

## Foreword

Today all Zimbabweans are affected by HIV and AIDS. Every family has lost members or takes care of infected family members, neighbours and friends. Everybody knows the major ways of transmission of HIV, but frequently we are still not talking entirely openly and freely about it. This strategy shall bring Zimbabweans closer to addressing the major way of HIV transmission in this country, where **HIV is predominantly transmitted through sexual contact**. It is assumed that between 80 and 90 % of infections are due to sexual transmission. Hence, promoting the adoption of safe sexual behaviours remains at the heart of HIV prevention in Zimbabwe.

In Zimbabwe much has been done to achieve behavioural change over the past two decades and recent reviews indicate that **behavioural change has already started**. These changes towards safer sexual behaviour need to be maintained, but we also strongly believe that much more can and needs to be done. Beyond awareness-raising and communication on Abstinence, Faithfulness, Condom (ABC), there is a need to address underlying factors for multiple partnering including imbalanced gender relations. So far, a majority of programmes has not been guided by systematic and strategic programming, nor were many programmes based on evidence from research. Since the inception of HIV and AIDS programmes in Zimbabwe, there has been no behavioural change (BC) strategy to guide various programme implementers. As a consequence there was limited focusing of prevention programmes, which partially resulted in duplication of efforts, but also large gaps in geographical and thematic coverage of programmes.

This Behavioural Change Strategy therefore provides **guidance to all stakeholders on their contributions to behavioural change promotion** over the period from 2006 to 2010. It spells out key expected outputs and areas of focus necessary for achieving results. It strengthens successful elements of the past response like promotion of condom use, but also focuses on new key aspects. Epidemiological evidence shows that **reducing multiple partnering including promotion of faithfulness** in marriage and other long-term relationships has to be in the centre of behavioural change promotion. **Underlying root causes of risk behaviours** like imbalanced gender relations and stigma associated with HIV will be addressed. Decentralized behavioural change planning and involvement of leadership at district and community levels are core elements of the Strategy. The key areas of focus are the same as those outlined in the National Strategic Plan on HIV and AIDS. Focusing on these key areas will result in more concerted efforts and is likely to make a greater impact.

The National AIDS Council (Government of Zimbabwe) calls upon all stakeholders to support this Strategy and make it a historic success story involving all Zimbabweans, adults and youth, married and unmarried, HIV positive and HIV negative. Behavioural change concerns everybody and over the coming five years we can continue saying: Today all Zimbabweans can make a difference in preventing HIV.



**Minister of Health and Child Welfare, Dr. David Parirenyatwa**

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## Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretroviral drugs
BC	Behavioural Change
BCC	Behavioural Change Communication
CBD	Community-Based Distributor (of Contraceptives)
CBO	Community-Based Organization
CSW	Commercial Sex Workers
DAAC	District AIDS Action Committees
DAC	District AIDS Coordinator
EHT	Environmental Health Technician
FBO	Faith Based Organizations
GIPA	Greater Involvement of People living with or affected by HIV/AIDS
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HR	Human Resources
IEC	Information, Education and Communication
IPC	Interpersonal Communication
M&E	Monitoring and Evaluation
MOESC	Ministry of Education, Sports and Culture
MOF	Ministry of Finance
MOHCW	Ministry of Health and Child Welfare
MOHTE	Ministry of Higher and Tertiary Education
MOWAGCD	Ministry of Women's Affairs, Gender and Community Development
MSM	Men who have sex with men
NAC	National AIDS Council
NGO	Non Governmental Organization
OVC	Orphans and other Vulnerable Children
PEP	Post-exposure prophylaxis
PLWHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PPTCT	Prevention of Parent-to-Child Transmission
PSI	Population Services International
RDC	Rural District Council
RH	Reproductive Health
STI/STD	Sexually transmitted infection/disease
T&C	Testing and Counselling
TOT	Training of Trainers
UN	United Nations
VAAC	Village AIDS Action Committee
VCT	Voluntary Counseling and Testing
WAAC	Ward AIDS Action Committee
WB	World Bank
ZDHS	Zimbabwe Demographic Health Survey
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan 2006-2010
ZNFPC	Zimbabwe National Family Planning Council
ZNNP+	Zimbabwe National Network of People Living with HIV and AIDS

## Executive Summary

The Zimbabwe National Behavioural Change (BC) Strategy is a multisectoral framework to reduce sexual transmission of HIV by promoting responsible practices. Comprehensive epidemiological and behavioural reviews form the basis of this strategy. They found that HIV prevalence had declined in Zimbabwe and that behavioural change including partner reduction and increased condom use had already started. At the same time, multiple concurrent partnerships and a number of related practices were still seen as key drivers of the epidemic. Imbalanced gender relations, relatively high levels of stigma and other factors continue to be underlying factors for risk practices that lead to new infections.

The Strategy builds on past successes and at the same time closes gaps in addressing key drivers of HIV. Four key outcome areas have been defined.

1. **Enabling environment** for behavioural change created including through increased leadership and gender-equality as well as reduced stigma associated with PLWHA

An enabling environment for behavioural change will be created through involvement of religious, traditional and administrative leaders as advocates and role models in responsible behaviours such as faithfulness in marriage and openness about one's HIV status. Furthermore, gender roles and imbalances will be addressed and stigma reduced through campaigns and involvement of PLWHA.

2. **Increased adoption of safer sexual behaviour and reduction in risk behaviour**

Partner reduction will be the first and key priority of the strategy. This will include an increased focus on promoting faithfulness, prevention in marriage and couple communication. Furthermore, youth will be protected from risky relationships and practices through communication programmes, skills-building, but also through targeting older men. Promotion of consistent male and female condom use will remain a key priority. BC messages for PLWHA will be strengthened. Specific socio-cultural practices, which increase HIV risk, will be addressed with concerned communities.

3. **Increased utilization of HIV prevention services** (T&C including post-test support, PMTCT, PEP)

BC promotion shall be integrated into sexual and reproductive health programmes, in particular promotion of family planning services. Utilization of PMTCT, testing and counseling services shall be promoted, including within pre-marriage counseling and as an entry point for couple counseling as well as positive prevention.

4. **Improved national and sub-national institutional frameworks** to address behavioural change

The priorities of this Strategy shall be mainstreamed into all other sectoral HIV initiatives. All districts of Zimbabwe shall develop district BC action plans and set up district BC fora. Minimum sets of action in support of BC shall be developed for each ward of Zimbabwe. BC tools and minimum packages of BC materials will be developed for different distribution channels. More emphasis will be given to implementers' skills building as well as integrating BC research and programmes.

## 1. Overview of the epidemic

Zimbabwe has experienced one of the highest levels of HIV infections in the world. Already in 1990 estimated average HIV prevalence was above 10 percent and the rising trend continued over the 1990s. Prevalence among pregnant women has peaked in the late 1990s around 30 %. Following the increase in HIV incidence and prevalence, the impacts arising from the illness began to affect the general population and all sectors. HIV and AIDS has strained the delivery of health services, led to a surge in the incidence of other diseases, such as tuberculosis, as well as placing intense pressure on health workers. AIDS-affected households are most vulnerable to food shortages. Women in rural areas face competing demands for crop production and care for family members suffering from AIDS-related illnesses. Economic impacts of HIV and AIDS have been severe on households as a result of loss of employment, leading to loss of household income, erosion of savings and increased health and funeral expenditures. The number of orphans has increased dramatically due to HIV and AIDS. Women are especially vulnerable to HIV infection.

Lately however, the overall status of the HIV epidemic has slightly improved and HIV prevalence now stands at 18.1 percent according to the preliminary findings of the Demographic and Health Survey 2005-06. Among other factors, the decline in HIV incidence and prevalence can be attributed to sexual behaviour change.

**Key Issue:**

Many Zimbabweans have started to adopt safer sexual behaviours like condom use and having fewer sexual partners. These behavioural changes need to be maintained and adopted by all Zimbabweans adults and youth, married and unmarried, HIV positive and HIV negative.

## 2. Findings of the behavioural change review: Where do we stand?

In 2005, the National AIDS Council led a consultative Behavioural Change Review process. The purpose of the review was to provide an evidence base for the development of a Behavioural Change Strategy and has assisted in providing insights and greater detail regarding behavioural change in Zimbabwe. The scope of the review covered a situation analysis of risk behaviours and vulnerability factors as well as a response analysis on past programmes.

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<sup>1</sup>This strategy is based on comprehensive epidemiological and behavioural review processes, which are summarized in detail in separate documents. These are:

- NAC: Comprehensive review of behavioural change as a means of preventing sexual transmission of HIV in Zimbabwe. Harare 2006.
- UNAIDS: Evidence for HIV decline in Zimbabwe: a comprehensive review of the epidemiological data. Geneva/Harare 2005.

Not all the findings of these reviews can be described in detail in this strategy. Therefore these two documents can be recommended as further reading.

Although Zimbabwe is in the mature stage of a generalised HIV and AIDS epidemic, there are important age, gender and geographical differences in HIV prevalence. The acceleration of the epidemic has largely been driven by sexual transmission, with 80 to 90 % arising from heterosexual transmission. In part, the scale of the epidemic at country level reflects its widely disseminated nature. HIV prevalence in small towns, farming estates and mines located in rural areas exceeds that in the major cities, whilst transmission into and within subsistence farming areas is also extensive. This pattern of spread reflects aspects of the country's relatively high level of development and social relations. Thus, for example, men have frequently taken up employment in cities, towns, plantations and mines, and have utilized the country's well developed transport infrastructure to maintain and make regular visits to their families in their traditional rural homes. Large income and gender inequalities have led to the establishment of local sexual networks that facilitate transmission even in rural areas. During the course of the epidemic a broad response to HIV and AIDS has developed in Zimbabwe with a multitude of stakeholders involved in HIV prevention initiatives with the aim of behavioural change promotion. At the same time, there was no national strategy in the area of behavioural change promotion despite some efforts to develop a behaviour change communication strategy under the 'Beyond Awareness' initiative, which, however, was not completed.

### 2.1. Knowledge and risk perception

Perceptions of vulnerability and basic knowledge about population-level risks of HIV and AIDS, as well as methods of prevention have been well-established since the middle 1990s. However, the levels of adequacy of practical knowledge related to prevention practices are questionable. This knowledge gap includes that of interventions such as Testing and Counselling (T&C), Prevention of Mother-to-Child Transmission (PMTCT), Anti-Retroviral Therapy (ART) or Post-Exposure Prophylaxis (PEP) and their availability. Females appear to consistently lag behind males in most areas of HIV and AIDS-related knowledge. While it is a common perception of Zimbabweans that the population is at risk, this is not consistently translated into personalized risk perception.

**Key Issue:**

Risk perception needs to be personalized by all sexually active Zimbabweans. Youth and adults, married and unmarried Zimbabweans need to be empowered to perceive their own risk of being infected and passing on infection to a loved one.

