



Government of Zimbabwe

EXTENDED ZIMBABWE NATIONAL HIV AND AIDS STRATEGIC PLAN 111

(ZNASP3)

2015 – 2020

COMMITMENT TOWARDS FAST TRACKING 90 90 90 TARGETS

BY 2020 AND ENDING AIDS BY 2030



Ministry of Health and Child Care



National AIDS Council

EXTENDED ZIMBABWE NATIONAL
HIV AND AIDS STRATEGIC PLAN

(ZNASP3)

2015 – 2020

NATIONAL AIDS COUNCIL

100 CENTRAL AVENUE

HARARE

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Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
ARVs	Antiretroviral Drugs
ASRH	Adolescent Sexual and Reproductive Health
DHS	Demographic Health Survey
DPs	Development Partners
EMIS	Electronic Management Information System
eMTCT	Elimination of Mother to Child Transmission
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
HTC	HIV Testing and Counselling
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MIPA	Meaningful Involvement of People Living with HIV
MOHCC	Ministry of Health and Child Care
MTR	Mid-Term Review
MSM	Men who have sex with men
NAC	National AIDS Council
NGO	Non- Governmental Organisation
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PAAC	Provincial AIDS Action Committee
PHDP	Positive Health, Dignity, and Prevention

PLHIV	People Living with HIV
PMTCT	Prevention of mother-to-child transmission
SBCC	Social and Behaviour Change Communications
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infections
SW	Sex Workers
TB	Tuberculosis
UNAIDS	United Nations Joint Programme on AIDS
VAAC	Village AIDS Action Committee
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WAAC	Ward AIDS Action Committee
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic and Health Survey
ZNASP II	Zimbabwe National HIV and AIDS Strategic Plan 2011-2015
ZNASP III	Zimbabwe National HIV and AIDS Strategic Plan 2015-2018

Acknowledgements

The Extended Zimbabwe National AIDS Strategic Plan III (ZNASP III) was developed through a participatory and extensively consultative process involving significant contributions and support from people living with HIV, public sector partners, cooperating partners, civil society organization, private sector organizations and various other stakeholders.

We wish to express our profound gratitude to all individuals and organizations that made invaluable contributions to the process of developing the Extended ZNASP III (2015-2020). We are most grateful for the technical input from cadres in the Ministry of Health and Child Care and the National AIDS Council for their role in finalising the ZNASP III document.

The support from the Minister of Health and Child Care, the Permanent Secretary, MOHCC, as well as National AIDS Council Board members and Senior Management is most appreciated. The technical inputs from the Steering Committee and relevant thematic groups that were involved and participated in ZNASP III preparation are also gratefully acknowledged. We thank all stakeholders and partners who gave their time to work on different aspects of this process. We also take this opportunity to convey special thanks to UNAIDS Country Office for providing necessary technical assistance.

We cannot over-express our gratitude to all others who have contributed and provided support in one way or the other in the development and production of this plan. We look forward to your continued partnership and support.

Preface

Zimbabwe has recorded significant progress in the response to HIV and AIDS in the recent past, with both the incidence and prevalence of HIV falling, while the number of people receiving antiretroviral therapy has increased. Coordination structures, which enable the participation of various stakeholders and harmonisation of the response, amplifying the multi-sectoral approach have also been strengthened.

HIV incidence dropped from 0.88% in 2011 to 0.48% in 2016, while HIV prevalence also dropped from 15% to 13.8% in 2016 providing hope and a solid platform upon which future prevention programmes can be strengthened to achieve the 90-90-90 fast track targets by 2020 and the eventual ending of AIDS by 2030. The number of people accessing treatment rose from 462, 000 2011 to 981,000 in 2016. The number of AIDS related deaths has also dropped from over 3000 per week in 2004 to less than a thousand in 2016.

These achievements have been based on an enabling environment that includes a vibrant National AIDS Council (NAC), which was established through an Act of Parliament (Chapter 14:15 of 1999) and is mandated to coordinate and lead a multi-sectoral response to HIV and AIDS. As part of the three ones, the National AIDS Council has established decentralized coordination structures and systems necessary to mobilize an effective HIV and AIDS response. The environment also includes the statutory National AIDS Trust Fund (NATF), which has partly financed the response and served as a global best practice for domestic financing of the response, upon which various donors and partners have rallied their support.

This extended national strategic plan [ZNASP III 2015-20], is a successor to the ZNASP III [2015-2018] and aligns the national response to elements of the ZIMASSET (2013-2018) priorities, the global 90-90-90 by 2020 fast track targets and the Sustainable Development Goals.

To sustain the trajectory of reduction of new infections achieved over the lives of the recent national strategic plans, this extended ZNASP III specifically aims at closing the tap of new infections. In this regard, high impact interventions contained here-in will target key and vulnerable populations including children, adolescents, young people, girls and women among others.

This Extended ZNASP III is outcome based and specifically seeks to achieve reduction of the HIV incidence among adults and adolescents by 50% from 0.48 in 2016 to 0.24 % by 2020, reduction of new HIV infections among children to less 50 cases per 100 000 by 2020, reduction of HIV and AIDS-related mortality by 50% for both adults and children by 2020 and eradication of HIV related stigma and discrimination by 2020. It is also designed to promote smart investment for more focused and high impact interventions, allowing for hybrid financing by Government on one hand and donors and partners on the other.

The Government of the Republic of Zimbabwe remains committed to the national response to HIV and AIDS and would like to thank stakeholders, partners and donors for their continued support. All stakeholders, partners and donors are urged to continue their commitments and support as we enter a phase of accelerated implementation of high impact interventions aimed at closing the tap of new HIV infections, universal ART coverage and viral load suppressions while also addressing co-infections of non-communicable diseases. Together we can End AIDS by 2030.

Dr .P. D. Parirenyatwa

Minister of Health and Child Care

Foreword

Zimbabwe is one of the 22 priority countries in the Global Plan for the elimination of mother-to-child transmission of HIV. The country has one of the highest HIV prevalence at 14% among adults aged 15 to 49 years.

Although Zimbabwe has experienced a period of severe economic and social challenges mainly between 2000 and 2009, it made remarkable strides in curtailing HIV and AIDS through collective and resolute efforts on HIV prevention, treatment and impact mitigation.

The national response is quite mature and advanced. The next four years are critical as the country further intensifies and fast tracks actions towards attainment of 90 90 90 targets by 2020 and ending AIDS in Zimbabwe by 2030. The Extended Zimbabwe National HIV and AIDS Strategic Plan III for 2015-2020 is a people centred plan meant to be inclusive so that every person in need especially young people, key populations, women and children can effectively and timely benefit from the relevant interventions and services on HIV and AIDS. It is designed to foster strong community empowerment and greater ownership and accountability for responses that are sensitive to the local needs and context. As such it also ensures that pockets of locations and population groups that have higher risk of HIV infection are prioritized. The plan is well aligned to the ZIMASSET and is aimed at contributing to the national vision of an Empowered Society and a Growing Economy.

In the last decade the country registered over 50% reduction of new HIV infections among adults and 80% in children born to HIV positive mothers. Similarly AIDS related deaths have also been reduced by over 60% as a result of highly successful prevention, treatment and support programme. Extended ZNASP III therefore offers the opportunity to scale up implementation of the comprehensive eMTCT plan and integrated approaches including Option B+ so that all HIV positive pregnant and breastfeeding women and their infected children have access to ART.

Zimbabwe has strong political commitment and leadership support at the highest level. Global solidarity, strong partnerships among all key stakeholders including communities, people living with HIV, civil society, implementing partners, government, public sector, private sector and development partners have characterised the national response over the years. These should be further reinforced and sustained during Extended ZNASP III and beyond as anything short of that will undermine the gains made so far and the intended impact of the plan.

Given the country's experiences in HIV and AIDS work since mid-1980s and the evidence that has accrued, NAC enjoins partners in the national response to focus efforts in (a) allocating more dedicated resources for priority and high impact interventions in line with Zimbabwe HIV Investment Case principles. (b) setting quality standards for these priority interventions; (c) getting coverage to levels where it will make population impact and difference; (d) efficient and effective response management and multi-sectoral coordination as well as, generation of real time data and strategic information and (e) better sectoral performance management of those priority interventions that are being implemented so as to improve efficiency and effectiveness.

The National AIDS Council wishes to urge all stakeholders to fully embrace Extended ZNASP III and identify with its ambitious targets and goal to prevent new HIV infections and reduce HIV related deaths towards ending AIDS by 2030.

Dr. Tapuwa Magure
Chief Executive Officer
National AIDS Council (NAC)

I.0 Introduction

I.1 Background

I.2 Development of Extended ZNASP III

The Extended ZNASP III (2015-2020) was informed by the Mid-term Review of the ZNASP III (2015-2018). The strategic plan was developed through in-depth analysis of available data including hot spots and a highly participatory process involving a wide range of stakeholders from government; civil society, faith based organisations, networks of people living with HIV and key affected populations; private sector, informal sector, traditional leaders, UN family and development partners. The development process includes:

Mid-term review (MTR) of ZNASP III 2015-2018: The MTR of ZNASP III documented progress to date and gaps in HIV response that need to be addressed. It also identified strengths and weaknesses of the current HIV response strategies. The process was informed by the epidemiological data review.

Technical Experts Team: A team of six consultants were hired to review and develop the extended ZNASP III. The team involved consultants for; Epidemiological data analysis and modes of transmission, Strategic information and evaluation, prevention, treatment and care, Gender, MIPA, Community systems strengthening and cross cutting issues, and the lead consultant who was supervising the process. The consultants worked with specific technical working groups and they reviewed available data and defined the results and strategic interventions for each thematic area. They also conducted key informant interviews with programme managers and policy makers.

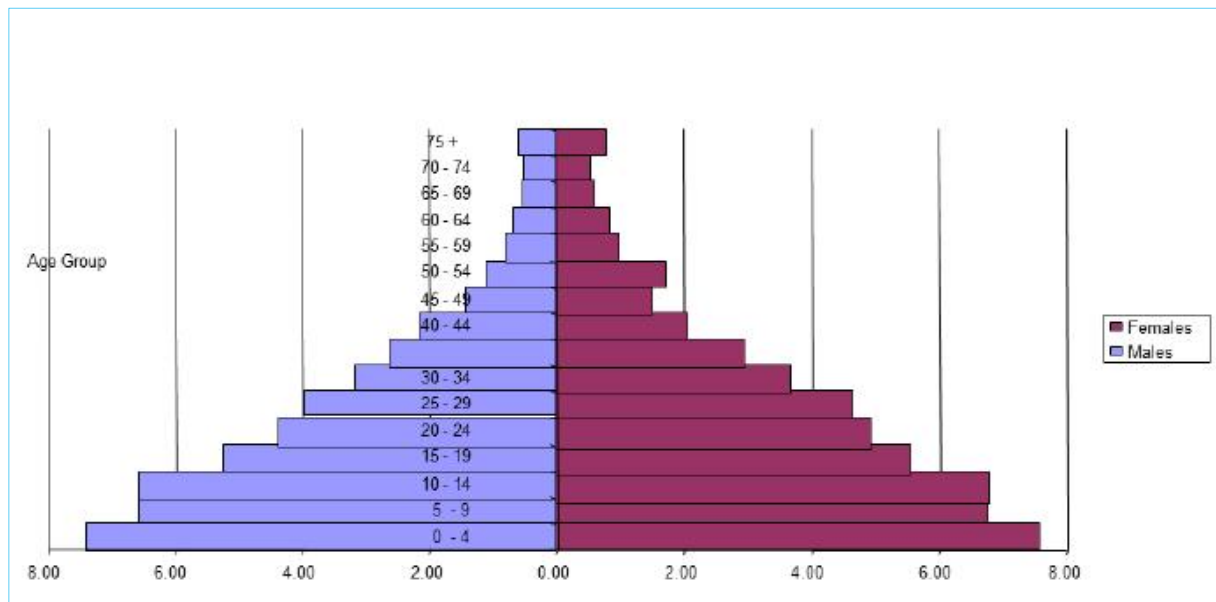
Stakeholders Participation: Stakeholder consultations were done throughout the 10 provinces and stakeholder consultation meeting was held to gather information on the HIV epidemic, needs and challenges in accessing HIV services. Government ministries, traditional leaders, informal sector, civil society, faith based organisations, networks of people living with HIV and key affected populations; private sector, UN family and development partners participated in the consultative meetings and provided their perspective on how the HIV response can be improved. The same stakeholders participated in the validation of the strategy document.

Consultative meeting: HIV prevention revitalization meeting was held to discuss gaps in HIV prevention and necessary immediate actions.

2.0 Overview of the National Response

Zimbabwe has a total population of 13.5 million of which female constitutes 52% of the population¹. The population varies with province and the sex ratio was consistently lower than 100, meaning that there are more females than males. The population age-sex structure is shown by the pyramid below.

Figure I: Population pyramid percent (Zimbabwe 2012 Census Report)



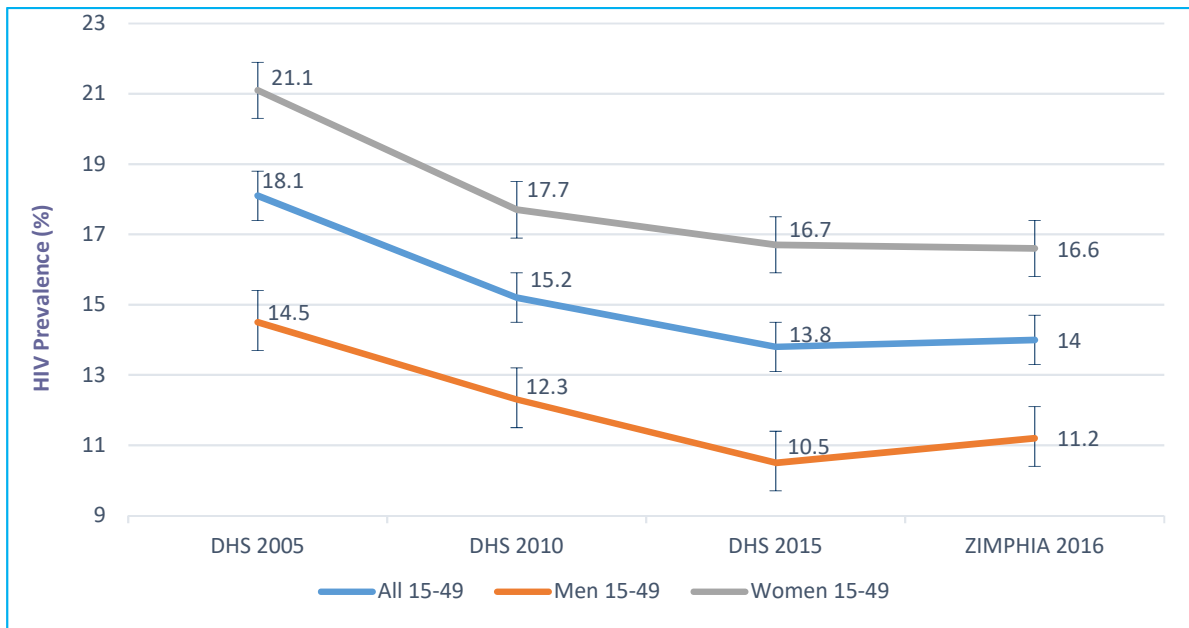
Zimbabwe has an estimated 1.4 million people living with HIV (PLHIV), 1.2 million of whom are between the ages of 15 and 64². Adult HIV prevalence has steadily decreased by 24% over the last ten years, from 18.1% in 2005 to 13.8% in 2015². Prevalence among children (0-14) is estimated at 1.6%. While the epidemic declined among both men and women (15-49), women continue to bear disproportionate burden with prevalence levels of 16.7% compared to 10.5% among men in 2015. The same gender disparity is true for new infections, where women have an HIV incidence of 0.67%, compared to 0.28% among men (15-49)³.

