85% and 80% respectively by 2015
	More eligible adults and children receive ART: Percent of adults and children with advanced HIV infection receiving antiretroviral therapy is increased from 57% among adults and 37% among children in 2010 to 80% by 2015
	More facilities are offering treatment services: Percent of health facilities that offer comprehensive ART services is increased from 7.82% in 2010 to 15.4% by 2015
	More facilities have the capacity to diagnose HIV infection among HIV exposed infants: Percent of health facilities that provide virological testing services for infant diagnosis for HIV exposed infants, on site or through Dried Blood Spots (DBS) is increased from X% in 2010 to X% by 2015
	Diagnostic capacity is increased: Percent of testing facilities (laboratories) with capacity to perform clinical laboratory tests is increased from X% in 2010 to X% by 2015

Strategic direction: ZNASP 2011-2015 aims to increase access to and utilization of ART services in order to ensure universal access to ART by all people that are eligible. Decisions on geographic priorities for expansion of ART services will be guided by provincial HIV burden data.

Priority strategies:

- Advocate for supportive policy environment to facilitate scale up ART services in Zimbabwe;
- Expand access to Pre-ART services for PLHIV that are eligible;
- Strengthen and expand ART services ;
- Strengthen human resource development for ART in the context of overall health workforce development;
- Strengthen capacity of community systems to support PLHIV on ART;
- Strengthen management and coordination of ART service provision;
- Strengthen procurement and supply chain management systems capacity to deliver a continuous and reliable flow of high quality, effective and affordable ART drugs;
- Strengthen laboratory capacity for HIV diagnosis and patient monitoring;
- Strengthen monitoring and evaluation for ART including outcome measurement;

4.2.2 TB and HIV co-infection management

Expected outcome level results	*More people infected with TB know their HIV status*: Percentage of TB patients who know their HIV status
	More TB patients co-infected with HIV are start or use CPT: Percentage of TB patients diagnosed as HIV-positive started on (or continuing on previously initiated) CPT during TB treatment
	More TB and HIV co-infected patients are started or continue on ART : The percentage of TB patients diagnosed as HIV-positive started on (or continuing on previously initiated) ART
	More PLHIV are screened for TB: Percentage of all people living with HIV screened for TB
	More PLHIV are provided with IPT: Percentage of people living with HIV started on IPT

Strategic direction: ZNASP 2011-2015 aims to reduce deaths from TB among HIV-positive people. In turn, this will help to achieve Zimbabwe achieve the MDG target of halving TB mortality by 2015

Priority strategies:

- Expand access to HIV testing among TB patients;
- Expand access to CPT for HIV-positive TB patients;
- Expand access to ART for HIV-positive TB patients;
- Strengthen TB screening among people living with HIV;
- Expand access to IPT among people living with HIV and who do not have active TB;
- Strengthen and expand the implementation of measures for TB infection control in health care facilities providing services to people living with HIV;
- Develop interlinked patient monitoring systems for TB/HIV and recording of TB deaths among people living with HIV; and
- Strengthen coordination of national level efforts to reduce the burden of HIV-related TB.

4.2.3 Nutritional support for PLHIV

Strategic direction: ZNASP 2011-2015 aims to prevent and reducing the incidence of severe malnutrition among adults and children living with HIV

Priority strategies:

- Strengthen human resource development for nutrition in the context of overall health workforce development;
- Strengthen key areas of policy and guideline development;
- Strengthen capacity of health facilities to provide nutritional care and support for adults and children living with HIV;
- Expand the coverage of therapeutic foods for severely malnourished adults and children;
- Develop and maintain quality assurance and standards for services and products; and
- Strengthen monitoring and evaluation systems for nutrition programming.

4.2.4 Community home based care

Expected outcome level results	*More men and women receive care and support:* Percentage of women and men age 18-59 who have been either very sick or who died within the past 12 months after being very sick whose households received at least one type of free basic external support to care for them within the past year is increased from 41% in 2005-6 to 60% by 2015

Strategic direction: ZNASP 2011-2015 aims to ensure a continuum of care for adults and children living with HIV and AIDS from community to health facility

Priority strategies:

- Strengthen capacity of services providers to provide quality and appropriate community home based care and support for adults and children living with HIV and AIDS;
- Strengthen linkages and referral systems between health facilities and community home based care services;
- Improve and strengthen procurement, logistics and distributions systems for community home based care services materials;
- Strengthen coordination of national, provincial and district level efforts provide quality and appropriate community home based care and support;
- Strengthen monitoring and evaluation systems for community home based care and support