### 2.2. Abstinence, age at first sex and age-mixing

There is no clear trend in age of sexual debut in Zimbabwe since the beginning of the HIV epidemic. The median age at first sex (the age when half of the young people already have had sex) is above 18 for both men and women. This means that age at first sex in Zimbabwe is among the highest in Africa. Therefore it is unlikely that early sexual debut has been and continues to be the major driving force of the epidemic in

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<sup>2</sup>This paragraph builds on findings detailed in: UNAIDS: Evidence for HIV decline in Zimbabwe : a comprehensive review of the epidemiological data. Geneva/Harare 2005.

Zimbabwe. Nevertheless, a minority of young people, in particular OVC and out-of-school adolescents, engage in early sexual activity and require attention of prevention programmes. Furthermore, age differences between women and men at first sex and in subsequent sexual experience are particularly high in Zimbabwe. The majority of young women has sexual experience with partners five and more years older, which exposes them to a group of men with high HIV prevalence. This must be seen as a major factor contributing to the relatively high HIV prevalence in young women.

Delay of debut has been the most prominent focus in prevention efforts among young people. Although some of these programmes may have assisted specific groups of young people to remain abstinent, they did not seem to cause any major changes at the population level. The review indicated that supporting the message to reduce the number of sexual partners and to delay the age of first sex should remain an important but not exclusive emphasis of prevention campaigns. International literature provides little reason to believe that the promotion of condom use among sexually active young people promotes sex. Similarly, there is little reason to believe that sexual and reproductive health education promotes sex. Age-mixing has hardly been addressed by programmes. This does not only require attention from the perspective of the young woman, but also needs to be integrated in promotion of faithfulness among men and male responsibility. Some IEC materials had focused on warning against so-called old “sugar daddies”, but not addressed the much larger number of relationships between women 15-29 and men 25-39, in which the majority of infections can be expected to happen.

**Key Issue:**  
Sexual relations between younger women and men who are five or more years older is the major entry point for HIV into the young generation. Different young people have different needs. Sexually active young people need support in avoiding multiple partnerships and accessing condoms. Those not yet sexually active need support in delaying debut.

### 2.3. Number of partners and faithfulness

According to survey data there is a decrease in number of non-regular partners in Zimbabwe, which is assumed to have contributed to declining HIV incidence. Concurrent partnerships (more than one partner in parallel) in adult and marriage relationships are a special risk, which exposes sex partners to particularly high levels of infection. The largely urban 'small house' phenomenon and the cultural background of polygamy provide a supportive context for multiple partnering which must be seen as a very important driver of the epidemic in Zimbabwe. Research indicates that partner reduction is a key requirement for successful HIV prevention in the Zimbabwean context. Despite declines

**Key Issue:**  
Multiple sexual relationships are a key driver of the HIV epidemic in Zimbabwe. More focus needs to be given to promoting faithfulness.

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<sup>3</sup> It should be noted that changing the age difference in partnerships across the entire population would most likely only lead to a moderate decrease in HIV incidence. If young women would start only having partners of their age, the already higher HIV prevalence in young women would increase new infections among young men. As a consequence, the increasing HIV prevalence in young men would make sexual relations with young men also more risky for young women.

in non-regular partnerships, overall levels of multiple partnering are still assumed to be high. Regular partnerships and marriage are a major source of infection to women and cannot be considered protective factors. In the past, programmes have not really focused on faithfulness, parallel relations and the so-called “small houses”. In an advanced HIV epidemic, which affects all population groups like in Zimbabwe, behavioural prevention aimed at partner reduction, particularly concurrent partners, is key to the overall success of prevention efforts.

#### 2.4. Condom use

Condom use at last sex with a non-cohabiting partner in Zimbabwe is higher than in most countries in the African region and has increased during the 1990s, but still needs to be increased given the high infection risk. Condom use in regular and marriage relationships remains low despite the fact that being in long-term relationships is not necessarily a protective factor. Condom distribution and social marketing programmes, which led to increased uptake and use in casual sexual relationships were

successful elements of the Zimbabwean HIV and AIDS response. These promotion and distribution strategies have worked and need to be sustained. More emphasis needs to be placed on correct and consistent use of male and female condoms, including in regular relationships. The female condom has a market and its increased distribution and social marketing will give couples and sexually active women an additional choice for preventing HIV infection.

**Key Issue:**

Condom use needs to be consistent until both partners are tested negative and remain faithful. This applies to unmarried and married couples. All sexually active persons need access to male and female condoms.

#### 2.5. Other practices that increase vulnerability to HIV infection

Local value systems allow for a number of practices that make Zimbabwean men and women vulnerable to HIV. These include:

- Polygamy (15 % of married women in a polygamous union in 1999)
- Widow inheritance
- Girl pledging and forced marriage
- Intra-vaginal practices (“dry sex”)
- Chiramu (a husband having sex with the younger sister of his wife)
- Post menopausal abstinence for women (during which the husband may have sex with other partners)

**Key Issue:**

Significant change is required in what is considered culturally acceptable and normal behaviour. Religious organizations and leaders at all levels can play a key role in this regard.

Umbrella bodies of faith-based organizations made concerted declarations of the Church's disapproval of risky traditional practices. This is a major development in the fight against this source of risk. The Church is uniquely positioned to create new norms

in this area in support of behavioural prevention. It also needs to be considered that other values and practices can be indirect reasons for vulnerability to HIV infection, for example, men are frequently justifying their dominant role over their wives by the fact that they have paid *Lobola*.

## **2.6. Existing modalities of co-operation, coordination and multi-sectoral approach**

Sectoral co-ordination structures for HIV and AIDS in general are in place in several sectors with a few exceptions. There is general recognition of the role of National AIDS Council (NAC) in supporting a coordinated response. Almost all groups at risk have already been identified and are receiving attention from behavioural change programmes, although the quality, consistency and comprehensiveness of programmes has varied greatly. Due to a scattered approach involving a large number of relatively small actors, coverage remained incomplete. Mapping exercises have shown that aspects of HIV prevention efforts have reached most districts, but hardly any district has seen a systematically designed response with district-wide coverage. There was wide coverage of awareness-raising programmes, many of which focused on specific activities and events, rather than on sustained and systematic interventions. Most were not linked to or embedded in other programme activities and in this context the behavioural change review report raised strong doubts about their efficacy and sustainability. The issue of how programmes expand is also of concern. Some programmes tend to expand by becoming more comprehensive rather than focusing on what is within their comparative advantage and developing good relations to other programmes with complementary services. Use of theoretical behavioural change models is concentrated in larger organisations, and is often not sustained through the delivery chain so that those individuals implementing programmes are not adequately versed in the frameworks on which their methodologies are based. Relatively high levels of stigma associated with HIV are illustrated by the very small number of public personalities and leaders openly living with HIV and AIDS.

## **2.7. Popular types of intervention**

Apart from condom distribution and social marketing, specific types of intervention have been particularly common in Zimbabwe:

*Peer education:* Peer education approaches have been very popular in Zimbabwe, but proven difficult to sustain in many contexts although there is some international evidence that they could be effective. They have proven most effective when not regarded as a stand-alone approach and when integrated with other strategies and approaches. The assumption that peer education is the best approach to educating young people needs to be critically re-examined. Evidently peer-education is not necessarily a low-cost, easy-to-implement option, but rather involves high maintenance and support and the success of projects depends on their connection to service networks.

*Information, Education, Communication:* Whilst there are many high quality manuals, workbooks, toolkits and communication tools, there seems to be a breakdown in the delivery chain. There are distribution problems given the fragmentation of the activities. This has led to users in need of such products having limited access to them. In some instances users of IEC materials have not been trained on how to use the relevant toolkits, workbooks etc. TV programmes with HIV prevention messages reached relatively wide coverage, particularly in urban areas.

*Testing and counselling (T&C):* In Zimbabwe, Voluntary Counselling and Testing (VCT) was widely considered a primary HIV prevention intervention. However, international reviews of the efficacy of T&C for prevention are critical about its value in prevention. There is some evidence that after an HIV test, HIV positive individuals and sero-discordant couples may change their behaviour, while there is no clear evidence for behaviour change in persons tested HIV negative. Prevention has mostly been approached from the perspective of those HIV negative and needing to avoid infection. Relatively little work has focused on motivating and involving people who are HIV-positive as a resource to work with and support avoidance of transmitting HIV. There are significant opportunities in this area and herein lies the greatest prevention potential of T&C. The integration of T&C services into sexual and reproductive health programmes offers opportunities for promotion through a number of new channels, especially family planning programmes.

Overall, it should be noted that Zimbabwe has made progress in terms of achieving certain aspects of behavioural change that led to HIV incidence decline, but that there are a number of behaviours and vulnerability factors that clearly need increased attention. Successful programmes like condom distribution and social marketing will be sustained and expanded, while the framework for addressing other key aspects, in particular multiple partnering and faithfulness is strategically redesigned.

### 3. Rationale for the Behavioural Change (BC) Strategy.

In Zimbabwe, HIV is predominantly transmitted through sexual contact with around 80 to 90 % of infections caused by sexual transmission. New medical prevention interventions are still under development (vaccines, microbicides, male circumcision), while existing medical interventions (such as bacterial STD management, which remains important in itself) cannot be expected to change the overall course of an advanced HIV epidemic that has already spread from groups at higher risk to the general population. Behavioural change promotion remains the key element of HIV prevention in Zimbabwe.

**Key Issue:**  
Behavioural change programmes are not just common sense. They require systematic and strategic planning as well as clear priority setting and targeting.

The purpose of this Strategy is to guide systematic and strategic programming in the area of promoting behavioural change as a means of preventing HIV transmission. The strategy mainly focuses on sexual

behaviours, but also addresses behaviours in relation to uptake of HIV prevention services. The Strategy seeks to develop a **comprehensive vision of behavioural change** that allows stakeholders to focus on addressing the **most critical behaviours like lack of faithfulness and insufficient condom use as well as key vulnerability factors such as imbalanced gender relations and stigma**. This BC Strategy seeks to establish a framework for national and decentralized behavioural change planning and thereby to overcome scattered targeting and increase geographical coverage of programmes. The Strategy requires involvement and action by all policy-making and implementing agencies of HIV and AIDS programmes, all sectors and all administrative levels from the national level to the provincial, district, ward and village levels. It spells out key expected outputs and areas of focus necessary for achieving these outputs between 2006 to 2010. The key areas of focus are in line with those outlined in the prevention component of the National HIV and AIDS Strategic Plan 2006 - 2010.