¹ Zimbabwe 2012 Census Report

² Zimbabwe Demographic and Health Survey Report 2015

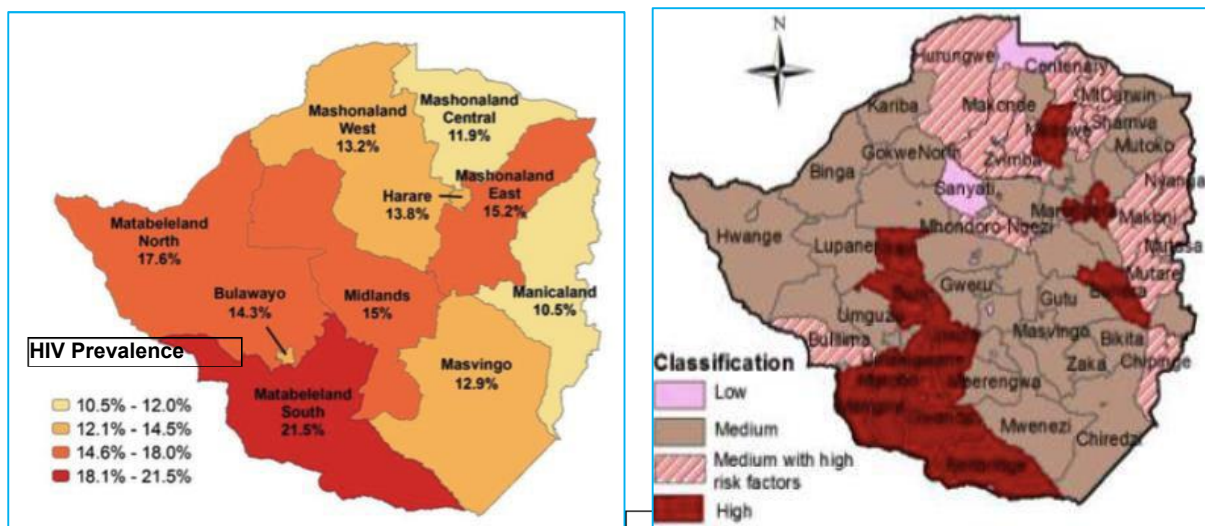
³ ZIMPHIA 2016 Fact Sheet

Figure 2: Prevalence of HIV among adults (15-49) in Zimbabwe



HIV prevalence varies by region with Matabeleland South having the highest adult prevalence of 21.5% while Manicaland has the lowest prevalence of 10.5% as shown by figure below. However, Manicaland has high estimated incidence, making it an important region to focus prevention efforts⁴. Zimbabwe’s 2015 Hot Spot Analysis helps explain these variations by overlaying HIV prevalence data with epidemic drivers such as STI prevalence, teenage pregnancy and condom knowledge, to create risk profiles for each district. The analysis shows that all districts of Matabeleland South as well as Bulawayo, Bubi, Nkayi, Mazowe and Marondera are HIV risk hotspots.

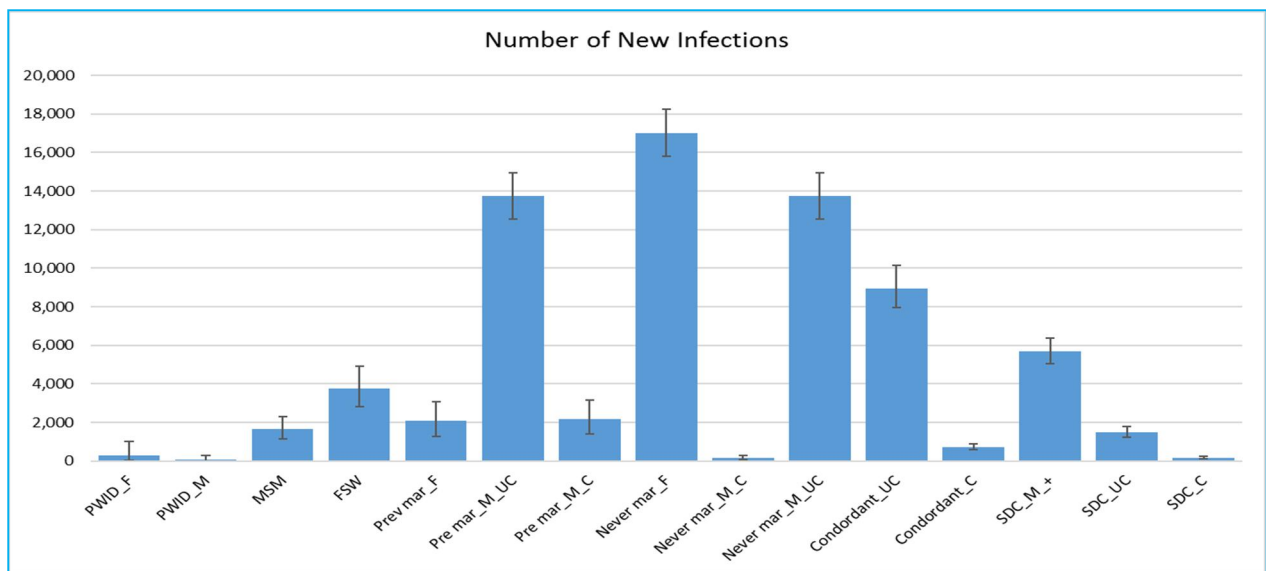
Figure 3: Adult HIV Prevalence (Left) and Hot Spot Risk Analysis (Right) (2015)



⁴ Hot spot analysis (2015), page 27

The HIV incidence in Zimbabwe was 0.483. Zimbabwe’s 2017 modes of transmission study shows that the greatest number of new infections, more than 16,000 a year – are occurring among never married women. Young women in particular experience dramatically disproportionate burden; in the 20-24 year age group, women have an HIV prevalence that is 2.78 times higher than their male peers. The following figures shows the output from the MOT 2017 study.

Figure 4: New Infections by population groups⁵



Social and structural drivers influence the circumstances within which adolescent girls and young women (AGYW) are made more vulnerable. For instance, 17% of women aged 15-19 who had sex in the last year had sex with a partner ten or more years older than them, 41% of girls report that their sexual debut before 18 years was unwanted and rates of transactional sex are high and increasing (from 2.9% in 2005 to 4.5% in 2015 among sexually active men age 25-49).

HIV sub-epidemics among other key and vulnerable populations in Zimbabwe also signal the need for a more targeted response. Preliminary results from the modes of transmission study show nearly 4000 new HIV infections a year among female sex workers (with a prevalence around 57.1%) and nearly 2000 new infections each year among men who have sex with men (MSM) (with a prevalence of about 23.5%). HIV prevalence among the wider LGBT community has been linked to risks associated with forced sex, a key gender-related consideration. Among prisoners, HIV prevalence is estimated at 28% in 2011 (26.8% among male detainees and 39% among female detainees)⁶.

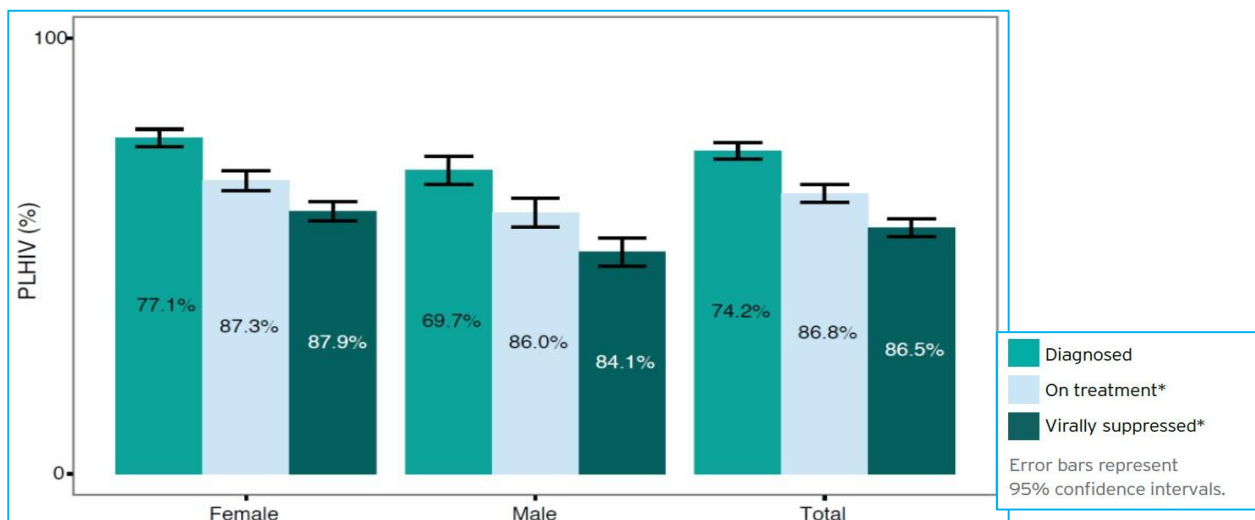
⁵ Draft Epidemiological data analysis and MOT survey report 2017

⁶ Zimbabwe Prison Service (2011). Assessment of HIV Prevalence and Risk Behaviours among the Prison Population in Zimbabwe. NAC & UNODC.

According to 2015 national HIV estimates the final vertical transmission rate was at 7.24%, and this was a significant decline from 30% in 2009. Data suggests that, Zimbabwe has the potential to achieve the international threshold for virtual elimination of vertical transmission (EMTCT) (<5% at 18 months), if strategic investments are sustained over the next three years. The Government of Zimbabwe has made a commitment to get to validation of EMTCT of both HIV and syphilis. However, early infant diagnosis (EID) remains a challenge, with EID by 6 weeks among HIV-exposed infants estimated as low as 45%⁷.

Zimbabwe is on track to achieve the 90-90-90 treatment cascade targets. As of 2016, 74.2% of all PLHIV know their status, 86.8% of those are on antiretroviral treatment and 86.5% of people on treatment are virally suppressed (Figure 4)³. Although the country has achieved high treatment coverage, issues of quality and retention in care remain a challenge.

Figure 5: Treatment Cascade and Progress towards 90-90-90 Targets, by Sex (2016)



The largest “leak” in Zimbabwe’s treatment cascade is ensuring that PLHIV know their HIV status. Therefore, strategies to increase testing are a key focus in this strategic document.

Zimbabwe’s TB incidence has sustained a downward trajectory from as high as 799/100,000 population in 2005⁸ to 242/100,000 population in 2015⁹. TB mortality excluding HIV declined by 50%, from 22/100,000 in 2005 to 11/100,000 in 2015, and TB mortality including HIV co- infection significantly declined by 75% from 158/100,000 in 2005 to 40/100,000 in 2015.

These gains were largely due to increased investment in TB diagnosis, treatment and stronger TB/HIV collaboration such as the scale up of antiretroviral therapy (ART) in the general population. Thirty five percent (35%) of facilities are now offering Isoniazid Preventive Therapy (IPT).

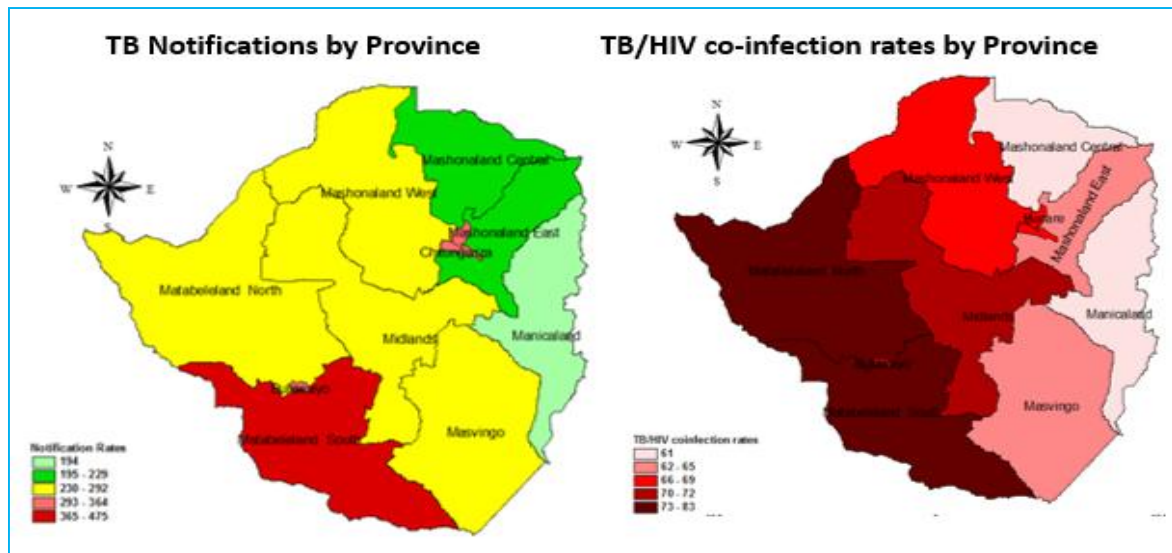
⁷ Zinyowera, S et al. The Zimbabwe HIV Early Infant Diagnosis (EID) Program for the period 2007-2012. Zimbabwe Ministry of Health and Child Care.

⁸ Global TB Report 2013, page 159

⁹ The Epidemiological review of TB disease and surveillance (May 2016) (As cited in team’s 7 Feb template)

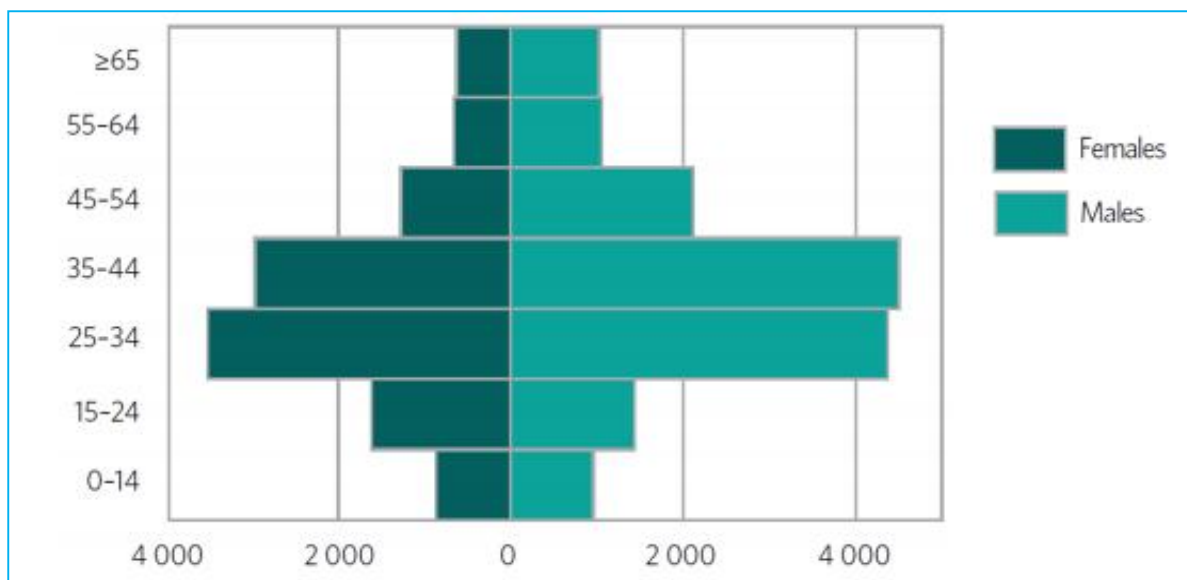
The country remains among the World Health Organization’s (WHO) list of 14 countries that are considered high-burden for TB, MDR-TB as well as TB/HIV co-infection. Further, latest treatment coverage data (72%) indicates nearly a third of TB cases go undetected and continue to act as a reservoir for community transmission, making intensified TB case finding a top priority. The following figure shows TB notification and co-infection rate by province

Figure 6: TB notifications and TB/HIV co-infection by province



The figure 5 shows that the TB epidemic in Zimbabwe is predominantly driven by HIV

Figure 7: Notified TB Cases by Age Group and Sex in Zimbabwe



The greatest numbers of new TB cases occur among men aged 35-44, while men aged 25-34 also bear a significant burden. Gender dynamics expose more men to TB than women in all age brackets, except for AGYW (15-24), who had more case notifications than their male peers. This may be linked to disproportionate HIV burden among this age group as compared to their male counterparts.

3.0 Vision, Goal and Objectives of the Extended ZNASP III



3.1 Vision

A Zimbabwe with zero new infections, zero discrimination and zero AIDS related deaths leading towards ending AIDS by 2030

3.2 Mission

Extended ZNASP III provides for well-coordinated, adequately resourced, evidence informed and results driven scaled up response to HIV and AIDS that leverages synergies and comparative advantages of all key stakeholders.

3.3 Goal

Improved wellbeing and healthy lives for all population groups through universal access to HIV prevention, treatment, care and support services.

3.4 Implementation Modalities

Prioritisation of sub-populations and geographical areas: Zimbabwe has a mixed epidemic. A common mistake is to invest in national response programmes that target the general population.

Yet, the extent of the epidemic is often not homogenous across the general population, manifesting differently in different populations and geographic areas. The extended ZNASP III recognises this by identifying key populations and hot spots areas.

Multi-sector responsibilities: The implementation of the extended ZNASP III is the responsibility of a wide range of implementing partners from the public, informal, faith based, PLHIV, private sectors, and civil society. These sectors will review their policies and strategic documents to re-align with the extended ZNASP III. National AIDS Council will coordinate these various sectors for comprehensive HIV response.

Political will, leadership and commitment: Zimbabwe has strong political commitment and leadership support at the highest level. The governments have demonstrated commitment towards the HIV response by sustaining the home grown financing mechanism of HIV and AIDS Trust Fund.

National AIDS Council (NAC): NAC under the Ministry of Health and Child Care is responsible for delivery of the results of the extended ZNASP III. In order to achieve this, NAC is responsible for resource mobilization, coordination of the response, and monitoring of the response.