4.2.5 Social protection for orphans and vulnerable children

Expected outcome level results	*More orphans and children in vulnerable households receive care and support:* Percentage of orphans and vulnerable children (OVC) under age 18 years whose household received at least one type of free basic external support to care for the child in the past 12 months is increased from 31.2% in 2005/6 to 50% by 2015

Strategic direction: ZNASP 2011-2015 aims to ensure that the most vulnerable children in Zimbabwe are able to secure their basic rights through the provision of quality social protection and child protection services

Priority strategies:

- Strengthen the capacity of households to protect and care for orphans and vulnerable children;
- Expand access to basic services for orphans and vulnerable children;
- Expand access to child protection services for orphans and vulnerable children;
- Strengthen the capacity of Government to lead, coordinate, regulate and monitor child and family protection service delivery.

4.3 Enabling Environment

It has been 25 years since the first case of HIV was identified in Zimbabwe. However despite over two and half decades in the national response to HIV and AIDS, there remain three key barriers that need to be attended to urgently in order to create an enabling environment for the national response. The first of these barriers is HIV related stigma and discrimination. The response analysis clearly showed that stigma and discrimination impedes access to and utilization of prevention, treatment and care and support services for all Zimbabweans, particularly those residing in rural areas. The ZDHS (2005-6) found that only 17% of women and 11% of men have accepting attitudes towards PLHIV. It is therefore that in order to create an enabling environment prevention, treatment, care and support, HIV related stigma and discrimination must be significantly reduced. Secondly, as articulated earlier, there are certain key aspects of the policy, legal and regulatory environment have been identified that block effective responses to AIDS and present obstacles to access to HIV services for key populations. In order to achieve the prevention, treatment, care and support results articulated in this strategy, these policy, legal and regulatory obstacles need to be addressed. Finally, effective HIV responses must be led by people living with and affected by the epidemic. The notable achievements in the response to date are largely the result of their engagement and involvement. However as the response analysis revealed, much remains to be done to ensure that people living with and affected by the epidemic are meaningfully involved in the national response. Addressing these 3 key barriers is critical to achieving the impact and outcome level results proposed in this strategy. To address these barriers, he following interventions will be implemented:

- HIV related stigma and discrimination reduction;
- Policy, legislative and regulatory reforms;
- Meaningful Involvement of PLHIV;

4.3.1 HIV related stigma and discrimination reduction

Expected outcome level results	*Zimbabweans have more accepting attitudes towards PLHIV:* Percentage of men and women aged 15 years and older who express accepting attitudes towards PLHIV is increased from 17% for women and 11% for men in 2005-6 to 51% for women and 33% for men by 2014.

Strategic direction: ZNASP 2011-2015 aims to tackle HIV related stigma and discrimination and their harmful effects

Priority strategies:

- Strengthen national capacity to challenge and address HIV related stigma and discrimination within the health sector and in the community; and
- Develop and implement a national communication plan to challenge and address HIV related stigma and discrimination

4.3.2 Policy, legislative and regulatory reforms

Expected outcome	*The policy environment for an effective national response improves:*

level results	National Composite Policy Index (NCPI) Score is increased from X in 2009 to x by 2015

Strategic direction: ZNASP 2011-2015 aims to promote an enabling policy environment for the national response to HIV and AIDS

Priority strategies:

- Review and revision of key laws, policies and regulations that block effective responses to HIV and AIDS;
- Strengthen the capacity of public sector and civil society champions to engage effectively in the policy, legislative and regulatory development process;

4.3.3 Meaningful Involvement of PLHIV (MIPA)

Strategic direction: ZNASP 2011-2015 aims to ensure that people living with HIV are involved in all decision-making processes that affect their lives.

Priority strategies:

- Strengthen the capacity of networks representing PLHIV to exercise their voice in relation to the delivery of HIV and AIDS services in Zimbabwe;
- Strengthen the capacity of networks representing PLHIV to effectively engage in national decision making processes; and
- Strengthen the capacity of PLHIV to participate effectively in governance of the national HIV and AIDS response in Zimbabwe

Section 5: Risks and mitigation strategies

In developing ZNASP 2011-2015, a number risks that may affect its implementation have been identified. These potential risks and proposed risk mitigation strategies are described in the table 3 below. The following risk rating codes are used: **H** (high risk), **S** (substantial risk), **M** (Medium Risk), **L** (Low risk) and **N** (negligible risk).