#### 4. Overall outcomes of the strategy

The overall goal of the strategy is **to reduce the number of new HIV infections**. The strategy is intended to design and support the delivery of results in the following specific outcome areas:

1. **Enabling environment** for behavioural change created including through increased leadership and gender-equality as well as reduced stigma associated with PLWHA
2. Increased adoption of safer sexual **behaviour** and reduction in risk behaviour
3. Increased utilization of HIV prevention **services** (T&C including post-test support, PMTCT, PEP)
4. Improved national and sub-national **institutional frameworks** to address behavioural change

#### 5. Guiding Principles for the Strategy

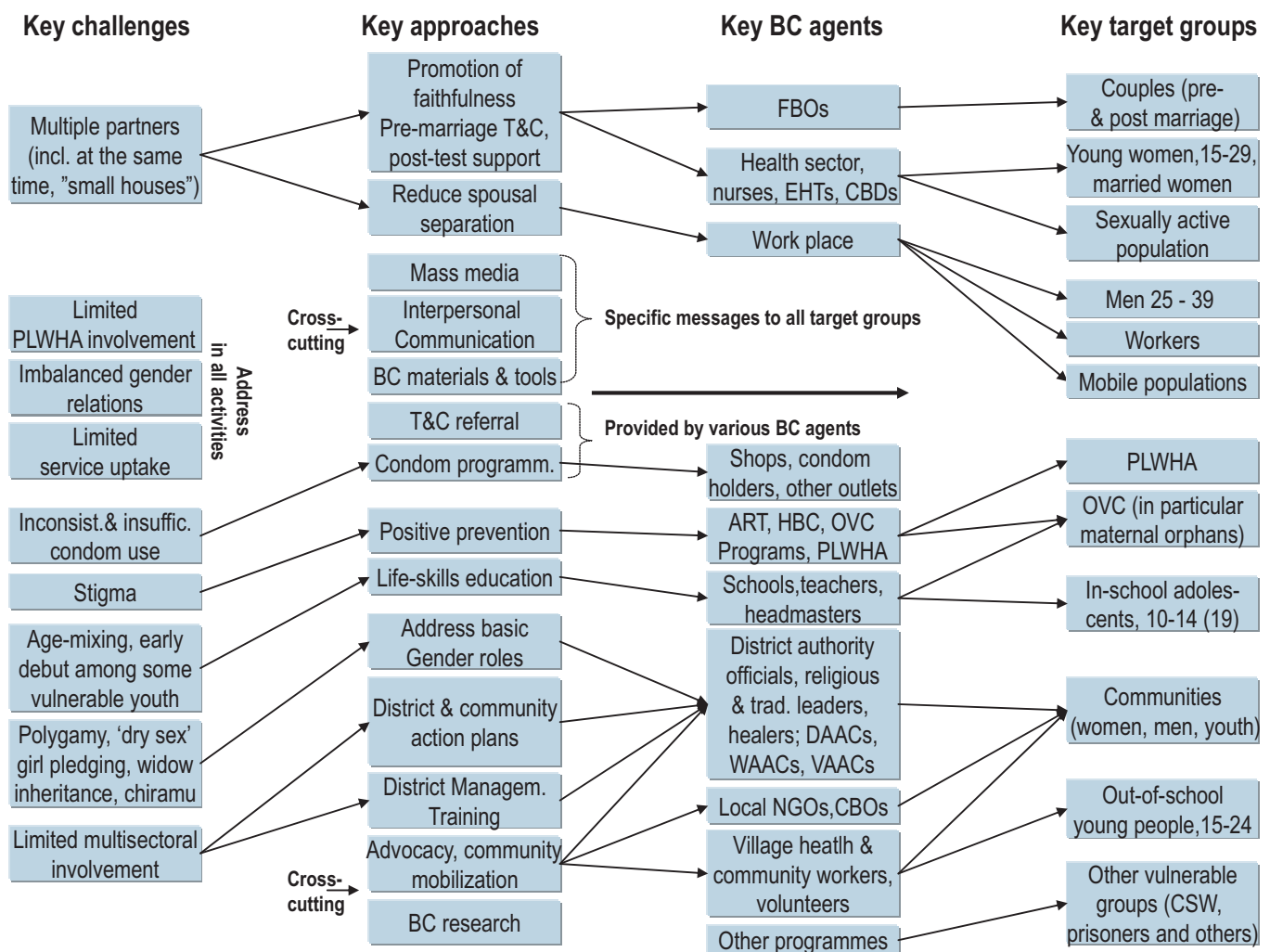
All stakeholders in the promotion of behavioural change make a commitment to adhere to the following guiding principles.

- a. Clear and consistent messages about HIV prevention and desired behaviours are required. Any negative statements about any effective HIV prevention method (abstinence, faithfulness to an HIV negative partner, condom use) need to be avoided by all stakeholders.
- b. It is essential to combat stigma associated with HIV and AIDS as well as HIV prevention services and meaningfully involve PLWHA in HIV prevention.
- c. All stakeholders need to lead by example and involve different kinds of leaders at all levels as advocates and role models.

- d. There is a need to increase participation of men in HIV prevention programmes, address gender relations and reduce the vulnerability of women and girls.
- e. Target groups need to be empowered to understand their personal risk, not only general biological or population risks.
- f. District structures, faith-based organizations and communities need to be involved in decentralized planning of behavioural change promotion.
- g. Behavioral change interventions should be developed based on epidemiological as well as behavioural information on age, sex and behavioural patterns of target groups.

## 6. Components of the BC Strategy

The chart below provides an overview of the key challenges, approaches, behavioural change (BC) agents and final beneficiaries of this strategy. The chart can be read as follows: Key challenges are addressed through key approaches using key behavioural change agents to reach general and specific target groups. Arrows indicate the flow of key strategies, but obviously the key themes concerning all target groups cut across all approaches and shall be addressed by all BC agents.



The strategy will be implemented through a multisectoral approach under the overall leadership of the National AIDS Council. Different stakeholders including line ministries, parastatals and district BC support organizations (NGOs and others) will assume roles in specific activity areas as outlined in *Annex 1 Results and Activity Matrix*. Specific activities like mass media programmes and development of BC materials will be directly designed by these national lead organizations. Most other activities will be designed through decentralized district level planning and implemented through selected behavioural change agents including district and religious leadership, DAACs, WAACs, VAACs, FBOs, CBOs, health workers, headmasters and others. Target groups will be segmented for specific strategy components. Specific attention will be given to particular age-groups, in which many new infections are occurring (men: 25-39 and women 15-29), to specific geographic locations including border towns, growth points and resettlement areas, to OVC and other vulnerable groups including commercial sex workers and sectors with high levels of spousal separation (transport, mining, security forces, domestic workers and others).

***Outcome area 1: Enabling environment for behavioural change created including through increased leadership and gender-equality as well as reduced stigma associated with PLWHA***

**Key Issues**

- Risk behaviours such as multiple partnering are partially rooted in value systems
- Gender disparities and gender based violence fueling the HIV and AIDS epidemic
- Stigma and discrimination against PLWHA preventing adoption of HIV prevention behaviour

**Objective 1.1. Increase capacity of leadership at all levels and communities to address risk behaviours and social relationships increasing vulnerability to HIV infection**

Risk behaviours cannot be seen in isolation and need to be addressed in the context of norms and values in society. In some contexts, risk behaviours are accepted or at least not objected to by members of communities. Reference to traditional values is also sometimes used as an excuse for risk behaviours, which may actually be relatively new rather than traditional. Under the leadership of the National AIDS Council, UN agencies and NGOs, careful and culturally sensitive advocacy shall be used to support normative change. Normative change means that underlying values that make people vulnerable to HIV infection need to be changed. Changing norms is not directed against traditional or modern values. It rather seeks to reinforce any positive values (such as faithfulness,

**Key messages:**

- Every district needs a behavioural change strategy
- We need leaders including men who are role models in faithfulness and advocates for behavioural change

mutual family care and gender equality), but question values that put communities at risk (e.g. stigma; male dominance; abuse of power, wealth or force to get sex). This will be done by increasingly enrolling traditional, religious and political leaders to speak out in favour of responsible behaviours such as faithfulness and share their own experiences and HIV status. Leaders shall be empowered and trained to become AIDS activists themselves. Positive role model examples will be systematically documented. At the national level, different public personalities including men will be supported to become advocates and should be provided with broad media coverage. Key messages of advocates will include promotion of faithfulness, stigma reduction, gender equality and other elements of this strategy. HIV and AIDS policies developed by faith-based organizations (FBOs) shall be operationalized and leaders of FBOs supported in becoming behavioural change agents.

The steps outlined in *box 1 (below)* give an overview of the approach that will be used to increase district capacity to address behavioural change and HIV vulnerability. This can and will be adjusted to the concrete needs of districts and communities. It is foreseen that specialized BC staff in NAC and decentralized support organizations, in particular NGOs, will assist districts in these processes.

**Box 1: Towards district behavioural change action plans and decentralized behavioural change planning**

Each district will require a district-specific approach based on the socio-cultural context and the organizational structures including existing HIV prevention efforts. The following steps are an example of activities that are recommended to take place at district level.

1. Identify potential BC agents among district, traditional and FBO leadership as key allies and role models in promotion of behavioural change, in particular regarding faithfulness;
2. Establishment of a district behavioural change forum (involving women, men, youth and PLWHA);
3. Identify and involve a district technical support organization (NGO, research organization or similar) for BC promotion building on or closely linking to existing local organizations;
4. Advocate with key stakeholders among the district, traditional and religious leadership and organizations;
5. Develop a district BC action plan and establish roles of different BC agents (including FBO leaders, district authorities, community leadership including traditional leaders and healers, DAAC, WAAC and VAAC members, health sector staff, headmasters, teachers, employers, staff and volunteers of ART, HBC and OVC programmes; youth volunteers) and set milestones;
6. Disseminate district BC action plan to a broader group of BC agents and train them in utilizing tools to promote BC;
7. Support to implementation of district BC action plans through the various BC agents including activities like:
  - Advocacy with community leaders and development of community level action plans addressing the key risk behaviours and vulnerability factors including gender issues and practices like inheritance rights, wife inheritance, polygamy;
  - Creating a decentralized pool of condom depot holders and distributors of BCC materials reaching all wards and villages (in addition to public sector distributors and social marketing outlets including DAAC, WAAC, VAAC members, HBC givers, employers, village community workers, PLWHA and others;)
  - Interpersonal communication by behavioural change agents with specific target groups on issues of major concern to the target group including faithfulness, safe sex negotiation and others
  - Support to each WAAC in identifying potential homes for post-test support groups and groups of PLWHA and setting up at least one post-test support/PLWHA group per ward;
  - Support to FBOs in introduction of systematic pre-marriage testing (referral) and counseling as well as post-test support in each ward;
  - Promote participation of PLWHA and establish district systems to monitor their discrimination and exclusion;
  - Community mobilization activities through existing structures and events;
8. Conduct district HIV and AIDS management trainings and planning as well as peer review meetings;

**Objective 1.2. Promote gender equality, reduce prevalence of gender-based violence and increase access of women to community resources**

Imbalanced gender relations shall be addressed comprehensively through a multi-media campaign on underlying imbalanced gender roles and norms. Respect for women and girls shall be promoted and their equal role in marital and other relationships emphasized. During pre-marriage counseling women shall no longer be advised to submit themselves to their husbands and instead gender equality and couple counseling be promoted. Women's representation in AIDS Action Committees at all levels, including in leading positions, will be increased to enhance their decision-making power. Legal support and sensitization programmes will be established to ensure women and girls benefit from property and inheritance rights enshrined in existing legislation. While not pretending to be able to resolve the issue of deepening poverty, especially female poverty, on its own, the implementation of the strategy will also make a contribution towards women's economic independence by integrating income generating components into such programs as HBC or allow a modest degree of profit-making from such activities as condom distribution. The female condom and educational tools that may assist in safe sex negotiation will be made more widely available.