Alignment with National, Regional and International Policy Frameworks

The extended ZNASP III is aligned to various national, regional and international policy frameworks that Zimbabwe has committed itself to. These include:

- **UNAIDS Fast Track**, which focus on achieving 90-90-90 targets by 2020 and eventual ending AIDS by 2030.
- **Sustainable Development Goals(SDGs)**, focus on ending AIDS by 2030
- **Abuja declaration on Health**, which place the fight against HIV and AIDS at the forefront and the highest priority issue in our respective national development plans.
- **National Health Strategy**, which outlines the health and community systems development priorities to ensure effective health service delivery. It also provides policy guidance on human resource for health and procurement and supply of pharmaceuticals and other medical products and health information systems, which impact on the delivery of the HIV response.

3.5 The Guiding principles

3.5.I The Three ones Principle

Zimbabwe subscribes to the “THREE ONES” principle which also guided the development of this extended ZNASP III. The three ones principle subscribes to:-

- One agreed HIV and AIDS action framework that provides the basis for coordinating the work of all partners and stakeholders
- One national AIDS coordinating authority with a broad-based multi-sectoral mandate

- One agreed country level M&E system.

The extended ZNASP III strategy is developed to guide the HIV response in Zimbabwe

3.5.2 Results based management:

There is strong desire by GoZ and its partners to realize value for money in line with ZIMASSET. The HIV and AIDS response will promote results, accountability and good governance at all levels.

3.5.3 Rights based approach:

In line with the Constitution of Zimbabwe, the national HIV response recognizes and upholds human rights and non-discrimination of PLHIV, key populations, people with disabilities, youths, women, children and others who may be socially excluded.

3.5.4 Equity and justice:

The HIV response will ensure equitable interventions. Resource allocation will be determined by the value, impact and potential for scaling up initiatives.

3.5.4 Evidence Based:

The identification and prioritisation of interventions for the HIV response will be evidence informed and respond to community needs.

3.5.5 Accountability:

Multi-sectoral and mutual involvement, financial and programme reporting will form the basis for Extended ZNASP III accountability at all levels.

3.5.6 Country Ownership, Shared Responsibility and Global solidarity:

Mutual collaboration and accountability between government, development partners, private sector civil society and communities

3.5.7 Gender sensitivity and responsiveness:

Gender mainstreaming and gender transformative approaches will inform the multi-sectoral response across all key priority result areas.

3.5.8 Sustainable financing:

The Extended ZNASP III will pursue the investment approach to resource mobilization and optimize on available resources.

3.5.9 Good Practices for learning:

Adoption and scale up of programmes should be informed by evidence. Evidence can be generated through documentation of best practices and replication.

3.5.10 Community involvement ownership and partnership:

Communities will be empowered to take control of their resources and programmes for sustainable well-being.

3.5.II Efficiency, effectiveness and innovation:

Entrepreneurship and value for money in programming. Programmers should continuously come up with new approaches to interventions.

4.0 Strategic Direction I:

Closing the Tap of New HIV Infections

4.1 Summary Prevention Roadmap; Strategies; Combination Prevention; MTR.

The two overarching goals of the national response have been, to prevent new HIV infections and to reduce HIV related morbidity and mortality. To this effect, prevention was prioritized in ZNASP II (2011-2015) and consistently so in previous strategic plans. Data indicating that incidence of HIV in both adults and children declined by more than 50 percent over the past fifteen years testifying to the progress that has been made as a result of the impact of scaling up behaviour change and biomedical HIV prevention interventions, intensifying PMTCT/ eMTCT efforts and expanding coverage of ART.

According to 2012 national HIV estimates, the rate of new HIV infections among adults drastically fell from a peak of about 5% in 1994 to 0.98% in 2013. Adoption and implementation of a combination prevention strategy sought to optimize complementarily and synergistic potential of core interventions that include, SBCC, HCT, VMMC, eMTCT, Condom promotion, and targeting young people and key populations for prevention.

4.1.1 Gaps

While there has been a remarkable decline of HIV incidence, prevention efforts still trail far behind the HIV trajectory, underscoring the imperative for intensification and acceleration of what has proven to work so as to achieve greater impact on the course of the epidemic. 71500 new adult HIV infections occurred in 2014 and a similar number is estimated for 2015 (2013 HIV estimates). 48 % and 53% of young women and young men (15-24 years of age) respectively do not have comprehensive knowledge about HIV and AIDS (ZDHS 2010-11), highlighting a significant gap in HIV and AIDS education among the youth due to a number of reasons that include insufficient reach and targeting of HIV prevention interventions, particularly to out of school youth compounded by inadequate resources for more effective and sustained programming for and provision of and increased access to more youth friendly services. According to 2010-11 ZDHS, 55% of adults did not know their HIV status, a situation that warrants further strengthening and expansion of HCT and other associated prevention interventions.

One million circumcisions need to be performed over the next four years in order for the country to achieve the set target of 1.3 million by 2018 and contribute to averting new HIV infections.

Relatively low uptake of VMMC, HCT and other HIV prevention services is attributable to demand and supply challenges that should be prioritized through addressing improved community engagement and mobilization and health system strengthening.

Even though combination HIV prevention strategy has been developed, there has been limited integration of its core interventions and with relevant health programs such as SRHR during its roll out. Furthermore, the delivery model of SBCC whereby about 3000 Behavioural Change Facilitators (BCFs) are utilised as local resource persons has been heavily reliant on external funding. Despite the need for SBCC in secondary schools, BCFs have no access due to education policy.

Lack of baseline data on key populations to enable estimation of the magnitude of the problem and issues of stigma and a challenging legal environment for certain groups such as sex workers and MSM pose hurdles for targeted programming and related monitoring and evaluation. The increasing trend of new clients treated for STI from 255821 in 2011 to 261032 in 2012 and 277708 in 2013 raises serious concerns that should be interrogated and attended to as the association between HIV and mainly ulcerative STIs is well known.

The 11.3% of married or cohabiting couples are sero-discordant (ZDHS 2010-11) raising the importance for condom promotion intensification particularly in such situations and other long term stable relationships. The high level of sexual violence against women (27% to 30%: ZDHS 2005 -06 and 2010-11) contributes to fuel HIV and thus requires more robust efforts to tackle all forms of gender based violence. There is significant none or late reporting of sexual violence that prevents or delays accessibility to PEP services within 72 hours by survivors.

4.2 HIV Testing Services (HTS)

HIV Testing Services is the entry point to HIV prevention, care, treatment and support. Knowledge of one's HIV sero-status and successful linkages to other services are critical for access to other interventions. Facility (PITC) and community based (self, index, door to door and mobile outreach testing campaigns) service delivery approaches are utilized to reach the target population. Seventy-four percent of PLHIV in Zimbabwe know their HIV status and 89 percent of PLHIV, who know their HIV status are on ART (ZIMPHIA 2016). The national programme has a strong network of clinics and health facilities that offer HTS. This is complemented by client-initiated HTS offered through a social franchise approach, with 17 fixed sites and 22 mobile teams covering all districts in Zimbabwe.

To increase uptake and coverage of HTS through maximisation and widening of choices, Zimbabwe launched the self-testing approach in 2016.

While access to testing services has improved, the yield in the general population is declining; although high among couples and key populations. To achieve the global 90-90-90 targets by 2020, there is need therefore, to adopt business unusual models to testing, focusing on couples, children and adolescents including key populations in specific geographical areas. Linkage mechanisms to post-test services need to be strengthened in order to reduce drop offs along the testing cascade.

4.2.1 HTS gaps

- Low yield of HIV positivity among the general population
- PITC not consistently provided due to high patient volumes and staff shortages
- Low uptake of HIV testing through couples, key populations and family index case testing,
- Lost opportunities to offer HTS, for children , adolescent and key populations
- Poor follow up and linkage for clients who test positive
- Inadequate capacity to cover all the entry points
- Poor referral linkages to care and support
- Lack of support for HIV-negative clients
- Low uptake of HTS by men

4.2.2 HTS priority strategies

- Targeted HIV testing and index testing for couples, children and adolescents including key populations in specific geographical areas.
- Scale up innovative and differentiated HIV testing models including lay testing, community testing, index testing and self-testing targeting high yield populations, such as sex workers
- Engage community leaders, including religious, traditional leaders and pro-gender groups to promote uptake of HTS by men
- Scale up point of care programming for couples families
- Scale up combination and integration of services; Strengthen innovative workplace programmes, including the informal sector
- Integration of HTS within routine health services/ The Primary Health Care supermarket approach
- Strengthen laboratory and human capacity for quality testing

4.3 Social Behaviour Change Communications (SBCC)

The BCC continues to be an instrumental tool in creating demand for the uptake of HIV prevention services in support of the endeavour to reach universal access to HIV prevention, treatment, care and support in the afore mentioned areas. Behaviour change interventions have been classified as high impact programs under the Combination Prevention Strategy, the Investment Framework and in the Prevention Revitalisation Roadmap. Building upon the lesson learned, social and behaviour change communication (SBCC) continues to focus on approaches and messages designed for specific populations. The Behaviour Change Facilitators (BCFs) through a door to door strategy for demand generation is key, however the BCFs should be chosen and specific key population so that they contribute to meaningful impact.

The model of delivery includes a range of communication channels, including mass media, social media, interactive materials, and interpersonal communication that includes home visits.

4.3.I Programme Gaps/Challenges

- The SBCC programme is creating demand that sometimes is not adequately followed up with service provision.
- Current approaches such as the door to door campaigns are not adequately reaching men and boys with HIV services.
- Capacity gaps of community volunteers to address social and cultural factors that influence behaviour
- Poor linkages between SBCC and service delivery points including tracking of referrals for attribution.
- Limited coverage for young people

4.3.2 Priority Intervention Areas

- Advocacy with key leaders at all levels for men to take a leading role in addressing socio-cultural barriers to adoption of safer sexual practices
- Innovative approaches to better target men that focus on reaching men in their places of leisure, using specialised BCFs and men peer educators, and ensure that messages are attractive for this population sub-group.
- The success of the SBCC hinges on a great part on provision of adequate services. Thus need to constantly link BCFs with service providers so that demand is created for services that are readily available.
- SBCC strategies should deliberately target young people and key populations as individuals and in family settings. Key areas should also include appropriate content on sexuality education in primary and secondary schools.
- Build the capacity of Behaviour Change Facilitators (BCFs) to enable them to address critical issues such as self-testing, adherence and counselling.
- Strengthen referral system /tracking feedback with psychosocial support
- Strengthen Research and monitoring and evaluation (M&E) at all levels.
- Social mobilization campaigns to emphasize demand creation and uptake of services
- Involve PLHIV as key actors for promoting combination HIV prevention

4.4 Elimination of Mother to Child Transmission (EMTCT)

Zimbabwe officially launched the Start Free, Stay Free, AIDS Free Framework in November 2016, a super fast-track framework for ending AIDS among children, adolescents and young women by 2020.

Start Free, Stay Free, AIDS Free Framework

START FREE	STAY FREE	AIDS-FREE
—	—	—
Every child should be born and remain HIV free, every pregnant woman/mother living with HIV should have access to lifelong HIV treatment.	Every adolescent and young woman should be able to protect themselves from HIV infection and realize their full potential without fear of sexual violence, abuse or exploitation.	Every child and adolescent living with HIV should have access to quality HIV treatment, care and support and realize their full potential without stigma and discrimination.

UNAIDS 2016

Zimbabwe has committed itself to eliminating mother to child transmission of HIV thereby reducing maternal and child, morbidity and mortality. This is being achieved through the four strategic pillars of comprehensive PMTCT namely:

- Primary prevention of HIV
- Prevention of unintended pregnancies among HIV-infected women;
- Prevention of MTCT;
- Provision of comprehensive care, treatment and support and follow up for the HIV positive women, her HIV exposed infant and family including the male partner.

Integrated service delivery models for eMTCT in ANC and MNCH settings are being scaled up, including provision of life long ART to HIV positive pregnant and lactating women to prevent HIV transmission to the baby and for the mothers own health.

To complete the continuum of care post-delivery, efforts are being made to accelerate early infant diagnosis and provision of cotrimoxazole prophylaxis to HIV exposed infants; and ensuring timely linkage to care and treatment for children who fall through the cracks and test HIV positive.

Zimbabwe is targeting to attain WHO process and impact indicators for eMTCT and is accelerating implementation to complete the last mile towards eMTCT as shown in the table below.

Table I: WHO process and impact indicators for validation of EMTCT of HIV and Syphilis

	ELIMINATION		PRE-ELIMINATION	Zimbabwe Data
	HIV	Syphilis	HIV	
IMPACT criteria	MTCT < 2% OR < 5% in BF populations Case rate ≤ 50 per 100,000 live births	Case rate ≤ 50 per 100,000 live births	MTCT < 2% OR < 5% in BF populations No case rate minimum	MTCT 5,2% (2016 UNAIDS Spectrum)
PROCESS criteria	ANC coverage ≥ 95% Testing coverage ≥ 95% ART coverage ≥ 95%	ANC coverage ≥ 95% Testing coverage ≥ 95% Treatment coverage >95%	ANC ≥ 90% Testing in ANC ≥ 90% ART coverage ≥ 90%	ANC 93% ANC testing 98% ART coverage 93% (2016 data)

WHO Global guidance for EMTCT

The validation criteria must be met in a manner consistent with basic human rights considerations. Key populations must be included to ensure equity in achievement of eMTCT.

4.4.I Programme Gaps

- Poor retention in care of mother baby pairs for the 18 months postnatal as a result of non-disclosure of HIV status to partners
- Low retesting of HIV negative pregnant, breastfeeding and exposed babies
- Low male participation in PMTCT
- Inconsistency in the implementation of user fees policy in ANC

- Religious and cultural barriers to utilising maternal and child health services
- Unmet demand for family planning among women living with HIV
- Long turnaround time on dried blood sample (DBS) results.

4.4.2 Strategic Response

- Advocate for retention of mother baby pairs in care
- Strengthen psychosocial support, family-focused approaches and index case testing
- Advocate for HIV negative retesting of pregnant, breastfeeding and exposed babies
- Develop a package of facility- and community-based interventions, of which male involvement and community mobilization is a significant component
- Enforce government policy on no user fees for maternal, new born and child health (MNCH) while ensuring that the government honours commitments on health financing such as the Abuja Declaration.
- Advocacy and communication on engagement with religious sects and traditional leaders on ANC, labour, delivery and post -delivery care
- Integrate family services into all OI/ART and MNCH setting at health facility and community levels
- Advocate for decentralization of EID testing to sub national level

4.5 Sexually Transmitted Infections (STIs)

Prevention and treatment of sexually transmitted infection (STIs) is central to HIV prevention as STIs play a significant role in facilitating HIV transmission. As such strategies to fight STIs have been an integral part of efforts to fight HIV and AIDS in Zimbabwe. In this regard, the proportion of adults aged 25 to 49 years reporting an STI in the last 12 months decreased from 4.6% in 2005 to 2.4% in 2015. This could be attributed to programmes that have resulted in behaviour change.

The Zimbabwe STI Guidelines highlight early detection and treatment of STIs as essential for STI management and control. There are strong calls for attention to be paid to the ever-changing etiology of STIs and their management to review and inform current syndromic management guidelines.

4.5.I Programme Gaps

- Limited trained personnel and equipment due to resource constraints
- Inadequate capacity to provide quality STI care, closing treatment gap for syphilis treatment in ANC,
- Weak and data collection systems and utilisation of data at local level,
- Poor laboratory capacity to support STI diagnosis and surveillance including gonococcal antimicrobial resistance testing
- Poor supply STI medicines and test kits.

4.5.2 Priority Strategies

- Strengthen the syndromic management of STIs
- Strengthen data collection and utilisation
- Strengthen capacity for detection and management of asymptomatic STIs
- Strengthen lab capacity for management of STIs
- Strengthen supply management for case management
- Strengthen HIV screening among STI patients

4.6 Condoms

Zimbabwe has a coordinated comprehensive condom programme, anchored on the public and social marketing distribution approaches. Condom programming is implemented as part of the HIV Combination Prevention Strategy, integrated with other services, including HTS, VMMC, PMTCT, behaviour change and others as well as care and treatment. Condom impact modelling and gap analysis by the Clinton Health Access Initiative (CHAI) (2015) has indicated that an estimated 2 million new HIV infections were averted by the increase in actual condom use between 1990 and 2016. The 2015 ZDHS show that condom use among young men 15-24 with multiple partners increased by one third from 50.5% in 2010 to 65.7% in 2015

NAC 2016 programme data indicates that male condom distribution was 104,423,569 against an annual target of 100,000,000 and 4,899,651 for the female condom against a target of 5,500,000. This was a decrease from 109,402,154 male and 5,573,786 female condoms distributed in 2015.

4.6.I Programme Gaps

- Negative perception of the public sector condoms due to its packaging
- Limited Government investment in condom programming leaving the responsibility to donors
- Dwindling donor support
- Limited availability of condoms in hot spots, high risk sexual activity occur
- Low levels of condom use in stable long term partnerships
- Lack of definitive policy on condom access among sexually active adolescents and youths
- Limited uptake of the female condom due to difficulties in using it
- Policy inconsistencies regarding condom availability in the tourism sector

4.6.2 Priority Strategies

Extended ZNASP III will adopt an aggressive approach to condom distribution to ensure significant decrease in the number of new HIV infections. This will be in line with the combination prevention strategy, which will include the introduction and roll out of Prep and other interventions.