Risks	Risk rating	Proposed Mitigation	Residual risk rating
Political and economic instability as a result of disputed elections may limit the measurable effectiveness of proposed interventions in short and medium term	**S**	Lessons learnt during the past instability in Zimbabwe and elsewhere have been well documented and will be used to guide HIV interventions in emergency and avoid disruptions in services	**H**
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 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 2011-2015, especially as it relates to reporting, implementation will suffer	**M**	Amendments will 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 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**

Section 6: Monitoring and Evaluation

Monitoring and evaluation of ZNASP 2006-2010 was identified as a key challenge in the MTR. The plan did not include a monitoring and evaluation framework that identified for all expected results, the indicators that would be used to assess progress, baseline values, performance targets as well as information on data compilation and reporting. Table 4 below articulates the monitoring and evaluation framework for the ZNASP 2011-2015

Table 4: Monitoring and Evaluation Framework ZNASP 2011-2015

Impact and outcome indicators		Expected Results					Data compilation and reporting		
	Baseline value (year)	2011	2012	2013	2014	2015	Data source	Institutional responsibility	Reporting frequency
Prevention									
Estimated Annual number of new HIV infections	66,155 (2009)					46,308	Modelling	NAC	Annual
% of HIV infected infants born to HIV positive mothers	30% (2009)					>5%	Modelling and PMTCT database	MOCHW	Annual
% of pregnant women aged 15-19 who are HIV infected	6.8% (2009)	6%		5%		4.5%	Sentinel surveillance survey	MOCHW	Biennial
% of young people aged 15-19 who are HIV infected	3.1% (w) ;6.2% (men) in 2005-6					2.17% (w); 4.3%(m)	ZDHS	MOCHW	Every 5 years
Contraceptive prevalence rate	60% (2006)					80%	ZDHS	MOHCW	Every 5 years
% of HIV positive pregnant women who received ARVs to reduce the risk of MTCT	42.6% (2008)	52%	62%	72%	80%	85%	Modelling and PMTCT database	MOCHW	Annual
% of infants born to HIV women who received a virologic test within 6 weeks of birth	X% (2010)					100%	PMTCT database	MOCHW	Annual
% of HIV positive pregnant women assessed for ART eligibility through CD4 testing	X%					100%	PMTCT database	MOCHW	Annual
% of health facilities providing ANC services that provide both HIV testing and ARVs for PMTCT on site	66% (2010)	75%	80%	85%	96%	100%	AIDS and TB unit annual report	MOCHW	Annual
Number of male circumcisions	11,102 (2010)	240,000	240,000	240,000	240,000	240,000	AIDS and TB	MOCHW	Annual

Impact and outcome indicators		Expected Results					Data compilation and reporting		
	Baseline value (year)	2011	2012	2013	2014	2015	Data source	Institutional responsibility	Reporting frequency
performed according to national guidelines							unit annual report		
% of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	6.6% (w) and 6.7% (m) 2005-6					50%	ZDHS	MOHCW	Every 5 years
% of PLHIV who know their HIV status	37% (2010)	45%	50%	60%	70%	80%	AIDS and TB annual report and modelling	MOCHW	Annual
% of individuals who are married or living together who received an HIV test In the last 12 months and know their results	6.4% (w) and 6.9% (m) 2005-6					50%	ZDHS	MOHCW	Every 5 years
Total number of male condoms available for distribution nationwide annually per person aged 15-49	16 (2009)					32	AIDS and TB annual report / Census	MOCHW	Annual
% of married women and men aged 15-49 who have had more than one sexual partners in the last 12 months reporting use of a condom during their last sexual intercourse	W=;M= 2005-6						ZDHS	MOHCW	Every 5 years
% of men aged 15-49 reporting sex with a sex worker in the last 12 months who used a condom during last paid intercourse	73.6%					85%	ZDHS	MOHCW	Every 5 years
% of men and women aged 18-49 who agree that children aged 12-14 should be taught about using a condom to avoid HIV	41.4% (w) and 48% (m) 2005-6					70%	ZDHS	MOHCW	Every 5 years
% of never married young women and	42.2%(w) and					65%	ZDHS	MOHCW	Every 5