All HIV prevention, care and support projects and programmes, will be encouraged to systematically mainstream gender into their design, implementation, data collection and evaluation, and gender will also be integrated into sectoral policies and programmes. Sexual abuse will be fought with a mixture of public monitoring and reporting, awareness-raising, and punitive approaches. Gender-based violence will be addressed at the district and community level through advocacy and interpersonal communication involving community leaders and men. Women who experienced early sexual trauma are more likely to engage in risky behaviour and therefore require specific counseling support. BC agents shall be trained in basic support to survivors of sexual and gender-based violence and their referral to psychosocial support. Gender disparities will also be addressed through promoting women's rights through the education system, faith-based organizations, civil society and mass media. Key stakeholders including NAC and district BC support organizations will advocate for the integration of gender issues into all district behavioural change strategies and community action plans. Women's access to community resources will be increased through national guidance and advocacy with community leaders. Each DAAC and WAAC shall allocate financial resources to women's support groups.

**Key messages:**

- Equality for women helps preventing HIV infection
- A real man does not use force and power to get sexual pleasure
- Women have the equal right to inherit property and to earn an income, thus being free from sexual exploitation
- Zero tolerance to sexual and gender-based violence

In addition to prevention of sexual violence, there is a need to increase access of survivors of sexual violence to post-exposure prophylaxis (PEP) the prevention of HIV infection within 72 hours after exposure through a course of ARVs. Information on PEP will be communicated through BC materials such as posters at public institutions

including health facilities, police stations as well as community leaders. This campaign should focus on areas where ARVs or PEP kits are available at health care institutions.

**Objective 1.3. Reduced stigma and discrimination as well as increased number of PLWHA openly discussing their status and involved in programmes including on HIV prevention**

HIV is still a taboo in many communities and work places, which has a negative impact on behavioural change and HIV prevention service uptake. Advocacy and support to all employers including public institutions and AIDS service organizations will enable them to create a supportive and non-discriminatory environment for PLWHA. This change in the environment is an essential first step. Only in such an environment can HIV positive people feel secure and comfortable to openly discuss their status. NAC and lead NGOs will support employers to develop HIV and AIDS workplace policies clarifying the organizational support and health care benefits for HIV positive people. Reduction of stigma and discrimination will continue to be promoted through mass media and interpersonal communication. All public institutions should be supportive of persons living with HIV and AIDS. Leaders of institutions, public personalities and community leadership will be involved in advocacy and campaigns to become role models including by being open about their HIV status. All trainings of health and other care providers will include modules on how to avoid negative attitudes (stigma) and discrimination against HIV positive people and stigmatisation of HIV prevention services. FBOs will be closely involved in stigma reduction and make a commitment to reject the idea that being HIV positive is a punishment by god.

**Key messages:**

- Don't be negative about being positive
- Discriminating against people living with HIV and AIDS is discriminating against relatives and friends
- Persons openly living with HIV and AIDS are courageous and deserve our respect. They made the experience. What can we learn from them?
- Someone who openly lives with HIV shows that he/she cares and does not want to infect others. Someone who is not aware of his/her status may be at risk of infecting others.

***Outcome area 2: Increased adoption of safer sexual behaviour and reduction in risk behaviour***

**Key challenges:**

- Multiple relationships (in particular having several partners at the same time) is the key behavioural challenge to be addressed
- Vulnerability of younger partners (usually females with older male partners) in relationships
- Insufficient and inconsistent condom use, in particular in multiple, regular and marital relationships

- Specific risk practices including polygamy, girl pledging, wife inheritance, chiramvu, intra-vaginal practices, gender based violence

### Objective 2.1. Reduce multiple sexual relationships and increase faithfulness

The risk of passing on the virus to a sexual partner is higher if the person who passes on the virus has been newly infected within the past months, because newly infected persons have a high viral load. Therefore a newly infected person who has two or more sexual relationships at the same time (concurrently) or short breaks between partner change has higher chances of passing HIV to the other partners than one with a long standing infection. This strategy will therefore focus on addressing the practice of having more than one regular partner at the same time and changing partners without an HIV test or during the window period. **The main focus and first priority of the national behavioural change strategy is therefore to promote a reduction in the number of partners and increase faithfulness both in marriage and other relationships.** Mass-media campaigns shall be launched to increase risk perception about multiple sexual relationships. Thereby, the so-called “small house” phenomenon will gradually be made socially undesirable. While multiple partnering shall be referred to as undesirable risk behaviour, persons who have engaged in multiple partnering including “small house” relations shall not be stigmatized, but offered opportunities to change. Faithfulness and the values of the family will be offered as positive alternatives. This will be complemented by advocacy with religious, political and community leadership to make them role models and activists for faithfulness, by interpersonal communication and community mobilization.

#### Key messages:

- Be faithful to one partner
- A good leader must be an advocate and role model for faithfulness
- The Zimbabwean man of today can be faithful
- Talk about HIV in marriage
- Be open to your partner about your HIV status
- Ask your partner for an HIV test before marriage or starting a sexual relationship
- One difficult hour of talk is better than two lives with HIV

Spousal separation is a long-standing practice not only among miners, truck drivers and domestic workers, but many other groups, in Zimbabwe, and, with significant implications for marital faithfulness and family life overall, constitutes a major factor of HIV vulnerability. Advocacy and work place policy development with employers will focus on minimizing spousal separation through a supportive work place policy that allows spouses to join their working partners or minimize long-term travel.

The risk perception of married women and their negotiation skills for monogamous relations as well as safer sex will be increased through interventions at health facilities and family planning providers. Specific attention will be given to men as a target group addressing their responsibility as husbands and fathers. Even when spouses are faithful, marriage is not necessarily protective, because one partner could have been infected before marriage. Therefore this strategy encourages the generalized promotion of couple communication within and before marriage as well as joint testing and counselling. Parents and educational institutions shall be encouraged to make open communication

about sexual matters part of young people's socialization process. Referral for HIV testing and pre-marriage counselling shall be offered across Zimbabwe at district and ward level. DAACs and WAACs will be mandated to identify the best institution or person within each district and ward to offer these services, mainly involving faith-based and community-based organizations.

**Objective 2.2. Reduce the vulnerability of young people, in particular young women, decrease the number of young people who have (unprotected) sex, and build the life-and relationship-skills of young people**

The different situations of young people point to the need for mixed strategies. This includes strategies that cater to young people who are not yet sexually active (support to delay debut), those who are already sexually active (promote faithfulness to one uninfected partner, facilitate access to condoms) and those who have already experienced negative consequences (mitigate impact of STIs, HIV, teenage pregnancies). There is a need for more differentiated targeting of sexually active and non-sexually active young people.

**Key messages:**

- No sex without knowing your partner's HIV status
- A real man does not abuse his power to have sex with a young girl

Age-mixing (persons from different age groups having sexual relationships) is a risk factor, mostly for younger women, because their older male partners have had longer sexual experience and are therefore more likely to be HIV positive. This does not mean that marriages, in which the man is five or more years older than the woman, are generally undesirable. It means that there is a need to address HIV transmission risk in such relationships both with younger women and adult men. For young women, the focus will be on increased risk perception of engaging in regular or casual relations with new partners, in particular if they are older and sexually experienced. Adult men will be targeted with appeals to male responsibility through mass media, leadership and at community level. Mass media, interpersonal communication and life-skills education will be used to increase risk perception and negotiation skills among women 15 - 29.

Early sexual activity is not the major driving force of the HIV epidemic in Zimbabwe. Nevertheless, there are vulnerable groups of young people who engage in early sexual activity with inadequate levels of protection. Schools will therefore be equipped to educate young people about gender, sexuality and life and negotiation skills. This will include education about all effective HIV prevention methods including abstinence, faithfulness and condom use. In-school and out-of-school programmes will provide adequate messages to sexually active and not sexually active young people as well as refer them to providers of HIV services including counseling, testing and condom use. Since early school-drop out by girls has been identified as a vulnerability factor, advocacy will focus on increased access of girls to secondary education. Mitigation and OVC programmes targeting orphaned children will be used to address the specific and high vulnerability of female orphaned children. In addition to life-skills education, this will involve counseling support and strengthened integration of out-of school youth

including OVC in existing and newly created youth groups. Specific attention will be given to involvement of HIV positive young people.

Life-skills, negotiation skills and relationships skills shall be provided to all young people through the education system (10-24) and other youth programmes including through integrated youth-friendly services and communication at health facilities. Skills-building shall be a key approach in all these efforts. While generic life-skills education remains important for society as a whole, the HIV epidemic requires prioritization of specific skills. All teachers shall therefore receive at least basic training to promote these special skills. This includes negotiation skills, in particular for young women, to increase their self-esteem and make them assertive in negotiating for monogamous relations, delayed debut or condom use. Furthermore, training in relationship skills including partner communication, gender issues and mutual respect shall be provided to both girls and boys.

### **Objective 2.3. Increase consistent male and female condom use**

The existing male and female condom programmes will be sustained. The levels of condom use with casual partners need to be further increased. Public sector distribution of condoms should be further expanded and mainstreamed into other programmes including T&C, PMTCT, ART, home-based care, family planning, tertiary colleges, workplace programmes, armed forces, police, prisons and other non-traditional outlets. Social marketing of condoms must be continued through

private sector retail outlets. In addition to social marketing and public sector distribution and following advocacy with community leadership, new condom holders shall be identified in each village. While promotion of faithfulness will be the key strategy for married couples, more focus needs to be given to condom use in marriage and in regular relationships, in particular during special situations such as pregnancy and breastfeeding, as well as after HIV testing. Condoms will be repositioned as a method of dual protection that is for the prevention of STIs/HIV, and pregnancy as well as Mother to Child Transmission of HIV. Male and female condom use will be promoted among discordant couples and HIV positive persons at testing and counseling facilities. Condom negotiation skills will be enhanced by development and dissemination of negotiation tools targeting both young and married women. Specific messages for men of different age groups including men 25-49 will be developed. Workplace programmes and community development fora will also be utilized to target older men. Access to male and female condoms by all sexually active persons including young people will be ensured and accompanied by creation of informed demand through advertising campaigns. Specific interventions involving interpersonal communication and promotion of condom use among mobile populations and sex workers will be scaled up. Training on the female condom will be provided to service providers and non-traditional distributors.

**Key messages:**

- Many Zimbabweans are good condom users, are you too?
- Condoms are strong and effective, if used consistently and correctly
- Use one every time
- Always use a condom

#### **Objective 2.4. Increase behavioural change promotion targeting HIV positive persons**

Specific messages and types of support are required to assist HIV positive persons in avoiding passing on HIV. HIV positive persons will be involved in and targeted through testing and counseling, post-test support groups, AIDS serving organizations, home-based care, and health service provision. Persons living with HIV and AIDS shall be involved in prevention efforts at all levels including as employees of AIDS service organizations, experts and volunteers. Testing and counseling, post-test support group leaders and ART service providers will be trained in delivering positive prevention messages. The representation of PLWHAs in AIDS Action Committees at all levels, including in leading positions, will be increased. Public awareness programmes should be led by PLWHA, who are willing to share their experiences.