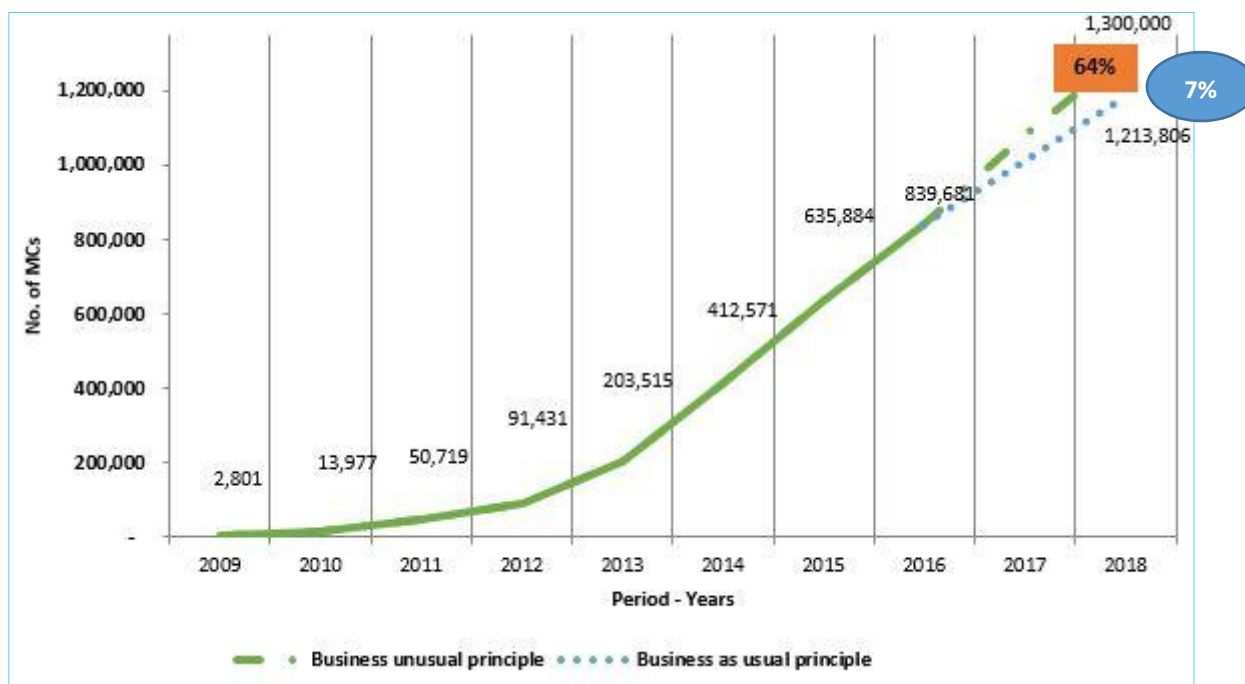
- Sustained and robust condom distribution appropriate to settings where high risk sexual activity occurs
- Re-enforce the benefits of consistent and correct use of condoms
- Enhanced advocacy for policy that allows access to condoms for sexually active adolescents and youths
- Strengthen marketing and innovative distribution of condoms among the target groups
- Increase awareness about the female condom and assess possibilities of making them more user-friendly to increase uptake
- Policy level engagement regarding condom availability in the tourism sector
- Rebranding and repackaging of the public sector condoms

4.7 Voluntary Medical Male Circumcision (VMMC)

The country adopted VMMC as one of the key combination interventions for prevention of heterosexual transmission of HIV. A policy and strategy were adopted in 2009 following studies that indicated that VMMC reduces the acquisition of HIV in heterosexual men by 50-60%. VMMC also provides an important opportunity for HTS as an entry point for early HIV care and treatment services, SRH information and referrals to other programmes; hence the integrated approach is being used.

According to 2015 ZDHS, the Percentage of men age 15-49 who report having been circumcised was 14%. Male circumcision prevalence is very low despite all the efforts. VMMC should aggressively focus on young men aged 20-29 and low-coverage districts. As of 2016, 839,681 procedures had been done, representing 64% of the 1.3 million national target of 2018. The graph below shows that the program should not be conducted in the “business unusual mode” if we are to achieve the target of 1,3Million. If business remains as usual the program will miss the target by 7% (86,194). Continued innovation and intensification of strategies is required to bend the curve.

Figure 8: Cumulative VMMC since 2009



VMMC is not uniform across regions; the coverage is highly inconsistent, with some districts already at saturation levels among the target group (15-29) while others lag far behind. Significant gaps also exist among young adult men. VMMC coverage among men aged 15-29 is 33%, but this significantly drops to 16% among men in their thirties and 12% in men older than 40. The following figure shows VMMC done by age.

4.7.1 Programme Gaps/Challenges

- Relatively lower coverage of VMMC especially among young adult men 20-29 years
- Limited number of facilities offering VMMC, Low knowledge on the benefits of VMMC for HIV prevention and reproductive health.
- Over reliance on external funding

4.7.2 Priority Strategies

- Conduct initial and refresher training for providers on all aspects of the VMMC service package
- Strengthen ongoing quality and performance assessments,
- Reinforce supervision and mentor the trainees.
- Strengthen and roll out advocacy and communication strategy targeting communities and leadership
- Efficiency models that include mass media campaigns on radio, social media and in schools, including celebrity endorsements to support the nationwide expansion of the MC services.
- Advocate for policy changes towards task shifting of the surgical component of the VMMC package to make use of nurses and clinical officers to conduct MC procedures.

- Ensure safe and efficient execution of the VMMC procedure and high-quality pre- and post-procedure services,
- Increase and sustain demand for the service.

4.8 Pre-exposure Prophylaxis (PrEP)

Zimbabwe has demonstrated strong political will by adopting the global 90-90-90 goals and committing to reducing new infections by 50%. However, this target may be difficult to meet without reducing infection among high-incidence populations (e.g., sero-discordant couples, AGYW, FSW, and MSM) through prevention methods appropriate for these populations. PrEP is one innovation that Zimbabwe has adopted and will be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination prevention approaches. Groups that are likely to be at substantial risk of HIV infection include¹⁰:

- Adolescent girls and young women
- Male and female sex workers
- At risk men (MSM, prisoners, truck drivers)
- Sero-discordant couples
- Women in relationships with men of unknown status
- Transgender people

Zimbabwe has been creating the conditions, policies, and practices needed to successfully roll-out and scale-up PrEP. Zimbabwe convened a national working group to adapt the WHO “test and start” guidelines in March 2016, including a subcommittee on PrEP. The country’s ART guidelines now include a chapter on PrEP. Truvada has been registered for prevention, but is currently approved only for treatment; no generics or other alternative forms of oral PrEP are approved for prevention. PrEP demonstration project led by CeSHHAR concluded in 2016. PrEP will be implemented in a phased out approach by starting with currently funded demonstration studies and DREAMS and full scale roll-out will be optimized based on lessons-learned, impact on averting HIV infections, and resource mobilization.

4.8.I Programmes gaps/Challenges

- ¹¹The key challenges for PrEP in Zimbabwe are securing funding for PrEP, identifying and agreeing on exact target geographies and populations, deploying an effective communications strategy, and navigating the health system capacity limitations inherent in closing Zimbabwe’s existing treatment gap while investing in “new” prevention methods.
- While FSW and AGYW are prioritized for HIV prevention, not all key populations are meaningfully included (e.g., MSM)
- Significant legal and cultural factors continue to marginalize MSM and FSW and obscure ability to quantify the size and HIV rates of these populations
- Balance between offering PrEP to people at substantial risk vs stigmatising PrEP as something for those practicing risky behaviour

¹⁰ Guidelines for Antiretroviral Therapy for the Prevention and Treatment of HIV in Zimbabwe

¹¹ OPTIONS Country Situation Analysis Interim Findings: Zimbabwe December 2016

4.8.2 Priority interventions

- Well-coordinated procurement and distribution system that serves public and NGO channels.
- Messages around PrEP need to be proactive, consistent, and come from multiple directions. Important messengers include: national and county governments, ministries, CBOs, celebrities, religious leaders, healthcare workers, peers and various forms of media.
- The creation and promotion of spaces that are stigma-free, youth and female friendly to facilitate uptake.

4.9 Post-exposure Prophylaxis (PEP)

Zimbabwe adopted guidelines that recommend the use of TDF/3TC/ATV/r for adults and adolescents for PEP. Health staff or those potentially exposed to HIV through sexual assault (rape, intimate partner violence, or sexual abuse) or through a high risk unprotected sexual encounter should be able to access PEP easily 24 hours a day 365 days a year. It is recommended that a victim of rape or sexual abuse or who has had an unprotected high risk sexual encounter, presenting within 72 hours of exposure be counselled and provided with the medicines recommended for post-occupational exposure prophylaxis. The key to success in PEP is avoiding delay in starting PEP.

4.10 Priority Sub-Populations

4.10.1 Key Populations

Key populations are defined as sub-groups of the population at “higher risk of being infected by HIV, who play a key role in how HIV spread, and whose involvement is vital for an effective and sustainable response to HIV. Zimbabwe considers gay men and other men who have sex with men, sex workers and their clients, transgender people and people who inject drugs as the four main key population groups, but it acknowledges that prisoners and people with Disability also are particularly vulnerable to HIV and frequently lack adequate access to services.

HIV sub-epidemics among other key and vulnerable populations in Zimbabwe also signal the need for a more targeted response¹². Preliminary results from the modes of transmission study show nearly 4000 new HIV infections a year among female sex workers (with a prevalence around 57.1%) and nearly 2000 new infections each year among men who have sex with men (MSM) (with a prevalence of about 23.5%)¹³. HIV prevalence among the wider LGBT community has been linked to risks associated with forced sex, a key gender-related consideration.

¹² UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs as the four main key population groups, but it acknowledges that prisoners and other incarcerated people also are particularly vulnerable to HIV and frequently lack adequate access to services. Figure 3 makes it clear that the number of new infections among people who inject drugs in Zimbabwe is extremely low, therefore they are not considered a key population in this country and disease context.

¹³ UNAIDS Programme Data 2015

¹⁴People with disabilities are twice as likely to self-report having HIV as those without disabilities. ¹⁵Among prisoners, HIV prevalence is estimated at 28% in 2015 (26.8% among male detainees and 39% among female detainees). ¹⁶Criminalization, stigmatization and marginalization drive both higher rates of infection and lower uptake of services. The 2014 PLHIV Stigma Index found that 90.8% of sex workers, 77.8% of MSM, 64.5% of people with disabilities and 100% of prisoners reported experiencing stigma and discrimination.

Micro planning Initiative

The National AIDS council in partnership with Ministry of health and Child Care have prioritized targeting Key populations as guided by the recently extended ZNASP III and the UNAIDS fast track targets Combination Prevention Strategy. To enhance more and better understanding of Key populations NAC in partnership with UNFPA and CeSHHAR is investing in strengthening a Micro planning initiative. Micro-planning is a proven approach to strengthening programmes for sex workers and other key populations.

The Micro-planning approach includes methods and tools that aim to systematically strengthen peer-based outreach. While the methods and tools mainly focus on outreach efforts, microplanning also supports high uptake and utilisation of clinic services. Based on routine data reported by Peer Educators (PE) during outreach, it enables them to improve their work while strengthening programme management. Micro-planning builds on Peer Educators' knowledge of hotspots and the sex workers who work there, sets practical targets with clear indicators, and is supported by weekly review and planning meetings with Peer Supervisors (PS).

Following are the main activities implemented under micro-planning.

- PEs are assigned responsibility for a specific area, usually a hotspot or 'cluster' of hotspots where they work and that they know well.
- In each hotspot cluster, PEs do simple 'walk-around' mapping with their PS and decide who will work with specific sex workers. The PE records their working names on her hot spot list.
- Each PE talks to sex workers on her hotspot list, offering condoms and information about the programme, and tries to convince them to visit the clinic and register with Sisters.
- For those who are registered, PEs use a Tracking Form to record the most important details about each outreach contact, and do a rapid risk assessment that will help guide their work.
- Outreach contacts – giving information, condoms, referrals – follow Sisters' programme priorities, are more frequent for those at higher risk, and are tailored to individual needs.
- PEs meet weekly with PS to review the previous week's work and plan work for the next week, setting priorities according to sex workers' risk and needs.

¹⁴ Sandfort, T. G., Baumann, L. R., Matebeni, Z., Reddy, V., & Southey-Swartz, I. (2013). Forced sexual experiences as risk factor for self-reported HIV infection among southern African lesbian and bisexual women. *PLoS One*, 8(1), e53552.

¹⁵ Ministry of Health and Child Care (2013). Living Conditions Among Persons with Disability Survey: Key Findings Report. Online at [http://www.unicef.org/zimbabwe/National_Survey_on_Disability_2013\(1\).pdf](http://www.unicef.org/zimbabwe/National_Survey_on_Disability_2013(1).pdf)

¹⁶ Zimbabwe Prison Service (2011). Assessment of HIV Prevalence and Risk Behaviours among the Prison Population in Zimbabwe. NAC & UNODC.

Mobile population/Cross border programmes

The Zimbabwe response recognises the vulnerability associated with mobile populations. Efforts to address these groups are along the highway corridors of Zimbabwe through the network of Sex Workers and their Clients Clinics following the known Zimbabwean hot spots. These clinics offer comprehensive SRHR services, HIV testing and Condoms. The same clinics are also situated at main border entry points and provide the prevention services.

4.10.1.1 Programme gaps

- Lack of strategic information including size estimation mapping, target and indicators
- Limited funding for KP programme
- Lack of specific policy and legal enforcement tools to address explicit needs of key populations
- Lack of comprehensive package of services tailored to the specific vulnerabilities and lived realities of key populations
- Treatment cascades for sex workers also reveal significant gaps that are particularly pronounced for young sex workers (<25 years of age) as only 21% young HIV-positive sex workers are currently accessing treatment.
- Lack of a defined minimum service package for key populations sub groups
- Limited approaches to address and fight levels of stigma
- Self-organisation for key populations is weak

4.10.1.2 Priority Interventions

To respond to the gaps in programming for the key populations Zimbabwe will need to strengthen the following:

- Undertake size estimates for KPs and baseline community mapping.
- Baseline mapping of financial resources /investments on KPs
- Delivering a minimum comprehensive package of prevention, treatment and support services through peer-led models, using a combination of outreach conducted from six and static sites approaches to provide a comprehensive package of care for key populations.
- Harm reduction services as well as interventions to address stigma, discrimination and violence against key populations. These services will be combined with legal support and legal literacy, and service to prevent and respond to sexual, physical and GBV.
- Tailor made comprehensive package to be tailored to include the priorities of young women selling sex, amplifying protection from violence, client negotiation, gaining confidence to use clinical services, and accessing education or income-generating opportunities, since evidence shows these are their priorities.

- Conducting advocacy for law and policy reform
- Strengthen referrals pathways to ensure continuum of care for Key Populations
- Adapt and roll out the micro planning KP response strategy

4.I0.2 Adolescents and Young People

Progress towards 90-90-90 among adolescents and young people in Zimbabwe is distinctly lagging compared to the adult population cascade. This is largely driven by a significant gap in achieving the first 90; among young people aged 15-24, just 52% know their HIV status. Further, the ZIMPHIA survey results indicate that prevalence of viral load suppression is markedly lower among youth aged 15-24, at 48.6% among HIV-positive females and 40.2% among HIV-positive males. The DHS 2015 data reflects low and declining knowledge of HIV prevention among young people (46.3% to 41.4% in young women and 41.7% to 41.4% in young men from 2010 and 2015).

Adolescent girls and young women (AGYW) in particular experience dramatically disproportionate burden and risk factors. Young women (20-24) have HIV prevalence 2.78 times greater than their male peers. 17.1% of women aged 15-19 who had sex in the last year did so with a partner that was ten or more years older (up from 15.2% in 2010 and 7.5% in 2005). Further, 41% of girls report sexual debut before 18 years as unwanted and rates of transactional sex are high, and increasing.¹⁷

Adolescents and young people have been prioritised in Zimbabwe's efforts to revitalise HIV prevention. Initiatives like the Sista2sista and DREAMS have been rolled out in hot spots districts in an effort to empower young women to make informed sexual reproductive decisions. The strategy prioritises parenting programmes aimed at empowering parents, guardians and/ caregivers with HIV and GBV prevention to complement the in and out CSE component.

4.I0.2.I Programme Gaps

- Low comprehensive knowledge on SRH, HIV and AIDS prevention methods – leading low risk perception, high risk sexual behaviours, teenage pregnancies, unsafe and illegal abortions)
- Significantly high HIV infections among young girls and women of reproductive age
- Low HIV testing coverage amongst the young people
- Lack of a defined minimum comprehensive package of SRH services for adolescents and young people
- Low access of SRH, HIV and AIDS services owing to age of consent to access services, consultation fees, low risk perception, stigma and discrimination
- Inadequate youth friendly SRH services for tertiary institutions and out of school youths
- Poor adherence and retention on ART among adolescents living with HIV
- Lack of SRH, HIV and AIDS disaggregated data for the 6 – 14 years category.