Impact and outcome indicators		Expected Results					Data compilation and reporting		
	Baseline value (year)	2011	2012	2013	2014	2015	Data source	Institutional responsibility	Reporting frequency
men aged 15-24 who used a condom the first time they had sexual intercourse	46.8% (m) 2005-6								years
% of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	45.6% (w) and 43.7% (m) 2005-6					85%	ZDHS	MOHCW	Every 5 years
% of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	1.3% (w) and 14.1% (m) 2005-6					0.6%(w) and 7% (m)	ZDHS	MOHCW	Every 5 years
% of women aged 15-19 who have had non-marital sex with a man 10 years or more older than themselves in the last 12 months, of all those who have had non-marital sex in the last 12 months	5% (2005-6)					2.5%	ZDHS	MOHCW	Every 5 years
% of large enterprises/companies that HIV and AIDS workplace policies and programmes	TBD						Workplace survey	ZBCA	biennial
% of donated blood units screened for HIV in a quality assured manner	100% (2010)	100%	100%	100%	100%	100%	ZNBTS annual report	ZNBTS	Annual
% of Health facilities with HIV post exposure prophylaxis available	X%						AIDS and TB Unit annual report	MOCHW	Annual
% of pregnant women infected with a sexually transmitted infection	0.8% (2009)			0.4%		0.2%	Sentinel surveillance	MOCHW	Biennial

Impact and outcome indicators		Expected Results					Data compilation and reporting		
	Baseline value (year)	2011	2012	2013	2014	2015	Data source	Institutional responsibility	Reporting frequency
							survey		
Treatment, care and support									
% of adults and children known to be alive and on treatment 12 and 24 months after initiation of antiretroviral therapy	75% (12 months) and 64% (24 months)					85% (12 months) and 80% (24 months)	AIDS and TB Unit annual report	MOCHW	Annual
% of adults and children with advanced HIV infection receiving antiretroviral therapy	57% (adults) and 37% (children)-2010					80%	AIDS and TB Unit annual report	MOCHW	Annual
% of health facilities that offer comprehensive ART services	7.82% (2010)					15.4%	AIDS and TB Unit annual report	MOCHW	Annual
% of health facilities that provide virological testing services for infant diagnosis for HIV exposed infants, on site or through Dried Blood	X% (2010)						AIDS and TB Unit annual report	MOCHW	Annual
% of testing facilities (laboratories) with capacity to perform clinical laboratory tests	X% (2010)						AIDS and TB Unit annual report	MOCHW	Annual
% of TB patients tested for HIV and who know their test results	X% (2010)						AIDS and TB Unit annual report	MOCHW	Annual
% of TB patients diagnosed as HIV-positive started on (or continuing on previously initiated) CPT during TB treatment	X%(2010)						AIDS and TB Unit annual report	MOCHW	Annual
% of TB patients diagnosed as HIV-	X% (2010)						AIDS and TB	MOCHW	Annual

Impact and outcome indicators		Expected Results					Data compilation and reporting		
	Baseline value (year)	2011	2012	2013	2014	2015	Data source	Institutional responsibility	Reporting frequency
positive started on (or continuing on previously initiated) ART							Unit annual report		
% of TB patients diagnosed as HIV-positive started on (or continuing on previously initiated) ART	X% (2010)						AIDS and TB Unit annual report	MOCHW	Annual
% of people living with HIV started on IPT	X% (2010)						AIDS and TB Unit annual report	MOCHW	Annual
% of women and men age 18-59 who have been either very sick or who died within the past 12 months after being very sick whose households received at least one type of free basic external support to care for them within the past year is increased	41% (2005-6)					60%	ZDHS	MOHCW	Every 5 years
% of orphans and vulnerable children (OVC) under age 18 years whose household received at least one type of free basic external support to care for the child in the past 12 months is increased from 31.2% in 2005/6 to 50% by 2015							ZDHS	MOHCW	Every 5 years
Enabling Environment									
% of men and women aged 15 years and older who express accepting attitudes towards PLHIV	17% women and 11% men in 2005-6					51% women and 33% men	ZDHS	MOHCW	Every 5 years
National Composite Policy Index (NCPI) Score	X?	X?	X?	X?	X?		UNGASS report	NAC	Annually

6.1 Strengthening Monitoring and Evaluation of the national response

Key gaps and challenges

To inform the development of this strategy, an M & E assessment was undertaken utilizing the *12 M & E components Monitoring and Evaluation Strengthening Tool*. The assessment identified the following key gaps and challenges:

- Both the NAC and the AIDS and TB unit had insufficient staff to enable them to fulfil their role in coordinating Monitoring and Evaluation of the national response:
- There is insufficient human capacity for HIV M & E at all levels;
- Mechanisms to communicate about HIV MM & E activities and decisions are weak;
- A multisectoral national M & E plan for ZNASP was never finalized and remains in draft form and that the plan itself had several weaknesses;
- Annual costed M & E work plans were not developed for each year of the ZNASP;
- M&E policy and strategies are not included in national HIV policy and NSP;
- Evidence based decision making is weak;
- Routine HIV programme monitoring was weak;
- Surveillance was weak, with implementation of key data sources such as health facility surveys, young adult surveys not undertaken;
- National database was weak and did not capture all data;
- No supportive supervision or auditing was conducted;
- Data dissemination and utilization was weak.

Expected outcome level results	Functional National Monitoring and Evaluation System

Strategic direction: In order to address these key weaknesses and challenges, the following priority strategies have been identified

Priority strategies

- Strengthen the capacity of the NAC and AIDS and TB to effectively coordinate the national response to HIV and AIDS;
- Strengthen the HIV M & E capacity of all implementers;
- Strengthen surveillance of the national response to HIV and AIDS;
- Develop and implement support supervision and auditing systems; and
- Create demand for and effective utilization of M & E products among decision and policy makers;

Section 7: Management and coordination of the national response

The following section outlines the coordination, governance and implementation arrangements for ZNASP 2011-2015. Zimbabwe has already established the necessary coordination structures and systems for an effective response. Multisectoral national coordination is facilitated by the NAC and its decentralized structures (Provincial, District, Ward and Village AIDS Action Committees). Health sector coordination is facilitated by the AIDS and TB Unit within the MOCHW. As described in earlier sections of the strategy, there exist a number of 'defacto' coordinating agencies that undertake coordination functions without a specific mandate. TWG provide technical guidance and coordination in a number of intervention areas. However, as the response analysis revealed these management and coordination structures need to be strengthened in order to achieve the results proposed in this strategy.

Multisectoral national coordination

- The NAC will undertake an organizational restructuring of the secretariat to align the structure to the needs of the ZNASP;
- The NAC decentralized structures will be streamlined to allow the NAC to operate more effectively. Accordingly, only two key decentralized structures will continue to operate i.e. the Provincial and District AIDS Action Committees. The functions of the Ward and village AIDS action committees will be mainstreamed within the Ward Development committees;

Sectoral Coordination

- The Zimbabwe National Network of PLHIV will coordinate associations of PLHIV;
- The Zimbabwe Business Coalition on HIV and AIDS (ZBCA) will coordinate the private sector response to HIV and AIDS;
- The Zimbabwe AIDS Network (ZAN) will coordinate civil society responses to HIV and AIDS;
- A development partners coordination group on HIV and AIDS will be established to coordinate financing partners responses to HIV and AIDS;
- A public sector committee on HIV and AIDS will be established and will coordinate the public sector response to HIV and AIDS

The NAC will provide space, and technical support for the structures to coordinate the national response in their respective jurisdictions.

The UN family's response to HIV and AIDS will continue to be coordinated through the UNJT on HIV and AIDS and the CCM will continue to coordinate and provide oversight to the implementation of the GFATM investments in the country.

Technical Working Groups (TWG)

The ZNASP 2011-2015 recognizes that there have been too many TWG, many of which are dysfunctional. There shall be the following TWG: (1) Prevention, (2) Treatment, care and Support

and (3) Enabling Environment. These TWG will be jointly reconstituted by the NAC and MOCHW, with revised TOR. These TWG will have review the utility of the existing sub-committees and strengthen them or dissolve them as appropriate. The NAC will provide space and technical support for these TWG.

Partnership forum

The national partnership forum will continue to meet quarterly at national level to strengthen the national response to HIV and AIDS through effective coordination among key stakeholders.

Planning and Reviews

In order to enhance coordination, Zimbabwe will adopt joint annual planning and reviews for the national response to HIV and AIDS over the life of this ZNASP. The planning cycle for this ZNASP will be aligned to the Government of Zimbabwe's fiscal calendar. The ZNASP 2011-15 mid-term reviews will be conducted in 2013, and the final evaluation will be conducted in 2015. The National Action Plan will be reviewed and updated biennially.

Section 8: Cost of Implementing ZNASP 2011-2015

This section will be completed once costing has been finalized