**Key messages:**

- We need an environment, in which people do not have to be scared about talking about their status
- Join a PWLHA and post-test support group
- Every community needs a PWLHA and a post-test support group
- We need HIV positive people as advocates and experts for HIV prevention

#### **Objective 2.5. Assess prevalence of other practices that expose women and men to HIV infection (including widow inheritance, girl-child pledging, polygamy, chiramu, intravaginal practices), increase personal risk perception of these practices and address them as root causes of HIV infection**

Action on specific risk practices needs to be based on assessments of the local context. In areas where specific practices are prevalent, risk perception on these practices such as wife inheritance, girl pledging, post-menopausal abstinence, Chiramu and others will be increased through advocacy with community leaders, faith-based organizations, IEC material and social mobilization. Promotion of faithfulness in specific local contexts will take these practices into account and develop specific local responses.

**Key messages:**

- Positive African culture promotes protection of women and girls
- Forced sexual relationships are unacceptable and cannot be part of Zimbabwean culture

Among district stakeholders, key behavioural change agents will be identified and equipped to advocate for normative change regarding these practices. The potential risk posed by these practices will also be highlighted through BC materials. As not all community members will necessarily abandon all mentioned practices within short periods of time, efforts shall also be made to make these practices safer (e.g. by promoting T&C in existing polygamous unions or before widow inheritance). Any forced relationships should be promoted as unacceptable by all organizations and behavioural change agents. DAACs shall be supported in developing structures to monitor and expose specific unlawful practices like property grabbing, forced sex and others. "Dry sex" through its impact on the intravaginal tissue is likely to increase chances of acquiring HIV. Internal washing of the vagina has not yet been widely researched as a risk factor, but according to recent findings may also pose a risk. Carefully worded BC materials will be used to increase risk perception of these intravaginal practices and shall be distributed by health care and family planning providers.

### ***Outcome area 3: Increased utilization of HIV prevention services***

#### **Key challenges:**

- High use of non-barrier methods of contraception despite high levels of HIV infection and unfaithfulness in marriage as well as low levels of HIV testing
- Low utilization of and partially limited access to counseling, testing and post test services especially in rural areas as well as insufficient utilization of PMTCT services
- Stigma associated with HIV prevention services

The reduction of stigma associated with HIV prevention services will be a cross-cutting priority in this outcome area. This will be achieved through addressing attitudes of service providers towards specific groups of clients including T&C clients, PLWHA and young people in pre- and in-service training in stigma reduction and youth-friendly service provision.

#### **Objective 3.1. Increase dual protection, HIV risk perception and HIV testing among family planning clients**

Zimbabwe has a high contraceptive prevalence rate and within long-term relationships mainly non-barrier methods are used, although a relatively low percentage of women and men are aware of their HIV status. Hence, it is very likely that a considerable number of family planning clients are at high risk of HIV infection. The HIV infection risk-perception of users of non-barrier methods of contraception should be increased through messages on packages of oral and injectable contraceptives and through interpersonal communication by family planning and health service providers who will be trained in promotion of dual protection and referral to HIV testing. Community-based family planning service providers shall be consistently trained on BC promotion and referral for HIV preventions services.

##### **Key message:**

- Non-barrier methods of contraception (pill, injectables and others) do not protect from HIV. If you do not know your HIV status and the status of your partner, use condoms (as well) until you and your partner are tested.

#### **Objective 3.2. Increase uptake of Testing & Counselling (T&C) and post-test support services**

Testing and counseling will be rolled out nation-wide to increase the knowledge of status among the general population. Since research indicates that knowledge of status alone does not necessarily lead to behavioural change, quality of counseling and support structures need to be strengthened to achieve and sustain behavioural

##### **Key messages:**

- Get tested, get real
- Take control of your life
- No test, no sex
- No test, no marriage
- No test, no children
- Seek support if you are tested positive

change. The T&C roll-out will therefore include training of public health service providers in counseling and further training of Primary Care Counselors. Faith-based organizations should become involved in encouraging couples to know their status together, including through T&C before marriage and within marriage. Mass-media will be utilized for increasing demand for T&C and referral for T&C mainstreamed into existing programmes across all sectors. Support will be provided to all WAACs in identification of institutional homes of at least one post-test support group and PLWHA support group in each ward of Zimbabwe and train FBOs and other selected existing community based organizations in setting up of post-test support groups. A key function of these post-test support groups will be to support HIV positive persons and discordant couples to adopt safe sexual practices. Close linkages to women's support groups, which shall also be created in each ward, need to be ensured in order to provide support for women who may face rejection or even violence when disclosing their HIV status.

### **Objective 3.3. Increased participation in Prevention of Parent-to-Child Transmission of HIV (PPTCT)**

This BC Strategy is about sexual HIV transmission, and therefore does not outline a comprehensive strategy on Prevention of Mother-to-Child Transmission (PMTCT). The focus here is on the linkages between sexual behaviour change, community norms and PMTCT. The medical perspective on PMTCT shall be complemented through a broader vision of Prevention of *Parent-to-Child* Transmission (PPTCT). This vision shall be built around the concept of responsibility within the family. This includes both partners' responsibility for preventing sexual transmission as a basis for mother-to-child transmission *and* the entire family's as well as the community's responsibility for ensuring that a pregnant woman can participate in PMTCT. Although PMTCT services are widely available, there is not sufficient information and low

**Key messages:**

- It's not only the mother's role to avoid that a baby gets HIV. It's also the role of men, families and communities.
- Know your status before planning children
- Protecting yourself is protecting your pregnant or breastfeeding wife and your baby
- Being faithful to your pregnant or breastfeeding wife is being faithful to your baby

male involvement in PPTCT. Knowledge levels on PPTCT and demand for PMTCT services will be increased through mass media, community mobilization, interpersonal communication and the public health system. These efforts shall be integrated with other aspects of reproductive health promotion, which are outlined in the National Reproductive Health Behaviour Change Communication Strategy by the MOHCW. Women will be targeted through family planning service providers and community-based organizations with messages on all aspects of PPTCT including family planning methods and dual protection. Through a campaign male and family involvement in PPTCT will be promoted to increase male responsibility and risk perception of transmission of new HIV infections to the mother and the child. In this context, faithfulness during pregnancy and breastfeeding will be promoted and female condom use introduced. Couple counseling for parents will be encouraged. The role of communities and families in ensuring access of women to all steps of PMTCT services

will be highlighted in the campaign and reinforced by messages on the need to avoid stigmatization of women participating in PMTCT.

### **Objective 3.4. Link and adjust behavioural change promotion to emerging medical interventions and new prevention technologies**

The **impact of the ART roll-out on behavioural change** is not yet established, but needs to be considered during strategy implementation. ART can have positive HIV prevention effects, since ART can serve as an entry point for targeting PLWHA with HIV prevention and since reduced viral load reduces likelihood of HIV transmission. In some contexts outside Zimbabwe it was also observed that successes in behavioural change promotion were reversed when ART was introduced. Since there was behavioural change in Zimbabwe, there is the possibility that ART roll-out may contribute to a partial reversal of behavioural change. While further research on the impact of ART on BC will be conducted, the ART roll-out needs to be accompanied by continued behavioural change promotion. The focus will need to be on behavioural change promotion among ART clients and on maintaining HIV risk perception among the general population.

A number of other developments require particular attention over the 2006-2010 period. The Technical Support Group on Behavioural Change will closely follow research around **new risk reduction methods** including vaccines, microbicides, and male circumcision. Three trials confirmed previous research on a reduced HIV infection risk for men who are circumcised. As a result there may be increasing demand for male circumcision or policy makers and service providers may decide to offer male circumcision as a service. Any new developments on male circumcision may have an impact on behavioural change programmes. Acceptability as well as feasibility of male circumcision in Zimbabwe need to be studied. Male circumcision may become an opportunity for increasing male involvement in HIV prevention, but there is also a possibility that any new risk reduction method can cause increased risk behaviour by men, which would need to be addressed in BC programmes. Developments regarding these emerging issues may require flexibility during the strategy implementation over the 2006-2010 period.

### ***Outcome area 4: Improved National and Sub-national Institutional Frameworks to Address Behavioural Change***

#### **Key challenges:**

- Uncoordinated behavioural change programmes overlapping in some thematic and geographical areas, while leaving important gaps in others
- Limited synergies between research, M&E and programmes
- Need to align policies and strategies

**Objective 4.1. National BC strategy disseminated and operationalized, district behavioural change action plans developed**

The principles and activities of this strategy will be integrated into all sectoral HIV and AIDS policies. Linkages to other programme areas including ART, OVC, and home-based care will be strengthened and promotion of behavioural change mainstreamed into all HIV and AIDS programmes. Certain policies will need to be aligned, for example the absence of condom promotion in schools needs to be aligned to the right of all sexually active persons to have access to condoms. The sexual offences act should be amended to reduce the burden of proof. The National AIDS Council will be in charge of facilitating these alignment and mainstreaming processes and therefore requires increased human resources for behavioural change promotion. As outlined in *box 1 (see outcome area 1)* decentralized behavioural change planning processes will be initiated and lead to district behavioural change action plans. As outlined in *box 2 (right)* a minimum package of behavioural change promotion shall be defined at ward level. The approaches of this behavioural change strategy shall also be mainstreamed into the sectoral HIV and AIDS policies.

**Box 2: Example for a ward minimum package in support of behavioural change promotion (model to be adjusted by WAAC and district leadership)**

- WAAC action plan on behavioural change promotion prepared with DAAC support
- WAAC and community leadership is actively advocating against multiple partnering and for condom use
- At least one post-test support group and PLWHA group in the ward
- At least one women's support group
- At least one group of men promoting male involvement in HIV prevention and responsible fatherhood
- At least four condom depot holders per village (one male adult, one female adult, one male youth, one female youth)
- One focal person for couple and pre-marriage counseling
- Testing and counseling offered in health facility or through regular outreach
- WAAC and all condom depot holders have minimum package of BC materials and tools
- WAAC is monitoring and exposing discrimination and

**Objective 4.2. Increase availability of behavioural change materials and tools including at decentralized levels**

New BC materials and tools will be developed on multiple partnering, risk perception for young people, male responsibility, positive prevention, dry sex, wife inheritance, girl pledging and others. To support the implementation of the strategy a National Information, Education and Behaviour Change Resource Centre will be set up within the National AIDS Council. In this resource centre, best practice materials and tools on all key areas shall be available in large quantities. The resource centre will link to existing decentralized distribution systems and regularly supply DAACs and district level implementers with minimum packages of BC materials and tools. An advisory board to the Resource Centre will set priorities in the development of new materials and reproduction of best practice BC materials with clear benefit statements. All stakeholders are encouraged to share BC materials in draft and final stage with the resource centre.