¹⁷ National Baseline Survey on the Life Experiences of Adolescents (NBSLEA-ZimStat)

4.I0.2.2 Priority strategies young people

Given the disproportionate HIV burden, number of new infections, and social and structural risk factors affecting adolescents and young people, Extended ZNASP III centres on high-impact prevention programs, specifically targeting adolescent girls and young women aged 15 - 24.

The strategy prioritizes key, sustainable components of evidence based models for adolescents and youths for scaling up in hot spot districts. The proposed strategies will focus on key settings that is youth in school, youths in tertiary and youths out of school.

- Establish and strengthen already existing SBCC programmes for young people using the peer approach model for all key sectors.
- Capacity build all state entities including the legal framework to offer youth friendly services
- Decentralise sexual reproductive health services to reach all young people
- Provide social protection to orphans and vulnerable children, adolescents and young people, prioritizing the young girl and young girls selling sex.
- Refurbish, rebrand and integrate sexual reproductive health services for all youth centers to reach all youths using the multi-sectoral approach
- Provide harm reduction services to address stigma, discrimination and violence against adolescent girls and young women
- Deliver age appropriate in and out of school combination HIV and GBV prevention for risk reduction, including PrEP targeting at risk adolescent girls and young women and family planning.

4.II Service Delivery Models

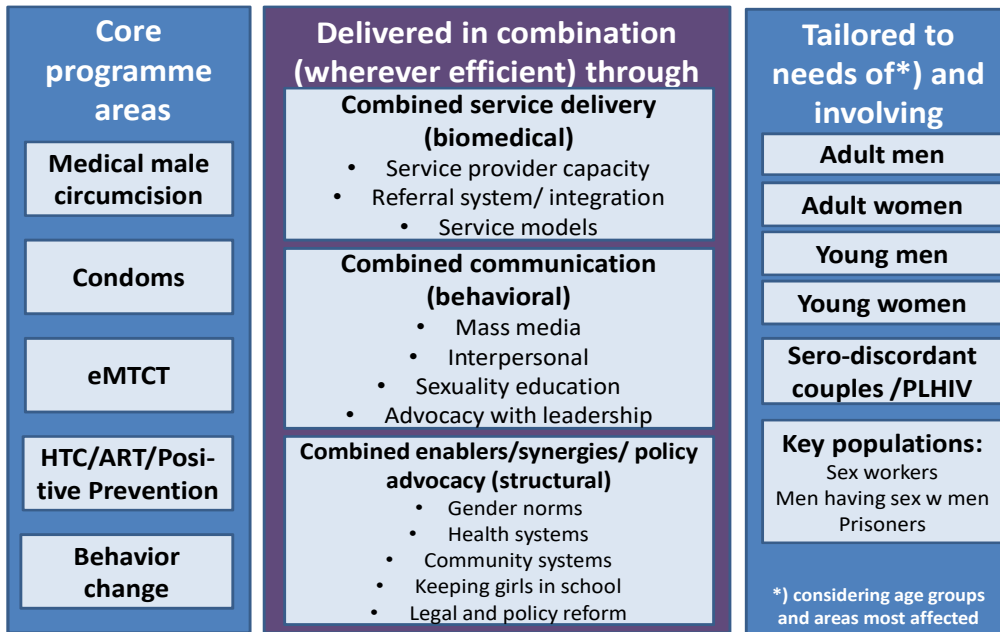
Sexual Reproductive Health (SRH) and HIV integration

Sexual and reproductive health (SRH) and HIV services are widely available in government health facilities. Family planning and STI services are the most widely available SRHR services at all types of facilities. Provider initiated testing and counselling (PITC) for HIV is provided in all facilities at every point of care. Despite a weak policy environment for integration at national level, there is some level of SRHR and HIV integration at service delivery and community levels. The SRHR and HIV services at primary care level, particularly at Rural Health Clinics, are under one roof as it is the same nurse who offers both services.

4.II.I Combination Prevention

The Combination HIV Prevention Strategy is a national programme guidance document on how the prevention interventions can be implemented efficiently, effectively and in combination. This strategy recognizes that there is no single HIV prevention intervention suitable for all populations and situations and thus the need to maximise the effect of complementary prevention interventions.

Focus of Zimbabwe Combination HIV Prevention Strategy



5.0 Strategic Direction 2:

Treat All: Reduce Morbidity and Improve the Quality of Life for People Living With HIV

Treatment, care and support remain at the core of provision of services for the infected and affected. While ZNASP III focused on expansion of the ART programme, the strategic thrust of Extended ZNASP III will be to maintain and improve quality of services in care and treatment service provision. This includes:

- a) Co-location and integration of care and treatment services with other programmes such as TB, MNCH and NCDs including mental health to harness efficiencies in service delivery
Implementation of differentiated service delivery models (DSD) in care and treatment service provision to address the varied and specific needs of different clients i.e. stable versus unstable clients, pregnant and breast feeding women, children and adolescents and key affected populations (sex workers and their partners, mobile populations, prisoners, artisanal miners etc.)
- b) Scale up of quality monitoring and quality improvement initiatives in care and treatment service provision
Capacity building of the health workforce to optimally implement recommended guidelines through blended learning approaches, practical attachments and mentorship support
- c) Strengthen adherence and patient tracking strategies to improve retention along the continuum of care
- d) Implementation of 'TREAT ALL' guidelines

The overall focus of treatment, care and support will be to achieve:

- Universal access to quality person-centred treatment, care and support services for PLHIV and TB;
- Strengthened institutional, community and household capacities to provide quality treatment for PLHIV;
- Universal access for OVC and TB/HIV co-infected clients
- Strengthen institutional, community and household capacities to support and care for OVC, PLHIV and TB.

5.1 Antiretroviral therapy

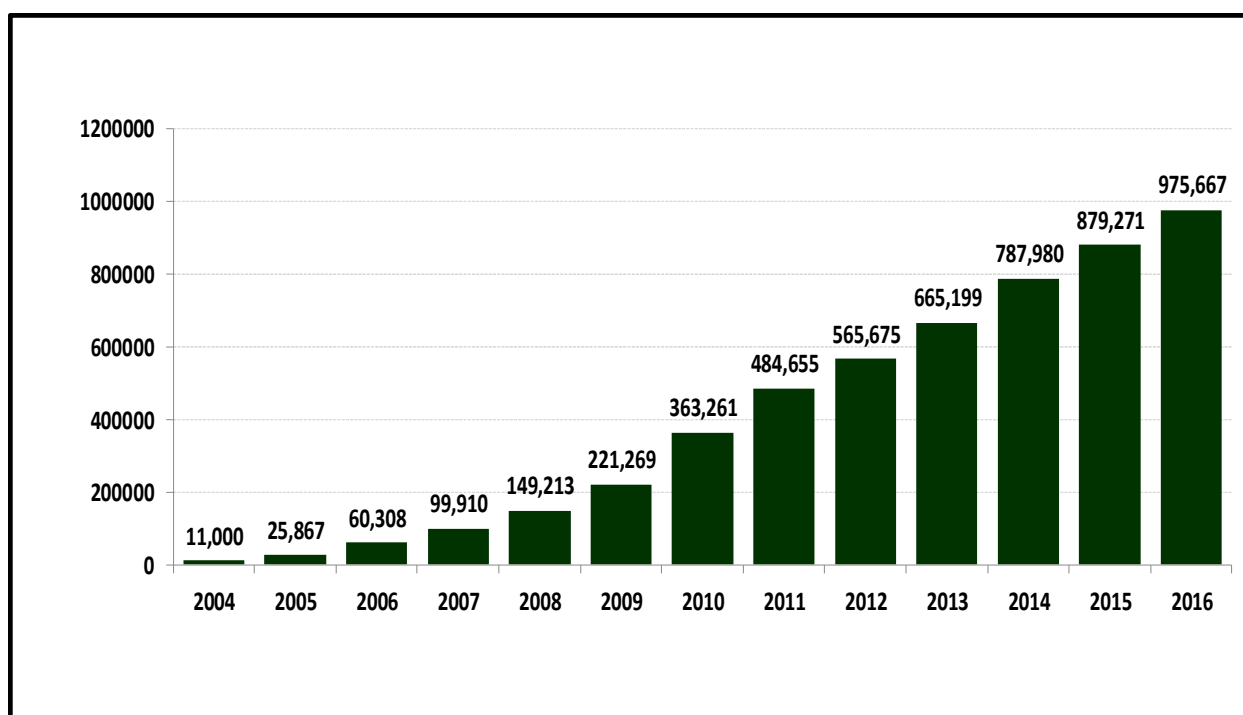
Zimbabwe is committed to providing antiretroviral therapy for all PLHIV. The overall goal of the ART programme is to reduce HIV-related morbidity and mortality among people living with HIV. The ART programme will continue to initiate strategies that link clients to enrolment for early treatment and enhance adherence and retention while ensuring improved quality of life and targeting the wider population of Zimbabwe. Targeted interventions will be implemented within the national response for key populations, children, young people, adolescents, discordant couples and PLHIV. Appropriate and comprehensive harm reduction and risk perception measures for non-infected adolescents as well as specific programmes to address the particular needs of adolescents living with HIV will be strengthened.

5.1.1 Benefits of the ART:

- Improved survival of persons living with HIV and AIDS,
- Improved quality of life for persons living with HIV and AIDS
- Reduced transmission of HIV from infected to uninfected individuals through expanded ART coverage and earlier initiation.

There has been a significant increase in the number of sites providing ART from 530 in 2010 to 1,566 in 2016. Overall ART coverage by December 2016 was 68.3%, with 83% ART coverage among children (0-14) while adult ART coverage was at 66%, based on the total number of people living with HIV in line with the “Treat All” approach. By end of 2016 the total number of clients on ART was 975,667 comprising 66,159 children and 908,508 adults. The GoZ has targeted to achieve ART coverage of 90% by 2020. This scenario is modelled to avert an additional 540,000 AIDS-related deaths over a 10-year period.

Figure 9: Number of people on antiretroviral therapy in Zimbabwe, 2004 – 2016



The success of the country in meeting the second 90% in treatment coverage hinges on two major points of intervention which are:

- Increasing yield among those tested through targeted testing approaches and;
- Plugging continued leakages along the HIV care cascade through improving linkages to care.

Despite ZIMPHIA demonstrating excellent progress in epidemic control at national level, biggest gap remains on the first 90% which is still 74,2% and worse still men and young people still experience lower level of testing (i.e. 42% of women 15-24 and only 26% of men 15-24 had tested in the last 12 months) while nnearly half of young people (15-24 years) living with HIV do not know their status.

5.1.2 ART retention

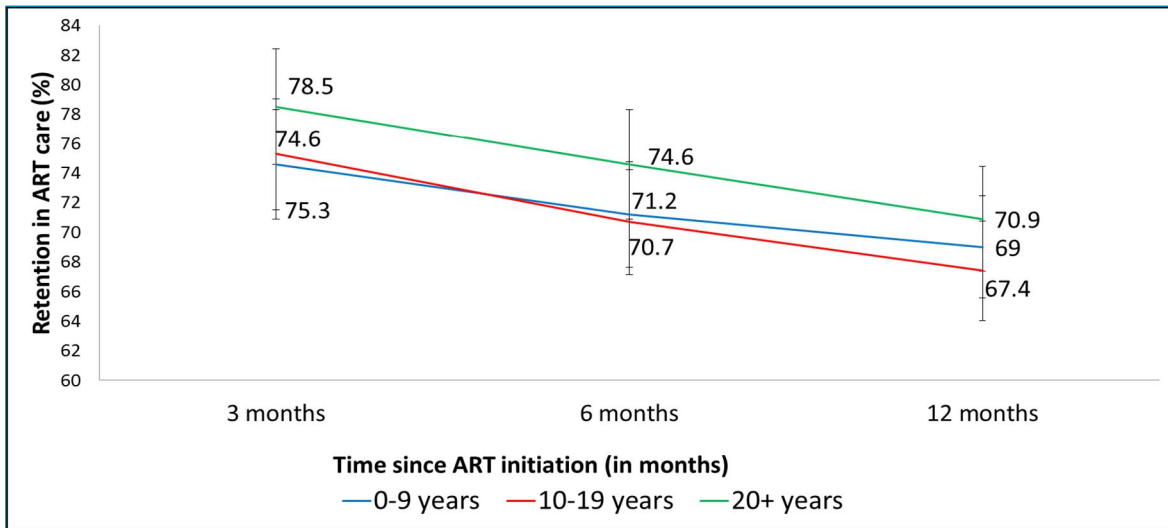
According to findings from a 2016 ART outcomes study which was commissioned by MOHCC, overall retention rates among clients on treatment at 12 months and 24 months were reported to be 87.7% and 83.0% respectively. On disaggregation by sex, both males and females had comparable retention rates with males having retention rates of 87.4% (85.6-88.9) and 81.8% (79.1-84.2) at 12 and 24 months respectively while females had retention rates of 88.0% (86.6-89.3) and 84.1% (81.8-86.1) at 12 and 24 months respectively.

Table 2: Overall Retention Rates by time of follow up

Outcome	Follow-up time (in months)							
	3 months (N = 3807)		6 months (N = 3807)		12 months (N = 3807)		24 months (N = 1992)	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Retained in ART care*	95.4	(94.7 – 96)	92.4	(91.5 - 93.2)	87.7	(86.6 - 88.7)	83.0	(81.3 - 84.6)

Compared to other age groups, HIV care retention rates among young children, adolescents and young people were low highlighting the need to deploy targeted and innovative approaches in this age group to control the epidemic.

Figure 10: ART retention among adolescents & young people



5.1.3 Viral load suppression and national progress on 90-90-90

According to the recent ZIMPHIA results, significant progress has been made so far by the country towards meeting the 3rd 90 as highlighted by 87% of people on treatment who were reported to be virally suppressed. In addition the prevalence of viral load suppression (VLS) among HIV-positive adults age 15 to 64 years in Zimbabwe was estimated as 60.4% with prevalence among females being 64.5% and 54.3% among males. Despite this progress viral load testing coverage still remains low with 14% of PLHIV on treatment having being offered a VL test by end of 2016 against a target of 50%.

Figure 11: Viral load Suppression-PLHIV

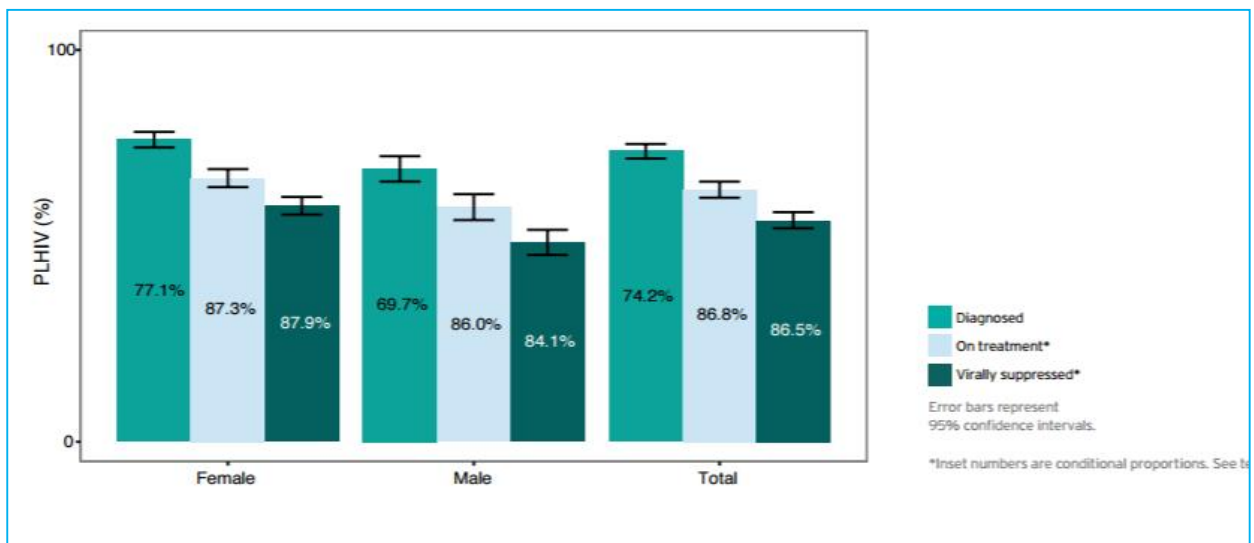
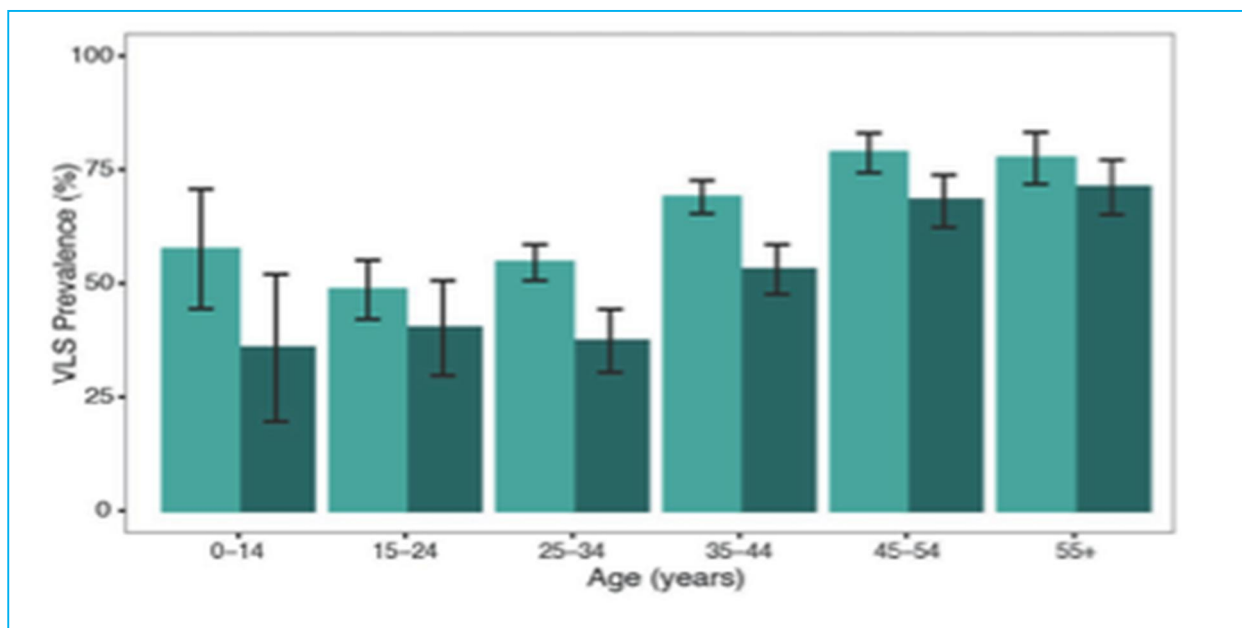


Figure 12: Viral load Suppression-Prevalence



Strong support from development partners has been, instrumental for the maintenance for the rapid expansion of ART. Adoption and initiating of HIV clinical mentorship by MoHCC as a key strategy to improve the quality and outcome of HIV treatment and care has been a crucial development to the health sector response to HIV.