#### **Objective 4.3. Increased capacity and skills to plan, implement, monitor and evaluate BC promotion**

The implementation of this strategy will require strengthening of capacity and skills in several lead organizations including NAC, line ministries, NGOs, FBOs, district authorities and others. These organizations shall receive training in BC promotion, management, planning, monitoring and evaluation of BC promotion. The indicators outlined in the BC strategy matrix will be integrated in the National Monitoring and Evaluation system. New indicators are required for specific components, in particular for monitoring involvement of district leadership, gender issues, stigma and discrimination. All key indicators shall feature in the district level action plans and be subject to regular reviews including peer reviews conducted during district management trainings.

#### **Objective 4.4. Improved linkages between BC research and programmes**

A BC research agenda will be developed and regularly updated. In addition, a BC Research Advisory Board should be created to coordinate and disseminate research. The board will facilitate dissemination of survey results to key implementers and thereby improve access to and utilisation of existing research in prevention planning. The board will periodically take stock of research priorities in support of prevention planning at a national level. Issues for further research will include:

- The influence of concurrent sexual relations on HIV prevalence and decline, including the extent of the 'small house' phenomenon and its influence on HIV transmission trends;
- New interventions and their effects on behaviours and services, such as the impact of ART on T&C provision and uptake; impact of ART on risk behaviours;
- Behavioural factors that influence service demand, access and provision;
- The prevalence of different types of identified cultural practice risks and their impact on the epidemic;
- Extent of and barriers to consistent and correct male and female condom use;
- Behavioural change among PLWHA;
- Operational research on development of integration of prevention programmes with care and support, most importantly for PLWHA.

#### **Objective 4.5. Increased funding for systematic BC programmes and equitable geographical distribution of funding**

The share of NACTF resources allocated towards BC promotion is recommended to be increased. Potential donors shall be included in the dissemination of this strategy and be invited to the National Prevention/Behavioural Change Forum. Modalities for harmonized donor support to behavioural change promotion shall be explored and more streamlined channels for external support developed.

**Cross-cutting priority: Address the needs of specifically vulnerable groups**

The vulnerabilities of women, men, young people, HIV positive and HIV negative persons, married and unmarried persons in different contexts have been addressed throughout the strategy. In addition, very specific activities will be required for other vulnerable groups including orphans and other vulnerable children, sex workers, mobile populations, prisoners, the disabled and men who have sex with men (MSM). There is a need to develop innovative strategies for these groups focusing on their empowerment and inclusion in decision-making, the allocation of resources for programs that address their specific needs, and community strategies.

**Orphans and other vulnerable children (OVC):** Numbers of orphans, in particular maternal and double orphans, are still expected to rise in Zimbabwe. Hence, OVC will become an increasingly important target group for HIV prevention, especially orphans who lost their mother and according to research are particularly vulnerable to early sexual activity and HIV infection. Therefore the current welfare approach of the NPA on OVC will be widened to integrate life-skills education, prevention and care. Behavioural change promotion for OVC also requires inclusion of OVC in localized advocacy to create a culture of respect for OVC, ensuring their access to services as well as monitoring and reducing their exclusion and abuse (forced marriage, sexual abuse and others). Psychosocial support and counseling including HIV prevention communication will be provided to caregivers of orphans including fathers, female heads of households and child headed households.

**Commercial sex workers (CSW):** The situation of CSW, their clients and existing HIV prevention responses will be mapped and reviewed. A specific strategy will be developed to address factors that push women into sex work (taking into account that some adult women make a decision for this profession) and HIV prevention needs of CSW. Particular attention will be given to approaches for increasing protection among HIV positive sex workers and to developing exit strategies for them. Male clients of CSWs will be addressed in the context of campaigns on male responsibility.

**Mobile populations:** Mobile populations in Zimbabwe include sex workers, cross border traders, uniformed personnel (soldiers, police, game rangers, militia customs and immigration officials), truck drivers, domestic workers and the farming community. Their particular vulnerability comprises separation from regular partners, engagement in causal and commercial sex and irregular access to prevention services. Mobile populations will be reached through intensified programming in specific geographical areas, further mainstreaming of behavioural change promotion in sector strategies, such as mining, transport, construction, agriculture, uniformed services and informal cross-border trade.

**People living with disabilities:** 3 % of Zimbabweans are living with disabilities. While it is important to ensure their access and remove barriers to general BC promotion activities and HIV prevention services, different groups of people living with disabilities also have specific requirements that need to be addressed including in terms of protection from abuse and access to special BC materials.

Research will be carried out and specific strategies will be developed for other groups at risk, which are not yet benefiting from any strategy or programme. In this context, the vulnerabilities of prisoners and men having sex with men (MSM) shall be subject to a review, which shall form the basis for targeted approaches.

## 7. BC Strategy dissemination and implementation

The National AIDS Council shall be responsible for supporting and coordinating mobilization for the BC strategy and monitoring its implementation. In this regard the National AIDS Council will work closely with the various umbrella bodies and networks of NGOs, PLWHA, FBOs, private sector and others.

### Dissemination

NAC will disseminate this strategy at national level to all sectors as well as at provincial and district levels. The strategy will also be promoted to the private sector, the public service, FBOs, civil society and others. The National AIDS Council through Provincial and District AIDS Co-ordinators will conduct trainings and facilitate development of action plans based on this Behavioural Change Strategy. This Behavioural Change Strategy will be disseminated in full text and as a summary poster.

### Implementation

The Technical Support Group on Behavioural Change will develop an operational business plan for the Strategy. The attached *Results and Activity Matrix* gives an overview of the key activities to achieve behavioural objectives. The business plan will define responsibilities and a division of labour according to the following key channels and clusters of activities:

- Mass media programming
- BC materials and tools
- District-level leadership, advocacy, strategy and action plan development
- Community mobilization and interpersonal communication
- Sector-specific action
- Research

The implementation of this Strategy shall involve all sectors and all levels from national, provincial, district, ward and village level.

In a context of limited resources it can be expected that there will be a need to further prioritize certain components of the strategy over others. Therefore prioritization within this strategy was based on the potential impact of activities on the epidemiologically most sensitive behaviours. As review processes have shown, multiple partnering in the general population is the key driver of generalized epidemics, but has not been in the very centre of the past response. **Based on the current evidence partner reduction and promotion of faithfulness, in particular among adult men, can be considered as the top priority area with the highest prospects from a cost-benefit perspective.** Further prioritization will need to follow the same principle and cost-effectiveness analysis of interventions. Obviously, relatively low cost interventions with a broad expected impact will receive highest priority. This will include creation of leadership commitment and advocacy around faithfulness, stigma and gender issues, development of district level action plans, mass media and condom programming.

## Annex 1: Results and Activity Matrix

### Goal: Reduced number of new HIV infections

**Target:** Reduce prevalence among women 15-24 and among men 15-24 by 50% by 2010 (as a proxy indicator for halving HIV incidence)

**Baseline:** YAS 2002: Women 15-24: 17%, Men 15-24: 5%, DHS 2005/06 (preliminary report): Women 15-24: 11%, Men 15-24: 4%,

### Outcome area 1: Enabling environment for behavioural change created including increased leadership and gender-equality as well as reduced stigma associated with PLWHA

#### Indicators (disaggregated by sex and age, wherever possible):

- Number of national level leaders speaking out against multiple partnerships
- Number of national level leaders disclosing that they are living with HIV
- Number of districts with at least one traditional/religious/political leader who has spoken out against multiple partners/disclosing he/she is living with the virus
- Percentage of community resources as well as District and Ward AIDS Action Committee resources programmed for addressing gender issues;
- Number of HIV positive persons who have joined a post-test support group
- Number of HIV programme staff, volunteers and behavioural change agents who live openly with HIV and AIDS
- Number of districts, wards and villages, which address gender issues in action plans

Key challenges	Objective	Strategic approach	Planned Activities	Target groups and areas	Responsible actors
Risk behaviours are rooted in value systems and some risk behaviours are still widely accepted. HIV is still a taboo in many communities and work places, which has a negative impact on behavioural change and HIV prevention service uptake.	1.1. Increase capacity of leadership at all levels and communities to address risk behaviours and social relationships increasing vulnerability to HIV infection	Development of district behavioural change strategies and community owned action plans and skills-building of key behavioural change agents	<p>1.1.1. Advocacy with national and provincial leadership including at the highest political level to involve leaders into behavioural change promotion including as advocates and role models for behavioural change, in particular faithfulness</p> <p>1.1.2. Identification of potential key behavioural change agents in each district and advocacy with district authorities and community leadership on behavioural change promotion including in the framework of skills-building of behavioural change agents</p>	<p>DAAC, WAAC and VAAC members, FBO leaders, traditional leaders &amp; healers, health sector staff incl. EHTs, CBDs, headmasters, teachers, employers, ART, HBC, OVC prg. staff, youth</p>	<p>NAC, UN agencies</p> <p>NAC, district BC support organizations</p>

Key challenges	Objective	Strategic approach	Planned Activities	Target groups and areas	Responsible actors
Imbalanced gender relations expose women to HIV infection. Economic dependency may force women into transactional sex. Gender-based violence leads to women not raising issues of safe sex within marriage. Sexual violence exposes women directly to HIV infection.	1.2. Promote gender equality, reduce prevalence of gender-based violence and increase access of women to community resources	Advocacy and mainstreaming of gender issues in community action planning processes	1.1.3. Strengthen the capacity of Zimbabwean district BC support organizations through organizational development and training, and train FBOs, NGOs and other key stakeholders in promotion of behavioural change	Staff of district BC support organizations and FBOs	NAC, TSG BC, district BC support organizations, UN agencies
			1.1.4. Skills-building for key behavioural change agents including in national BC strategy and BC promotion focusing on key issues such as multiple partnering, consistent condom use, stigma, gender and specific cultural practices	See 1.1.1.	NAC, district BC support organizations
			1.1.5. Community mobilization through trained behavioural change agents (supported by district BC support organizations)	All sexually active community members	DAACs, district BC support organizations, behavioural change agents
			1.1.6. Based on district behavioural change action plans develop community level action plans on behavioural change		
			1.1.7. Support to implementation of community level action plans		
			1.2.1. Advocacy with leadership at national, provincial and district levels on gender equality and roles as well as to introduce processes that ensure women access to existing community resources		
1.2.3. Allocate financial resources for women's empowerment including by introducing modest allowances for community activities, which are mostly performed by women (condom holders, HBC and OVC workers)	Women 15-49	RDCs, DAACs, WAACs			
1.2.4. Establish focal points for monitoring discrimination against women and expose unlawful practices like property grabbing, forced marriage, gender-based violence and child abuse	All community members	DAACs			
			1.2.5. Ensure that 50 % of members of DAACs, WAACs and VAACs and an increasing number of leaders are women	DAACs, WAACs and VAACs	NAC, RDCs