In addition to CD4 monitoring, the ART programme has introduced viral load monitoring. Laboratory capacity has been further strengthened through refurbishment of infrastructure, procurement and upgrading of equipment for viral load monitoring. However, viral load monitoring remains centralized.

Procurement and supply chain management systems for medicines and other consumables were being strengthened as part of the broader health systems strengthening and integration of service delivery systems. However, funding for procurement is heavily dependent on donor funding which is unsustainable.

A roadmap for the strengthening of the National Pharmaceutical Stores was developed for implementation. Pharmacovigilance systems of ART, anti-TB and opportunistic infections medicines in adults and children, including those under PMTCT are in place but need continuous review and strengthening to ensure early detection of adverse events. Although the Medicines Control Authority of Zimbabwe (MCAZ) plays a key role in conducting post-marketing surveillance activities for medicines, there are still challenges in reporting adverse events to ART, TB and other associated medicines.

Care and support services have been reviewed to incorporate new approaches in light of improved access to ART including their involvement in demand creation and supporting adherence and retention.

The adoption of the Differentiated Models of Care under ZNASP III, such as Community ART Refill Groups (CARGS), Community Adolescent Treatment Supporters (CATS) and ART Adherence Clubs may partially explain the relatively high ART retention rates recently reported.

Decentralization of ART services is on track with 1 566 out of 1 722 sites currently providing ART. The key success factors that contributed to the achievements of the ART programme in the country include:

- Leadership and political commitment and partnerships
- Effective ART programme management and implementation
- Investment to strengthen the health system
- Integrated human resources capacity building and training activities
- Integrated service delivery and scaling up ART services
- Community participation, through CARGS, CATS and Adherence Clubs
- HIV Drug Resistance monitoring and timely generation of strategic information and use
- Effective mobilization and use of financial resources to support ART scale-up

5.2 HIV and Tuberculosis (TB) Integration

Zimbabwe is among all the lists of 30 HBCs for TB, TB-HIV and MDR-TB. TB incidence has shown a decreasing trend from 799/100,000 in 2005 to 242/100,000 population in 2015. The estimated TB prevalence for all forms of TB among all age groups was 292/100,000 population in 2014 and the case detection rate was 70% (TBPS). Childhood TB (<15 years) notifications constituted 5-7% of all notifications over the past several years and was 8% in 2015, against a national target of 5-15%. This indicates that a third of TB cases remain undetected hence continue to act as a reservoir for community transmission. Therefore, intensified TB case finding and programs integration become top priority interventions to improve childhood and other high risk groups TB case identification.

TB/HIV co-infection rates declined from 86% in 2009 to 70% in 2015, largely due to the effective rollout of ART, TB and CTX preventive therapy whose coverage was 72% and 95%, respectively in 2015. TB mortality and that due to HIV declined from 2005 to 2015 by 50% (22 to 11/100,000) and 75% (158 to 40/100,000) respectively, this being attributed to increased investment in TB diagnosis and management, including stronger TB/HIV collaboration.

5.2.I Programme gaps

Gaps and challenges	Strategic/Priority Interventions
Limited support for TB/HIV integrated services	<p>Innovative supporting mechanisms to integrate TB/HIV services to maximize impact</p> <p>Facilitate co-location of TB and HIV services to support one stop service delivery</p>
Low uptake of IPT among PLHIV	Mobilize funding, scale up of provision and decentralization of IPT to all OI/ART sites
Weak implementation of TB Infection Prevention and Control measures	Promote TB IPC practices in TB-HIV care settings
Limited skills and capacity of health providers to provide quality integrated care	Capacitate and mentor health workers in provision of quality, comprehensive and integrated care
Gaps and challenges	Strategic/Priority Interventions
Limited coordination of TB/HIV services	Strengthen mechanisms for provision of better coordination of TB/HIV services
Limited availability of essential first and second line TB medicines, preventive medicines (INH/CPT) and laboratory reagents including Gene Xpert cartridges	Procurement of TB and preventive medicines, laboratory reagents and consumables
Limited capacity for diagnosis of childhood TB and availability of IPT for children under 5 who are contacts of index cases.	Increase childhood TB case detection and strengthen uptake of IPT in children under 5 years

Gaps and challenges	Strategic/Priority Interventions
Lack of capacity of community TB care delivery	Strengthen community TB care delivery
Limited capacity in case detection and diagnosis of MDR-TB leading to missed opportunities/cases	Ensure quality assured universal access to TB drug resistance testing
Limited implementation of active case finding initiatives for high risk groups.	Scale up systematic screening for TB high risk groups and engage all care providers.
Programmes fragmentation and verticalization affecting provision of a comprehensive package	Strengthen integration of reproductive, maternal, newborn child and adolescent health (RMNCAH) and school health programs

5.3 Non Communicable Diseases (NCDs)

It has been noted that worldwide Non communicable diseases (NCDs), including heart disease, stroke, cancer, diabetes and chronic lung disease, are collectively responsible for almost 70% of all deaths worldwide. The rise of NCDs has been driven by primarily four major risk factors: tobacco use, physical inactivity, the harmful use of alcohol and unhealthy diets (increased fat and sodium, with low fruit and vegetable intake). It has also been noted that people living with HIV are at increased risk of developing a range of non-communicable diseases (NCDs), including cardiovascular disease, diabetes, chronic lung disease and some types of cancer (Kaposi Sarcoma, Non-Hodgkins Lymphoma and cancer of the cervix. As more people age with HIV, they face challenges of morbidity and mortality from NCDs due to the HIV infection or due to side effects of the ARV medicines.

Despite the great strides in the HIV programming, Zimbabwe is now facing new threats in the form of non-communicable diseases, most of which are associated with HIV. The World Health Organization (WHO) in 2014 noted that Non communicable diseases accounted for 31% of all deaths. In addition it was also noted that the HIV and AIDS pandemic is augmenting the rate of HIV related cancers with 60% of new cancers in Zimbabwe being associated with HIV and AIDS (ZNCR, 2005). With effective ART, people living with HIV are also living longer and experiencing NCDs associated with ageing. Both HIV and NCDs require health systems that can deliver effective acute and chronic care and support and adherence to treatment. Chronic HIV care provides the opportunity for screening, monitoring and managing NCDs, especially through primary care. Integrating interventions such as nutrition assessment, dietary counselling and support, smoking cessation, promoting exercise, monitoring blood pressure and where available cholesterol as part of the HIV care provide opportunities for reducing the risks of NCDs among people living with HIV.

Chronic hepatitis B virus infection affects 5–20% of the 33 million people living with HIV worldwide, and hepatitis C affects 5–15%, although this may be up to 90% among people who inject drugs (9, 10). The burden of co infection especially for Hepatitis B viral infection is greatest in low and middle-income countries, particularly in South-East Asia and sub-Saharan Africa and has been an increasing cause of morbidity and mortality among people living with HIV, including those on ART.

5.3.1 Programme gaps

- Lack of supportive Policies and strategies for NCDs and HIV
- Limited skills and capacity of health providers to provide quality integrated care
- Inadequate and fragmented funding for NCDs
- Lack of research and surveillance in NCDs

5.3.2 Strategic/Priority Interventions

- To provide policies and strategies for NCDs and HIV
- Capacitate and mentor health workers in provision of quality, comprehensive and integrated care of NCD and HIV
- Intensify resource mobilization for people with NCDs
- To carry out research to find gaps and challenges for NCDs and HIV

5.4 Nutrition and HIV

It is well known that malnutrition and HIV infection are related in a vicious cycle. The HIV epidemic continues to have a devastating impact on health, nutrition, food security and overall socioeconomic development in developing countries such as Zimbabwe.

Nutrition plays a critical role in comprehensive care, support and treatment of people living with HIV. Complex interactions exist between nutrition and HIV/AIDS resulting in a peculiar symbiotic relationship between the two.

The relationship between malnutrition and HIV and AIDS can create a vicious cycle in which malnutrition weakens the immune system and increases susceptibility to infections on one hand, while on the other hand frequent infections and illnesses may impair food intake and nutrient absorption, eventually leading to the depletion of nutrient stores in the body. Severely malnourished people living with HIV are four times more likely to die of complications compared to their well-nourished counterparts. The World Health Assembly passed the resolution WHA 59.11 on nutrition and HIV and AIDS in May 2006 which recommended that nutrition should be integrated into a comprehensive response to the HIV and AIDS pandemic. The recent Zimbabwean nutrition and HIV profiling study (MoHCC; 2015) indicated that the nutrition care and support component of the HIV and AIDS programme was weak and yet preventing malnutrition is a key objective in HIV and AIDS management. Compliance and adherence to antiretroviral therapy (ART) is dependent upon the availability of household food. Clients are more likely to take and tolerate ARV oral drugs if they are food secure.

Programme Gaps

1. The recent Zimbabwean nutrition and HIV profiling study (MoHCC; 2015) indicated that the nutrition care and support component of the HIV and AIDS programme was weak and yet preventing malnutrition is a key objective in HIV and AIDS management. Compliance and adherence to antiretroviral therapy (ART) is dependent upon the availability of household food. Clients are more likely to take and tolerate ARV oral drugs if they are food secure.
2. It has also been highlighted that HIV testing among children managed in the integrated management of acute malnutrition (IMAM) programme is much lower than the targeted 90% when it has been shown that a high percentage of malnourished children are HIV positive.

Priority Intervention Areas

- i. Integration of Nutrition & HIV & TB in guidelines for both Nutrition & HIV to facilitate referral and linkages
 - a. Provision of national guidelines, anthropometric equipment and nutrition commodities
 - b. Development and distribution of national guidelines and job-aides for health workers
 - c. Development and distribution of nutrition and HIV IEC materials for community members
- ii. Capacity building of health care providers to deliver Nutrition Care and Support services in addition to the care and treatment of HIV and AIDS and capacity building of CBOs and community health workers on HIV& AIDS, Tuberculosis & Nutrition to be able
 - a. To integrate nutrition assessment, counseling and support in management of HIV and TB clients attending outpatient and inpatient district health facilities
 - b. To strengthen HIV care and treatment by improving nutritional status of HIV and TB clients on antiretroviral therapy
 - c. To improve access of HIV and TB clients to nutrition community programmes
- iii. Development of a sustained coordination structure for Nutrition and HIV component
- iv. Integration of Nutrition & HIV M&E indicators into HIS

5.5 Care and Support – Orphans and Vulnerable Children (OVC)

Evidence is showing that adolescent and young people are vulnerable to HIV therefore this plan will promote appropriate and comprehensive clinical HIV care that is age appropriate and integrated into sexual and reproductive health and psychological, educational and social services in the country. The strategies for care and support for the OVC are as follows:

Strategies

- Scale up of social welfare and social protection systems within a family-centred social development framework approach
- Strengthen child welfare monitoring to facilitate access to and provision of support for health, education, nutrition and psychosocial services.
- Improving coverage of HIV prevention, treatment, care and support programmes for OVC

6.0 Strategic Direction 3:

Resilient Sustainable Systems for Health (RSSH)

6.1 Management and Coordination of the Response

The multi-sectoral response to HIV and AIDS has brought together a diversity of stakeholders each with their own niche and unique mandates. The key sectors in the response are:

- Civil Society
- Faith Based Organizations
- Private Sector
- Informal Sector
- People Living with HIV
- Public Sector

The institutions and structures are briefly highlighted below.

6.1.1 National Level Response Institutions and Structures

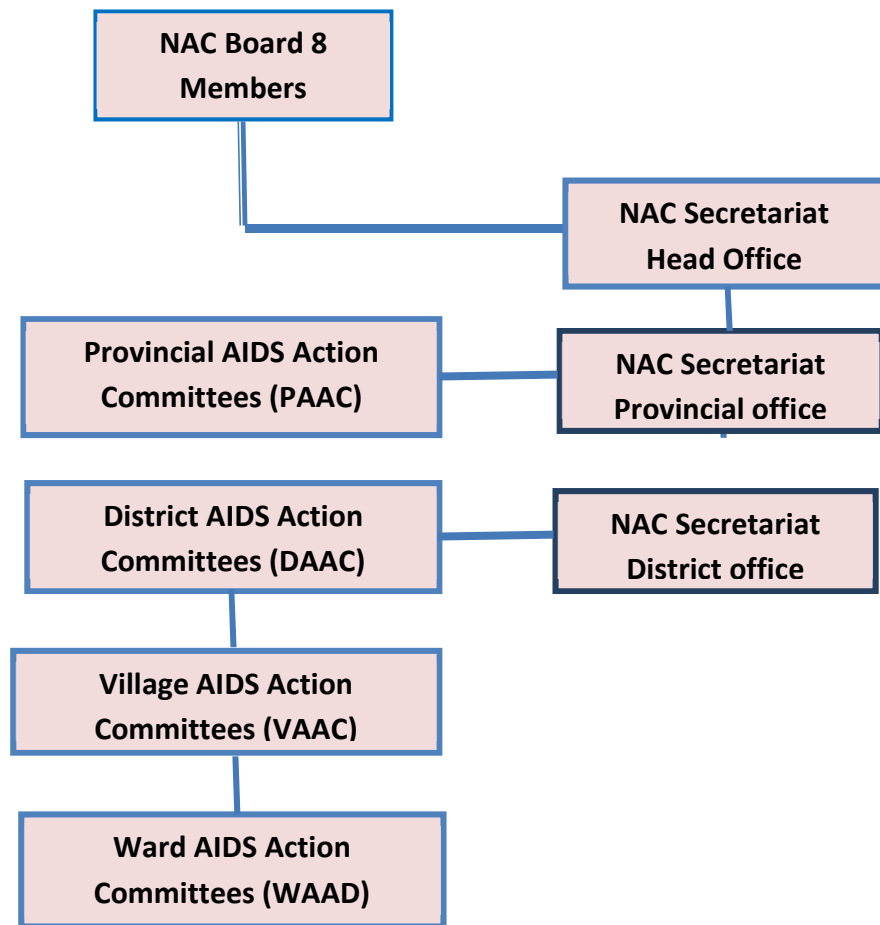
Established by an Act of Parliament in 1999, the National AIDS Council (NAC) has the mandate to lead interventions to mitigate the spread of HIV; manage, coordinate, and implement programs that reduce the impact of HIV and AIDS. NAC's role and comparative advantage is to administer the National AIDS Trust Fund and to lead, coordinate, monitor and evaluate the multi-sectoral national HIV and AIDS response. In line with global targets in ZNASP III, Zimbabwe aims at reaching 90-90-90 targets by 2020 and to have ended HIV and AIDS by 2030.

Through effective leadership and responsive stewardship NAC has been providing and continues to provide credible coordination and management to the response. Functional institutional management and coordination arrangements are in place. The figure below gives the organogram of structures in place to manage the response effectively and efficiently. At the helm of managing the National HIV and AIDS response is an eight-member board inclusive of the Chief Executive Officer. The Board reports to the Minister of Health and Childcare. Whilst at Provincial level the multi-sectoral Provincial AIDS Action Committees (PAAC) are in each of the 10 provinces.

PAACs are tasked with facilitation, coordination, promotion and monitoring implementation of HIV and AIDS activities at lower levels and District AIDS Action Committees (DAACs) in 85 NAC districts provide responsive stewardship at the district levels.

The National AIDS Council has provided strong coordination and management of the multi-sectoral national response through its decentralized structures. This coordinating structure has ensured inclusion of hard to reach communities, key populations, PLHIV, as well as other government sectors, non-state-actors, the private sector, and for profit companies and partners, faith based organizations and traditional leadership. Zimbabwe continues to mobilise resources from both domestic and international sources to support the national HIV response. The country is currently developing an HIV investment case to ensure sustainable financing of the national response and has completed a hotspot geospatial mapping to support decentralized smart investment and prioritization.

The national Monitoring & Evaluation (M&E) system has been decentralized to district level and is linked to key sectoral systems including the MOHCC HIV M&E systems. This system has provided the evidence necessary to support evidence and results based management of the response



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Generally, a supportive policy environment has prevailed and enabled a highly multisectoral participation in the HIV responses from engagement, dialogue, proposal development, program planning, resource mobilization, implementation and monitoring and evaluation. Functional and decentralized broad based NAC- led coordination and management structures have been a strong anchor for the national response to HIV.

This has further been reinforced by the National AIDS Levy that is provided for by an Act of Parliament as well as solidarity and resource support from development partners (DPs) that have both helped the country to plan and execute HIV interventions over the years.

The ZIMASSET and the ZNASP III are well linked to deliver urgent and high impact programmes and services directed towards ending AIDS in the country, and present an opportunity for multi-sectoral programming and convergence of interventions at service delivery level. Gender responses, the linkages between HIV and sexual and reproductive health, TB and malaria responses, linkages between HIV and maternal health and child survival, strengthening education and social protection, food security, livelihoods and youth empowerment are all key synergistic areas. NAC and its development partners are drawing on their comparative strengths to support the implementation of proven high impact interventions for adolescent, maternal, infant and youths and adults.

Partnerships with private sector and academia to support resource mobilization, quality of equitable service delivery and operational research cannot be over-emphasized. A strong government led AIDS response at all administrative levels will support cross sectoral linkages and collaboration for scaling up of prevention, treatment and care and support efforts.

Community system engagement and strengthening has been realized to a limited extent through involvement of community based health workers, groups and volunteers that have served as a crucial interface between the health system and the community for improved access to and increased demand for HIV services including increasing community buy-in for the efforts on HIV.

Gaps and Challenges

- Lack of harmonization of data attributed to different funding streams and vertical reporting requirements resulting in multiple databases.
- Domestic funding of the response currently stands at 20% compared to international partner funding which contributes 80%.
- There has been stagnation in remittances from the AIDS levy owing to the prevailing geo-political and poor macro-economic performance in the country
- Coordination of key populations has been minimal due to unclear legal framework surrounding groups such as commercial sex workers, prisoners, men who have sex with men.
- Limited funding has affected interventions such as livelihoods for PLHIV and nutrition
- Limited capacity to manage grants of service organizations
- Within the established structures weaknesses in performance have been reported owing mostly to lack sitting allowances for PAACs and DAACs.
- WAACs roles appear to have been superseded by behavior change facilitators

Core Strategies

- Build and sustain high level political and technical commitment
- Entrench good governance and strengthen multi-sector and multi-partner accountability for delivery of ZNASP III results

- Increase innovative ways of mobilizing funds both domestic and international
- Decentralization of HIV prevention and treatments services
- Advocate for legislation and policies that address the needs of key populations in the response
- Identify current livelihoods initiatives with evidence for sustainability
- Create private/public partnerships to
- Intensify resource mobilization and direction of funds to hotspot geographical area
- Identify legislation and policies that impact on interventions targeting key populations
- Monitor and review progress towards regular review of policies
- Innovative strategies of tapping into the informal sector

6.1.2 Results Base Management

Zimbabwe developed an Agenda for Sustainable Socio – Economic Transformation (ZIM ASSET) 2013 – 2018 in order to enable economic growth and wealth creation to achieve sustainable development and social equity. ZIMASSET is result based agenda that will enable Zimbabwe to achieve economic growth. In order to implement the development agenda, the country adopted the Results Based Management (RBM) strategy as a tool in all government sectors to ensure the desired results are achieved. RBM is a management strategy by which an organization ensures that its processes, products and services contribute to the achievement of desired result (outputs, outcomes and impacts). RBM rests on clearly defined accountability for results and requires monitoring and self-assessment of progress towards results, and reporting on performance.

Core strategies

- Integrate RBM with Results-Based Personnel Performance System (RBPPS).
- Adopt RBM in all services delivery system
- Integrate RBM with Results Based Financing
- Strengthen reporting and accountability

6.1.3 Results Based Financing

Performance-based financing (PBF) or pay-for-performance (P4P) is a form of incentive where health providers are, at least partially, funded on the basis of their performance to meet targets or undertake specific actions. It is defined as fee-for-service-conditional-on-quality. In many low- and middle-income countries P4P programmes are implemented with the support of development partners and are referred to as Results-Based Financing (RBF). RBF is an umbrella term for an instrument that links rewards with performance. RBF is a key strategy in motivating health care workers to perform.

Strategies

- Roll-out RBF to health facilities
- Strengthen performance measurement

6.2 Human Resources for Health

The health delivery system in Zimbabwe like elsewhere in the SADC region has experienced brain drain of both medical and paramedical staff that are critical to implementing the response.

This was as a result of low budgetary allocations to the social sectors, in particular to health. There have been barriers to recruiting and retaining health workers.

The migration of skilled and experienced health personnel to other countries has over the years been blamed on low salaries and poor working conditions locally. Experts also say the Staff-Monitored Programme (SMP) adopted by Government to cut spending two years ago could be a new push factor with a negative impact on the implementation of the response. The SMP was approved by the IMF's management in June 2013 through an understanding with Government to put public finances on a "sustainable" course by freezing public sector recruitment.

This has resulted in maintaining the freeze in all ministries, including the health sector. As a result, 400 nurses and doctors posts countrywide were frozen despite the fact that the country's public health system has a 2 500 staff deficit. Zimbabwe's doctor to patient ratio, is estimated to be 1:8 000, well above the 1:500 recommended by the World Health Organisation. In the health sector, Zimbabwe is currently operating with a staff establishment that was set in 1983 despite a shift in the disease burden and catchment populations.

While cost-cutting brings relief to the country's economy, public health also has a direct influence on macro-economic performance. The ability to offer a mentoring and supportive supervision is also affected. Overcrowded inadequate infrastructure and lack of requisite equipment is also affecting service provision. The supply chain management of commodities especially shortage of drugs and sometimes expired drugs due to oversupply has also affected implementation of the response

Gaps and Challenges	Strategic response
Human Resources for health	
Delays in rationalisation of staff in line with increased disease burden	Conduct periodic staff establishment audits to match disease burden and catchment populations served
Freezing of posts and inadequate resources	Lobby government for more posts based on evidence
Demotivated staff	Improve, broaden and sustain staff retention allowances Broaden performance-based financing for HRH
Inadequate resources	Innovative strategies in resource mobilization

Gaps and Challenges	Strategic response
Inadequate staff capacity for integrated service delivery	Capacitate, mentor and monitor staff Strengthen task shifting to enable health providers to provide comprehensive care
Medicines and technologies	
Inadequate laboratory facilities and resistance testing at district level for all services	Strengthen procurement and supply chain management of laboratory commodities to ensure availability and functionality of laboratories
Weak procurement and supply chain management e.g. forecasting and quantification at all levels	Strengthen procurement and supply chain management to ensure consistency in availability and accessibility of commodities needed for HIV and TB
Service Delivery	
Weak referral system and feed-back between health facilities and health facilities and community health workers	Identify bottlenecks to referral system and feed-back between health facilities Strengthen and monitor referral and feedback systems between health facilities and community health workers
CSOs and community (incentives) impacting negatively on quality of care.	Maintain and motivate community based health workers
Health information systems	
Use of multiple unstandardised registers and verticalization of program specific data M&E	Standardize registers and compact indicators
Low coverage of electronic data systems	Strengthen and scale up patient monitoring and continue the transition to electronic reporting in facilities

Gaps and Challenges	Strategic response
Poor management of data at source	Capacitate and mentor health workers at data source
Poor data storage because of lack of storage space and overworked staff	Strengthen storage space and increase staff complement
Community participation	
Inadequate visibility of the role and participation of civil society and communities across all programmes	<p>Increase visibility and coverage of CSOs and communities across continuum of care in remote communities</p> <p>Increase the role of males in community initiatives</p>
Limited and fragmented support for community health workers	<p>Strengthen and integrate support for community based health workers</p> <p>Classify the community based health workers according to the new Communities Systems Strengthening</p> <p>Capacitate and strengthen community structures to track and monitor disease</p>
Non-uniform distribution of CSOs across all levels of response	CSO mapping and equitable distribution to avoid duplication of effort
Leadership and governance	
Governance challenges in broader health system, including centralised resource allocation	<p>Capacitate leadership in broader health system governance</p> <p>Decentralize, monitor and enforce accountability in resource allocation</p>
Poor performance management and fragmented accountability mechanisms	<p>Monitor and Enforce accountability mechanisms</p> <p>Strengthen performance based retention</p>

Health Financing	
Gaps and Challenges	Strategic response
Reduced domestic funding for the response	Strengthen continued revenue generation and allocation to health in line with the Abuja commitments Increased private sector engagement
Service delivery	
Poor quality health service delivery	Increase the capacity of health institutions to provide quality service to clients

Outputs	Core Strategies
Increased staffing levels commensurate with catchment populations and disease burden	Increasing staff establishment across all critical professional grades
Increased proportion of health facilities providing comprehensive quality of care	Strengthening health systems for provision of comprehensive and integrated HIV&AIDS treatment and care services along the continuum of care
Increased health facilities with improved infrastructure	Targeted strengthening of health systems infrastructure
Increased proportion of health facilities implementing evidence based interventions	Strengthen use of data for decision making and policy formulation

6.3 Community Systems Strengthening

The role played by community groups and networks as ‘critical enablers’ to the HIV response cannot be over-emphasized. As much as programmatic strategies and efficacious technologies play a central role in the HIV response, networks and groups, carry the bulk of the HIV burden. CSOs provide strategic opportunities to increase access to services and geographical coverage. They reach marginalized vulnerable and underserved community groups with ease. The advantage of community groups and networks in the response is in their ability to adopt community-based interventions.

This facilitates community empowerment, participation and ownership of interventions targeted towards the response and likely to ensure continuity and sustainability.

CSOs provide a range of services either as standalone or integrated services depending on organization's capability and comparative advantage. These services are highlighted below:

- Community mobilization,
- Distribution of health commodities such as condoms, bed nets,
- Community TB DOT,
- Monitoring and Advocacy for quality of health services
- Dissemination of health promotion messages, including dissemination HIV prevention messages.
- Strengthening treatment literacy and adherence support through community groups such as Community ART Refill Groups (CARGS) and the Community Art Treatment Support (CATS)
- Provision of spiritual /pastoral care.
- Mobilizing material and financial support.
- Training home based care caregivers.
- Provision of palliative care to CHBC patients and their families

It is against this background that Extended ZNASP III also acknowledges the importance of CSOs in the implementation of the response.

Gaps and challenges	Strategic response
Lack of visibility of CSO involvement in the Strategy	Inclusion of CSOs in ZNASP III response
Lack of capacity of communities to adequately and effectively contribute to the response	Identify gaps in community response and capacitate CSOs
CSOs weak governance	Strengthened CSOs governance
Lack of monitoring systems to track progress of interventions	Capacitate CSOs in M&E
Weak linkages with other service providers	Identify bottlenecks in linkages with other service providers along the continuum of care Strengthen linkages with other service providers among the continuum of care
Fragmented and parallel approach to interventions	Strengthen harmonized comprehensive programming

Outputs	Core Strategies
Improved capacity of communities to adequately and effectively contribute to the response	Strategic inclusion of CSOs in the response
Proportion of CSOs with improved governance	Capacitate and strengthen CSOs governance structures and accountability
Improved CSO in data collection and management	Strengthen CSOs in M&E and ability to monitor and track diseases
Increased collaboration among CSOs	Strengthen and monitor CSOs linkages in the response
Proportion of CSOs with improved programming skills	Capacitate and strengthen programming and reporting skills for CSOs

6.4 Monitoring and Evaluation (M&E)

The Extended Zimbabwe National AIDS Strategic Plan III is supported by the Monitoring and Evaluation (M&E) Plan for ZNASP (2015 to 2020). The M&E Plan serves as the cornerstone of measuring progress towards set milestones and targets. The Plan was developed in accordance with the “THREE ONES” which stipulates/:

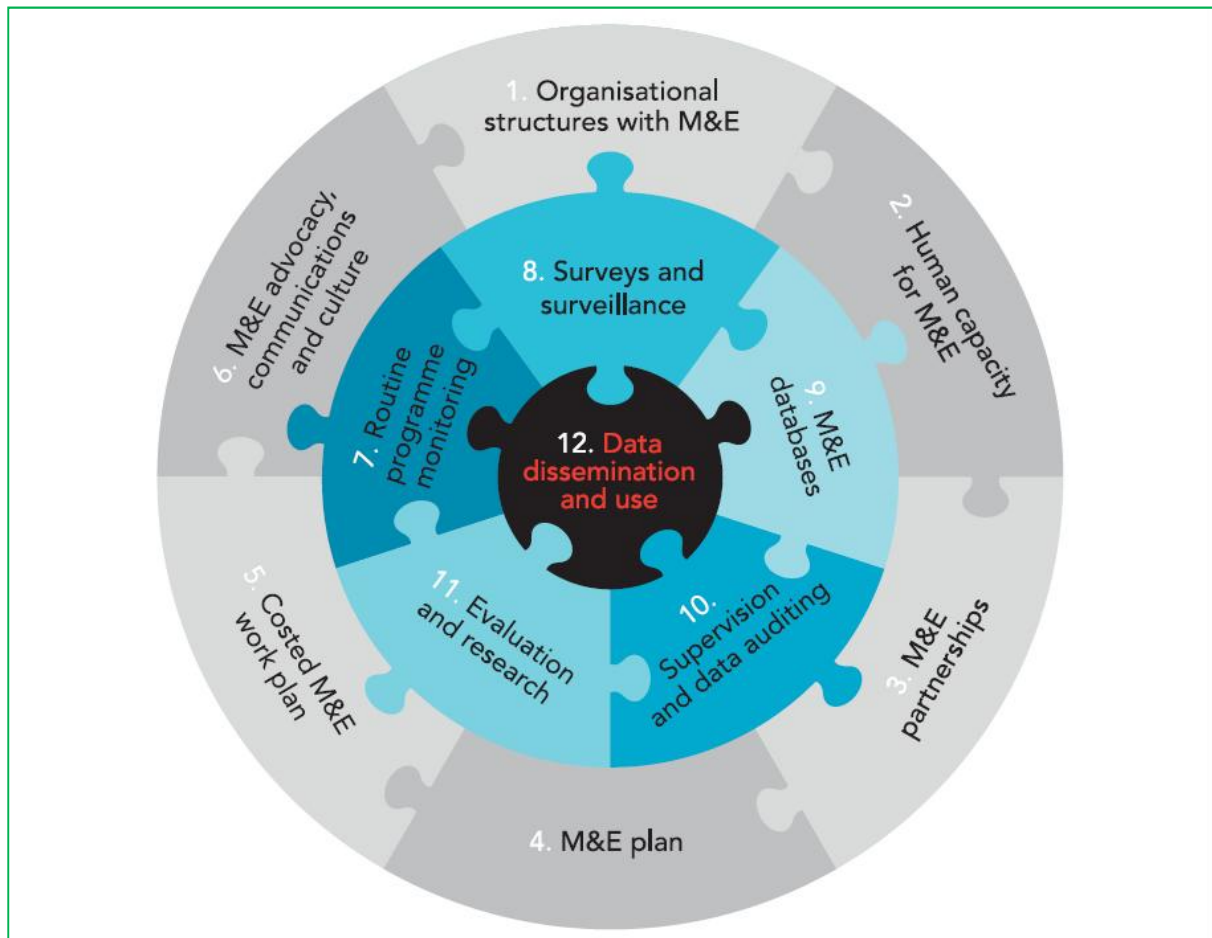
One agreed HIV and AIDS action framework that provides the basis for coordinating the work of all partners and stakeholders

One national AIDS coordinating authority with a broad-based multi-sectoral mandate

One agreed country level M&E system.

In order to abide to international recommended standards, the M&E Plan was guided by the UNAIDS I2 Component Framework for Developing a Functional National M&E System.