Key challenges	Objective	Strategic approach	Planned Activities	Target groups and areas	Responsible actors
Stigma and discrimination of PLWHA are still relatively high, although there is some progress in areas where PLWHA are involved in interventions. Although there are initiatives involving PLWHA into prevention and behavioural change efforts, the role of PLWHA is still rather marginal.	1.3. Reduced stigma and discrimination as well as increased number of PLWHA openly discussing their status and involved in programmes including prevention initiatives.	In parallel to scaling up T&C and post-test support, PLWHA will be recruited for HIV prevention programmes. This is expected to decrease stigma and promote open communication about HIV and AIDS.	<p>1.2.6. Mainstream gender and meaningful involvement of PLWHA in all community action planning processes</p> <p>1.2.7. Integrate promotion of gender equality as a core element into HIV and AIDS life-skills education</p> <p>1.2.8. Community mobilization on gender-based violence (GBV) in support of the national plan of action against GBV</p> <p>1.2.9. Promotion of uptake and referral to PEP by selected multipliers including community leaders, CBDs and police officers</p> <p>1.3.1. Organize To Ts for PLWHA in HIV prevention, stigma reduction and BC and set up pools of trainers in each province</p> <p>1.3.2. Continue and further develop campaigns on stigma reduction</p> <p>1.3.3. Establish focal points for monitoring and exposing discrimination against PLWHA such as exclusion from meetings</p> <p>1.3.4. Advocacy with and support to all employers to create enabling working environments, which allow for PLWHA to be open about their status</p> <p>1.3.5. Involvement of PLWHA into HIV prevention programmes at all levels including as staff, experts and volunteers</p>	<p>All community members</p> <p>School-children, 10-18</p> <p>All community members</p> <p>Victims of sexual violence, other persons with recent high-risk exposure</p> <p>PLWHA</p> <p>General population</p> <p>PLWHA</p> <p>Employers and workers</p> <p>PLWHA</p>	<p>DAAcs, district BC support organizations, behavioural change agents</p> <p>MOESC</p> <p>NGOs, district BC support organizations MOWAGCD</p> <p>MOHCW, ZNFPC, decentralized NAC structures, police</p> <p>District BC support organizations, ZNNP+, NAC</p> <p>NAC, district BC support organizations, ZNNP+</p> <p>DAAcs, FBOs</p> <p>All sectors, Zimbabwe Business Council on HIV and AIDS, NAC</p> <p>All HIV prevention programme implementers</p>

## Outcome area 2 increased adoption of safer sexual behaviour and reduction in risk behaviour

### Indicators (disaggregated by sex and age, wherever possible):

- ? Percentage of persons reporting condom use at last sex with co-habiting and non co-habiting partners
- ? Percentage of married persons reporting sex with more than one partner in the past 12 months.
- ? Percentage of young women who had sex with a partner who is 10 or more years older during the past 12 months
- ? Percentage of people aged 20 to 49 years who disapprove of members of married or co-habiting couples having multiple partners.
- ? Percentage of young women aged 13-19 who disapprove of having sex with older men in exchange for material goods or money
- ? Percentage of males aged 20 to 49 years who believe that it is natural for men to have many partners.

Key challenges	Behavioural Objective	Strategic approach	Planned Activities	Target groups and areas	Responsible actors
Levels of multiple sexual relationships (including the so-called "small house" relations) are still relatively high and likely to be a major factor fuelling the HIV epidemic. Risk of concurrent relationships (two or more sexual relationships at the same time) and risk within marriage are underestimated. Marriage is not a protective factor, not only because of unfaithful partners, but also because one partner may already have been infected before marriage and in many cases will not know his/her status	2.1. Reduction in multiple sexual relationships	Develop a campaign on faithfulness including media, IEC materials and interpersonal communication. Specific attention needs to be given to men as a target group. Encourage open communication between partners on safer sexual practices. Pre-marriage counselling, marriage enrichment seminars, couple education	2.1.1. Develop a media campaign with role models on faithfulness, television dramas and radio programmes; performing arts (role play, theatre, drama, music), focus on involvement of male role models (e.g. soccer stars)	Men 24-49 years Women 15-39 years	Organizations with experience in mass media programming
			2.1.2. Develop materials on faithfulness highlighting the high risk of multiple relations and benefit statements on faithfulness		Members of TSG on BC, NGOs, FBOs
			2.1.3. Promote open discussion on faithfulness and T&C among couples before marriage through pre-marriage counselling	Women 15-29, men 20-39	FBOs, CBOs
			2.1.4. Creating role models for faithfulness among men (e.g. soccer stars, actors, musicians)	Men 20-39	NAC, district BC support organizations
			2.1.5. Advocacy with employers to minimize spousal separation	Specific sectors including mining, army, agriculture	NAC, sector ministries, UN agencies
			2.1.6. Address multiple partnering and faithfulness through advocacy and community mobilization at district and community level including issues such as age-mixing and couple communication (also see outcome areas 1. and 4.)	All sexually active population	DAAC, district BC support organizations, FBOs, BC agents

Key challenges	Behavioural Objective	Strategic approach	Planned Activities	Target groups and areas	Responsible actors	
Sex with older partners is the major source of infection of young women (15 – 24). Young men are then mostly infected via young women who had sex with older partners (average age difference 7 years). This is related to economic dependency and cultural practices. Overall levels of sexual debut in Zimbabwe are already high. Therefore early debut was not the major driving force of the HIV epidemic. Nevertheless, there are some vulnerable groups of young people who engage in early sexual activity with inadequate levels of protection.	2.2. Reduce the vulnerability of young people, in particular young women, decrease the number of young people who have (unprotected) sex, and build the life- and relationship-skills of young people	Increase risk perception among younger women and older men (who are also at risk because of relatively high prevalence levels in younger women), target older men with messages on male responsibility, partner reduction and condom use. Provide skills-building for young people in-school and identify district level channels to provide vulnerable young people including orphans and youth out-of-school with life, negotiation and relationship skills	2.1.7. Pre-marriage counselling and marriage enrichment seminars	Married couples, discordant and HIV positive couples, couples deciding to marry or have sex, other regular partners	FBOs	
			2.1.8. Develop materials on couple communication			District BC support organizations, community level NGOs, local leaders
			2.2.1. Multi media campaign focusing on risk perception of casual sex and entering new relationships, especially for younger women with older partners and promoting negotiation skills for knowledge of status of partner before sex	Young women (10-24) including out of school, young women, in particular growth points, border towns	Organisations with experience in mass media programming, FBOs, all sectors	
			2.2.2. Multi-media and community-based communication on male responsibility and positioning abuse of power to receive sex as undesirable	Men 15-49 (particularly 25-39)	Organisations with experience in mass media programming	
			2.2.3. Training of teachers in life-skills education promoting negotiation skills and relationship skills and increasing risk perception of unprotected sex, and in particular the increased risk with older partners	Teachers, in-school young women (10-19)	MOESC, MOHTE, district BC support organizations	
			2.2.4. Involvement of parents through schools, community and youth centre discussion events	Parents of young people 10-24	MOESC, MOHTE, district BC support organizations	
			2.2.5. Targeted localized communication with vulnerable young people including orphans and girls who have dropped out of school on ABC, social norms and gender relations	Adolescents 10-19 including OVC	District BC support organizations, MOESC, FBOs, UN agencies	
2.2.6. Involvement of vulnerable youth in district, ward and village level HIV and AIDS programmes	Youth 15-24	DAACs, NGOs, FBOs, UN agencies				
2.2.7. Support the establishment of regular meeting points for vulnerable young people at existing community structures (eg. youth-friendly afternoons at health facilities, churches, community centres), in-school anti-AIDS clubs and Girls' Education Movement clubs, provision of BC materials, skills-building, lay counselling and support	Young people 10-24	DAACs, MOHCW, ZNFPC, UN agencies				

Key challenges	Behavioural Objective	Strategic approach	Planned Activities	Target groups and areas	Responsible actors
Levels of condom use at last sex with a non-cohabiting partner are relatively high, but can still be increased. Levels of condom use in marriage are very low. Socialization creates barriers to communication on sex and negotiating safer sex, in particular within marriage.	2.3. Increased consistent male and female condom use	Expand the existing public and social marketing sector condom programmes based on an analysis of currently underserved groups	2.3.1. Promotion and distribution of male and female condoms through public health system, NGOs, community-based distributors and new condom holders in all villages, all behavioural change agents including health sector staff, district and community institutions 2.3.2. Social marketing of male and female condoms including advertising campaigns emphasizing condom efficacy 2.3.3. Develop BC materials on condoms including such that are acceptable for use in the education sector	All sexually active persons, in particular men 25 – 49, married couples, young people and mobile populations	ZNFPC, MOHCW, NGOs, work places, decentralized NAC structures
Prevention messages have been focused on HIV negative persons and on how to avoid becoming positive. Specific messages are required for HIV positive persons.	2.4. Increased adoption of safer sexual practices among HIV positive persons.	Mainstream positive prevention into T&C, ART and HBC service provision	2.4.1. Development of BC materials specifically targeting HIV positive persons 2.4.2. Training of T&C, ART and HBC service providers in positive prevention 2.4.3. Training of selected members of PLWHA and post-test support groups in positive prevention 2.4.4. Involve HIV positive persons in HIV prevention programmes	PLWHA Service providers	MOHCW, ZNFPC, NAC, PSI, UNFPA, MOESC, MOHTE NAC, TSG on BC, ZNNP+, PLWHA ZNNP+, PLWHA
Risky practices like widow inheritance, girl-child pledging, polygamy, chiramu, intravaginal practices expose women and men to HIV infection.	2.5. Assess prevalence of other practices that expose women and men to HIV infection (including widow inheritance, girl-child pledging, polygamy, chiramu, intravaginal practices), increase personal risk perception of these practices and address them as root causes of HIV infection	Integrate discussion on these practices in community level action planning processes	2.5.1. Participatory district level rapid assessments on the prevalence of the mentioned practices 2.5.2. Develop and distribute BC materials on each of the specific practices 2.5.3. Community mobilization events by district BC support organizations, FBOs and other trained key behavioural change agents 2.5.4. Interpersonal communication by trained behavioural change agents including health sector staff (dry sex), FBOs (polygamy, inheritance, girl pledging, chiramu)	PLWHA Community leadership and members Community leadership and members Community leadership and members Community leadership and members	District BC support organizations, ZNNP+ All implementers District BC support organizations, FBOs, DAACs NAC, TSG on BC, district BC support organizations, FBOs DAACs, district BC support organizations, FBOs DAACs, BC agents, FBOs

### Outcome area 3: Increased utilization of HIV prevention services

#### Indicators (disaggregated by sex and age, wherever possible):

- ? Percentage of persons ever tested for HIV
- ? Number of couples jointly tested for HIV (including before marriage)
- ? Number of post-test support groups set up
- ? Number of condoms distributed and sold

Key challenges	Objective	Strategic approach	Planned Activities	Target groups and areas	Responsible actors
Zimbabwe has a high contraceptive prevalence rate and within long-term relationships mainly non-barrier methods are used, although a relatively low percentage of women and men are aware of their HIV status.	3.1. Increase dual protection and HIV risk perception among family planning clients	The HIV infection risk-perception of users of non-barrier methods of contraception should be increased.	3.1.1. Condom promotion, distribution and social marketing (see outcome area 2.3.) 3.1.2. Include messages on HIV testing and dual protection in the promotion and packaging of non-barrier methods of contraception 3.1.3. Include referral for T&C and promotion of dual protection in training of family planning and public health service providers	See 2.3. All sexually active population All sexually active population	See 2.3. ZNFP, MOHCW, other FP providers, UNFPA ZNFP, MOHCW, other FP providers
Although levels of persons tested for HIV in Zimbabwe are not low in the regional comparison, T&C uptake is still much too low given the scale of the epidemic. T&C is not an aim in itself, but requires linkages to other services including post-test support and positive prevention. Pre-marriage T&C is not yet being implemented. Capacity of counsellors in terms of BC promotion is limited. T&C needs to focus more on supporting HIV positive persons in avoiding transmission to others.	3.2. Increased uptake of T&C and post-test support services	Establish a national referral system for T&C, promote a policy on pre-marital T&C	3.2.1. Community mobilization and promotion of uptake and referral to T&C by all behavioural change agents including establishment of a national referral system including a standard referral slip 3.2.2. Support WAACs in identification of institutional homes of at least one post-test and PLWHA support group in each ward of Zimbabwe and train FBOs and other selected existing CBOs in set up of post-test support groups 3.2.3. Development of BC materials with clear benefit statements on T&C including for persons who may test positive 3.2.4. Mass media campaigning on the benefits of T&C	All sexually active population PLWHA, discordant couples All sexually active population All sexually active population	All stakeholders NAC, MOHCW, district BC support organizations, FBOs, CBOs, NAC, MOHCW, district BC support organizations, organizations with experience in BC

Key challenges	Objective	Strategic approach	Planned Activities	Target groups and areas	Responsible actors
Although PMTCT services are widely available, there is inadequate information on PMTCT. There is low male involvement in PPTCT. Home deliveries are not covered by PMTCT services.	3.3. Increased participation in PPTCT	Complement medical PMTCT approach with a broader vision of PPTCT building on the responsibility of both partners, families and communities	<p>3.3.1. Community mobilization and promotion of uptake and referral to PMTCT</p> <p>3.3.2. Promotion of contraception and dual protection among women living with HIV and AIDS</p> <p>3.3.3. Mass media campaign on PPTCT including on male involvement and male responsibility addressing the high risk of a newly infected man passing on HIV and AIDS to the mother and baby</p> <p>3.3.4. Development of BC materials with clear benefit statements on PPTCT</p>	<p>Couples, pregnant women and their partners, families, communities</p> <p>HIV positive women</p> <p>Couples, pregnant women and their partners</p> <p>Couples, pregnant women and their partners</p>	<p>All BC agents, MOHCW, district BC support organizations, ZNFPC</p> <p>MOHCW, ZNFPC, other FP providers</p> <p>MOHCW, NAC, organizations with experience in mass media</p> <p>NAC, MOHCW, organizations with experience in mass media</p> <p>NAC, research community</p> <p>NAC, MOHCW, all ART providers</p> <p>NAC, MOHCW</p>
Any new developments including increased ART availability or new prevention technologies (male circumcision, microbicides, vaccines and others) may influence sexual behaviour. It is critical to prevent that optimism about new interventions leads to increased risk behaviours.	3.4. Link and adjust behavioural change promotion to emerging medical interventions and new prevention technologies	Conduct research on the impact of new interventions on sexual behaviours	<p>3.4.1. Conduct analysis of trends in sexual behaviours during ART roll-out regarding the influence on ART roll-out on behaviours.</p> <p>3.4.2. Mainstream BC messages into communication on ART roll-out</p> <p>3.4.3. Hold national consultations on any new HIV prevention technology (eg. male circumcision) that may become available or demanded at a larger scale in Zimbabwe</p>	<p>All sexually active population</p> <p>All sexually active population, ART clients</p> <p>Key stakeholders in HIV prevention</p>	<p>NAC, research community</p> <p>NAC, MOHCW, all ART providers</p> <p>NAC, MOHCW</p>

### Outcome area 4: Improved national and sub-national institutional frameworks to address behavioural change

#### Indicators:

- ? Number of districts that have implemented a district behavioural change action plan and regularly reviewed progress
- ? Number of wards, in which a minimum package of action in support of BC is available
- ? Number of districts, in which a minimum package of BC materials was distributed
- ? Number of implementers reporting to the National M&E system on BC

Key challenges	Objective (including indicators and targets)	Strategic approach	Planned Activities	Target groups and areas	Responsible actors
The absence of a national BC strategy has led to inconsistent and uncoordinated approaches. Certain policies were not aligned, condom promotion in schools or the sexual offences act, which cannot be enforced in a context of entirely voluntary testing. There is no national lead agency on BC and therefore a need to strengthen the capacity of NAC to coordinate and ensure operationalization of the BC strategy. Capacities of other key players such as line ministries and district BC support organizations need to be enhanced.	4.1. National BC strategy disseminated and operationalized, district behavioural change action plans developed	Development and operationalization of a BC strategy which provides a guiding operating framework for key sectors undertaking BC.	4.1.1. Dissemination of BC strategy to all sectors and districts	Decision-makers and key stakeholders across sectors and in all districts	NAC, district BC support organizations, TSG on BC, UN agencies
			4.1.2. Development of BC operational plan	Donors, finance institutions	NAC, TSG on BC
			4.1.3. Engage a BC Coordinator at NAC HO to oversee and support BC programming by different sectors	NAC	NAC, UNFPA
			4.1.4. Development of district behavioural change strategies	District institutions and communities	NAC, DAACs, UN agencies, district BC support organizations
			4.1.5. District HIV management team trainings and peer reviews	District leaders and managers	NAC, UN agencies
			4.1.6. Mainstreaming BC strategy into sectoral HIV and AIDS policies	All sectors	NAC, TSG on BC
			4.1.7. Align existing policies/ guidelines to BC strategy, eg National HIV and AIDS Policy, Work Place Policy, CHBC Policy, T&C Policy	Policy makers	NAC, MOHCW, all sectors

Key challenges	Objective (including indicators and targets)	Strategic approach	Planned Activities	Target groups and areas	Responsible actors
Although a large number of BC materials are available, many important issues (new services, faithfulness, risk practices like polygamy and others) only received marginal attention. A breakdown in the delivery chain of BC materials. There is a need for a more structured approach to communication.	4.2. Increased availability of behavioural change materials and tools including at decentralized levels	Develop a national system for distribution of BC materials to the district and community level	4.2.1. Develop a tool kit for training of behavioural change agents and compile an advocacy package for behavioural change promotion at district level  4.2.2. Establish a set of best practice BC materials, develop new materials to close any gaps and introduce a joint reproduction system to save printing costs  4.2.3. Set up of a national BC resource centre, in which all best practice BC materials are available for nation-wide distribution  4.2.4. Develop minimum packages of BC materials for different distribution channels including DAACs, WAACs, health facilities, schools and others	DAAC, WAAC and VAAC members, FBO leaders, traditional leaders & healers, health sector staff incl. EHTs, CBDs, headmasters, employers, ART, HBC, OVC prg. staff, youth  All types of target groups  All stakeholders involved in HIV prevention  All types of target groups	NAC, TSG on BC, UN agencies  TSG on BC  NAC with support from TSG on BC  TSG on BC
The linkages between M & E systems and BC programmes are insufficient. There is only incomplete information on geographical and target group coverage in BC programmes.	4.3. Indicators on BC included in national M&E system	Enable joint progress monitoring and better allocation of resources through more comprehensive information on coverage	4.3.1. Development of BC indicators and incorporation in the M&E system including new indicators capturing issues relating to stigma reduction and open communication about HIV and AIDS  4.3.2. National mapping of BC programmes within the framework of overall mapping of the response to HIV and AIDS	All stakeholders involved in HIV prevention  National, provincial and district level planners and managers	NAC, TSG on BC, M&E task force  NAC, M&E task force, UN agencies
There is a need to improve design and reporting on behavioural surveillance research and standardize indicators. Behavioural change programmes and strategies are not in line with current research findings and epidemiological trends.	4.4. Improved linkages between BC research and programmes	Standardised reporting systems and research design ensures uniformity and comparability of data	4.4.1. Establishment of a behavioural change research advisory board and development of an HIV prevention research agenda  4.4.2. Documentation of best practices in BC	All implementers of BC programmes  All implementers of BC programmes	TSG on BC, research institutions  NAC, TSG on BC, UN agencies

Key challenges	Objective (including indicators and targets)	Strategic approach	Planned Activities	Target groups and areas	Responsible actors
Inadequate resourcing of some BC programmes	4.5. Increased funding for systematic BC programmes and equitable geographical distribution of funding	Disseminate and clearly communicate BC strategy to donors	4.4.3. Provide guidance and technical support to BC implementing partners	All implementers of BC programmes	NAC, TSG on BC, UN agencies
			4.4.4. Accompany district BC action plan and programme development with operational research	District level implementers	University of Zimbabwe, NAC, UN agencies
			4.4.5. Conduct specific behavioural surveys and disseminate findings of surveys to key stakeholders (including 2005 DHS)	All stakeholders	NAC, TSG on BC, research advisory board
			4.5.1. Increase allocation of NACTF resources towards behavioural change promotion	DAACs, WAACs	NAC
			4.5.2. Develop a resource mobilization plan and develop more streamlined channels for resources in order to harmonize donor support	Bilateral and multilateral donors	NAC, TSG on BC, UN agencies
			4.5.3. Involve donors in the NAC led HIV prevention/behavioural change forum	Bilateral and multilateral donors	NAC, TSG on BC

## Annex 2: References

- Central Statistical Office (1999): Demographic and Health Survey 1999. Harare
- Central Statistical Office (2006): Demographic and Health Survey 2005-2006. Preliminary Report. Harare
- Government of Zimbabwe (1999): National HIV/AIDS Policy- Republic of Zimbabwe. Harare. Government Printing and Publications
- Ministry of Health and Child Welfare (2004): The HIV Epidemic in Zimbabwe- Background, Projections, Impacts and Strategic Response. Harare
- Ministry of Health and Child Welfare (2005): Zimbabwe National HIV/AIDS Estimates 2005- Preliminary Report. Harare
- Ministry of Health and Child Welfare, Zimbabwe National Family Planning Council, National AIDS Council, and US Centers for Disease Control and Prevention. 2004: The Zimbabwe Young Adult Survey 2001-2002. Harare
- National AIDS Council (2006 a): Comprehensive Review of Behavioural Change as a Means of Preventing Sexual HIV Transmission in Zimbabwe. Harare
- National AIDS Council (2006 b): Zimbabwe National Strategic Plan 2006-2010. Harare
- UNAIDS (2005 a) Evidence for HIV Decline in Zimbabwe- A Comprehensive Review of Epidemiological Data. Geneva/Harare
- UNAIDS (2005 b): Intensifying HIV Prevention. Geneva