Figure 13: “12 Component Framework for Developing a Functional National M&E System”



In order to improve the availability of the strategic information, the country is investing in research and evaluation, use of modern technology on routine programme monitoring – Electronic Patient Monitoring System (ePMS) & Health Records (EHR) and HIV case based surveillance. The 2016 to 2020 research priorities were defined in order to promote generation of evidence. Concerted effort is being put in size and HIV estimates to inform programming.

HIV Estimates, Size estimates and data modelling

In order to inform targeting and setting baseline, size estimates are critical. The country is now generating HIV estimates annually to provide denominators. The country is moving into use of evidence in guiding programming, therefore data modelling is a key component is evidence generation. The following are strategies that will be used:

- Capacity building of national and sub-national level staff on HIV estimates.
- Strengthen generation of evidence through data modelling
- Strengthen generation of baseline data through size estimates
- Strengthen sharing and use of estimate

HIV case based surveillance system

HIV case-based reporting and patient monitoring is essential for ensuring quality and continuity of HIV care and treatment by generating data along the course of HIV disease from diagnosis to entry into care, initiation of ART and viral suppression. It enables programmes to monitor the treatment and health status of patients over time, and performance across health facilities and geographic settings. The following strategies are going to be implemented to improve patient monitoring;

- Capacity building of health care workers on HIV case-based surveillance
- Roll-out of HIV case-based surveillance system to all health facilities
- Strengthen cohort patient monitoring
- Strengthen HIV case reporting

Electronic Patient Monitoring System (ePMS)/ Electronic Health Records (EHR) and HIV databases

There has been investment to develop an electronic patient monitoring system (ePMS), primarily designed for PLHIV in care. It has, however, not fully integrated the reporting requirements of other health conditions such as TB and malaria as HIV positive status is the key entry point to the system. There are efforts to pilot a more comprehensive electronic health record (EHR) for all health conditions within the broader context of a robust national health information system. The pilot has demonstrated successes so far in providing health workers with one system that is capturing data for all diseases and conditions. The system has been able to reduce the number of registers in use. The ePMS has been rolled out in a phased approach, with 634 sites functioning as of December 2016. The following strategies will be implemented for the strategic period.

- Scale up ePMS coverage.
- Strengthen and link patient level information systems, unique identifiers, and district level information systems to support HIV, TB and health programs in more integrated ways.
- Expand ePMS modules including VMMC, HTS and HIV case based surveillance
- Establish macro database which will gather together ePMS datasets from all health facilities in the country.
- Integrate electronic health system with the Electronic Health Record system (EHR).

Research, Surveys and documentation

The call for evidence informed policies and programmes in response to HIV and AIDS has been getting stronger in Zimbabwe and the Southern African region where the burden of the pandemic is most felt. Ending AIDS will strongly depend on the evidence used to develop policies, strategies and programmes. In this regard, strong capability for research and evaluations will continually be built to reflect accelerated efforts to achieve the 90-90-90 by 2020 targets and eventual ending of AIDS by 2030.

Partners from various organisations developed the National HIV and AIDS Research Priorities (2016-2020) to provide guidance and clarity on areas for which new and further evidences are required, to ensure that Zimbabwe spends the available limited resources in the areas of greatest need and avoid unnecessary duplications. A summary of the priorities is attached to this ZNASP as addendum. Specific strategies to strengthen research and evaluation in extended ZNASP III will include the following:

- Provide small grants for operational research in line with the research priorities
- Conduct population based surveys ie DHS
- Provide mentorship to up and coming researchers in areas in the research priorities

- Conduct regular research dissemination through a variety of platforms such as workshops, meetings, websites, social media, publications and others.
- Regularly collect, strengthen and popularize the HIV and AIDS research database
- Strengthen utilisation of evidence in policy formulation and programme development and improvement
- Streamline and popularize uniform M&E tools
- Provide capacity building in monitoring and evaluation for staff in NAC and partner organisations
- Conduct regular data quality assessments

The following are the gaps, challenges and strategies to improve the system.

Gaps and challenges	Strategic response
Lack of critical personnel at MoHCC to head M&E unit	Capacitate M&E units at all levels of the response
Unclear linkage between health information (data generation point) and the directorate of M&E in the Ministry.	Identify clarity of linkages
Lack of link between patient level information, unique identifiers and district level information system to support HIV, TB and health programs	Strengthen and link patient level information, unique identifiers and district level information system to support HIV, TB and health programs
Lack of capacity at data generation points	Strengthen capacity and monitor data generation points
Weak data utilization at source, district and provincial level other than at national level,	Strengthen data analysis and utilization at identified levels
Multiple paper forms have created multiple data collection points	Scale up patient monitoring and continue transition to electronic reporting in facilities through implementation of the EHR Strengthen support for data quality for the DHIS II
Lack of nationally recognised unique patient identifier.	Roll-out of the HER system Strengthen data management

Gaps and challenges	Strategic response
Weak patient level information system in the coordination of these systems	Adapt and roll out of HIV case based surveillance Strengthen patient level information system in the coordination
Limited dissemination of data in M&E at other levels other than national levels	Strengthen data dissemination at identified levels
Quarterly data audits being carried out not part of integrated supportive supervision	Strengthen quarterly data audits
Lack of decentralization of data reviews at all levels	Strengthen data reviews at identified levels
Inadequate data elements capture M&E system especially data on key populations.	Conduct size estimates for key populations Strengthen data capture across all target groups in the response

6.4.I 12 M&E components

Gaps and challenges	Strategic response
No nationally endorsed curricula to address M&E gaps	Design nationally endorsed M&E curricula
No annual, costed, national HIV M&E Workplan	Costed national HIV M&E Workplan
None utilisation of data for action.	Develop data use plan
No national guidelines to ensure that the paper based patient record supports quality and continuity of health records.	Roll-out Electronic Health Record Improve paper based patient record supports quality and continuity of health records

Gaps and challenges	Strategic response
Weak mechanisms in place to provide feedback to reconcile discrepancies in reports as part of the reconciliation process. .	Strengthen feedback mechanisms
Not all planned surveys have been done	Operationalize the national research agenda Strengthen accountability and adherence to surveys and Surveillance plan
No guidelines to ensure harmonisation of information systems across the different service points.	Strengthen harmonization of different service points.
Limited utilization of evaluation and research findings to inform policy formulation, planning and implementation.	Strengthen dissemination and usage of research findings
Data analysis and use at facility level is still weak.	Strengthen data analysis at all levels

Output results	Core Strategies
Nationally endorsed curriculum on M&E	Design and an M&E curriculum
Improved strategic information management and utilisation	SOPs to guide strategic information management and utilisation
Improved utilisation of evaluation and research findings	Capacity building for conducting research, evaluations and dissemination.
Improved surveillance and data analysis	Capacity building for surveillance and data analysis Capacity building on HIV case based surveillance

6.5 Cross Cutting Issues

6.5.I Gender

The gender component operationalizes the gender principle of the extended ZNASP III to ensure that all stakeholders mainstream gender into their HIV programming responses and across all key priority result areas. It also ensures that resources are channelled to the more vulnerable population groups in the identified geographical areas.

To date some of the key successes have include advocacy for policy reforms e.g. advocacy for early marriage policy. commitment to addressing GBV evidenced by the launch of *Zero Tolerance 365: National Programme on Gender Based Violence (GBV) Prevention and Response*” (2016 –2020) a national commitment to eradicate GBV and child marriage and promote gender equality in the country. The Government of Zimbabwe has also ratified regional and international policies aimed at addressing GBV and to promote gender equality

The gender programme is aimed at engaging existing and identifying additional key stakeholders and partners involved in programming on gender and HIV as well as identify and explore key issues affecting women and girls in the context of HIV, SRHR including violence against women, barriers to services and related policy gaps and priorities. It is also aimed at strengthening dialogue between communities, civil society organisations, and government. The programme will build on the positive responses with an emphasis on the meaningful engagement of women living with HIV and other affected women as well as strengthening capacity to engage men and boys in the HIV and AIDS responses.

The key challenges being addressed include violence against women, failure of women to negotiate safe sex, limited availability of HIV services for key populations, early marriages, stigma and discrimination, male domination in sexual relationships, transactional sex and high inconsistent and incorrect use of condoms. A gender responsive approach is critical in addressing issues of HIV and AIDS and dealing with the epidemic in Zimbabwe, where gender inequality is a key driver of HIV transmission and gender based violence. ZNASP III represents a key entry point for programming to address issues affecting women and girls, and gender inequality more broadly.

The 2013 Gender Assessment also helped to understand some of the key gaps which need further strengthening in the next phase of the extended ZNASP III

6.5.I.I Gaps

- Lack of capacity to mainstream gender
- Limited funding
- Fragmented coordination mechanisms among partners implementing gender and HIV activities
- Inadequate linkages between the National Gender and HIV Technical Working Group and coordination mechanisms at operational levels.

- Barriers to access services by women and girls
- Gender inequality and disparities in opportunities and economic benefits between men and women
- Fragmented policy framework to support the reduction of HIV infections among adolescent girls and young women

6.5.1.2 Core Strategies

- Economic empowerment of women and girls
- Mainstreaming of gender across all key result areas of the response
- Strengthened information sharing platforms for gender implementing agencies
- Strengthened holistic gender transformative interventions
- Harmonised implementation and coordination of gender activities
- Strengthened comprehensive programming for SRH and HIV and AIDS
- Strengthened policy framework that protects the rights of women, adolescent girls including key populations:
- Increased number of men and boys who participate in gender sensitive HIV programmes and services
- Increased resources and capacity for gender mainstreaming into HIV/SRH programmes

6.5.2 HIV workplace and wellness

The workplace response to HIV and AIDS has remained subdued due to the prevailing harsh economic environment. The majority of companies and organisations have scaled down operations resulting in workplace HIV prevention programmes not receiving the deserved priority.

Out of the 47 sectors in the country only 11 currently have national strategies and policies in place. Strategies in place include the Public Service, Private Sector and Informal Economy. Sector specific policies have also been developed for the mining, agriculture, tourism, textile industry, motor industry, small and medium enterprises, transport and engineering sectors. However, translating the strategies and policies into action has been limited by funding and lack of technical capacity.

HIV focal persons have been established in all government ministries to facilitate development and implementation of workplace HIV and wellness programmes. A technical working group for the informal economy and a Private sector HIV and Wellness Board have also been put in place to coordinate the workplace response to HIV and AIDS

Gaps

- Limited senior management commitment
- Limited funding

- Limited capacity to develop and implement workplace policies and programmes
- Lack of monitoring and reporting mechanisms
- Weak coordination mechanisms
- Gender inequality and disparities in opportunities and economic benefits between men and women

Strategies

- Strengthened coordination mechanisms
- Strengthen monitoring of the HIV workplace and wellness programmes
- Advocacy for senior management commitment
- Increased funding for workplace programmes
- Strengthened information sharing platforms
- Capacity building of organisations to develop and implement policies and programmes
- Strengthened gender transformative interventions at the workplace

6.5.3 Meaningful Involvement of People Living with AIDS (MIPA)

The Extended ZNASP III recognizes the important role played by PLHIV in the national response and will ensure their involvement in all interventions, therefore includes MIPA as a cross cutting issue in the strategy. The strategy provides for meaningful involvement of people living with HIV (MIPA) Multi-sectoral actors at all levels are expected to adhere to this guiding principle. In line with this principle, PLHIV should be involved holistically in the national response to HIV and AIDS as per the 1999 UNAIDS ladder of participation.

In 2016, the country amplified the MIPA Concept by adopting Positive, Health, Dignity and Prevention (PHDP) approach which recognises that PLHIV are more than patients and thus will not be treated as vectors of the epidemic. Instead they are supposed to fulfill their SRHR needs just like anybody else.

To date, PLHIV have been involved at all levels of the national response including representation in the coordination structures such as AIDS Action Committees, and Country Coordination Mechanism, Global Fund and UNAIDS boards, as well as participation in national and international conferences, conducting of community monitoring on a regular basis, advocacy with policy makers, community and religious gatekeepers.

The 2014, Zimbabwe Stigma Index findings helped to broaden understanding of the extent and forms of stigma and discrimination faced by people living with HIV, strengthening the advocacy efforts of organizations fighting for improved rights for PLHIV.

6.5.3.1 Gaps and Challenges

- Fragmented coordination for PLHIV sector
- Inadequate skills, knowledge systems and resources for PLHIV to fully participate in the national response

- Inadequate linkages between health facilities and community-based structures
- Lack of inclusivity of all sub-groups of PLHIV in the response
- Inadequate and fragmented funding for MIPA
- High levels of stigma impeding progress regarding MIPA.
- Barriers to access to services for people living and in particular those with disability

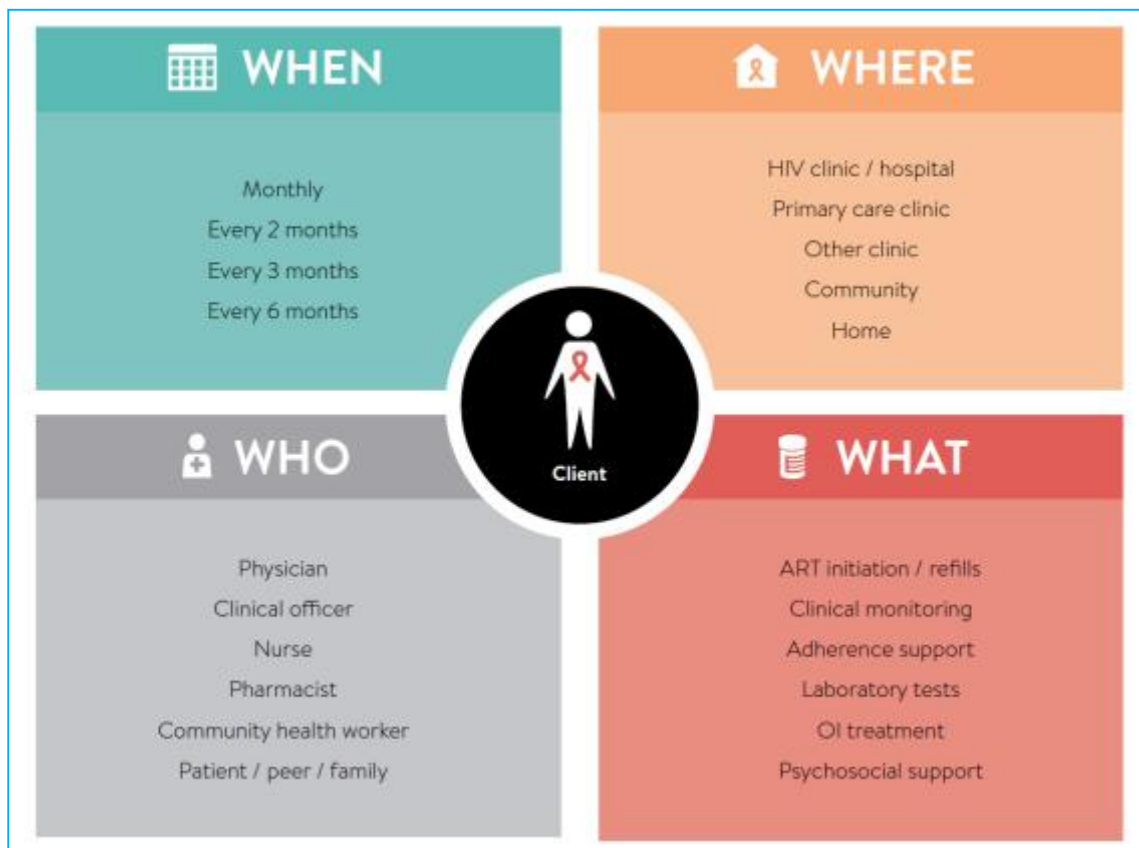
6.5.3.2 Cores Strategies

- Strengthen Coordination mechanism for PLHIV
- Build capacity for organisations representing and working with PLHIV for better service delivery and strengthened linkages
- Intensify resource mobilisation for MIPA and effective utilisation of resources
- Strengthen interventions which address stigma such as PHDP, Support groups formation and other anti- stigma campaigns
- Advocacy with policy makers, faith based organisation and service providers.
- Strengthen inclusive programming to better reach key and most at risk populations such as people with disability and living with HIV.
- Strengthen livelihood through CATS and CARGs

6.5.4 Differentiated Care

With the introduction of “Treat All” and the intention to meet the 90-90-90 targets, innovative strategies are needed to identify those who currently do not know their status, link them to care and retain them on ART within a health system that is already over-burdened. Continuing to provide services in the same way for all clients regardless of their differing needs is not only inefficient for the health system, but also places an unnecessary burden on the client. Differentiated service delivery has been defined as a client-centred approach that simplifies and adapts HIV services across the cascade to reflect the preferences and expectations of various groups of people living with HIV (PLHIV) while reducing unnecessary burdens on the health system. By introducing differentiated service delivery, the health system can refocus resources to those most in need. The client is at the centre of all models of differentiated care.

The building blocks of Differentiated Care Models



Strategies

- Strengthen demand generation using community based cadres
- Roll-out HIV differentiated care
- Capacity building of Health care workers
- Capacity building of community care workers
- Roll-out CARGs and CATS
- Strengthen community based interventions

6.5.5 Integration

Integration of services is key in efficiency gain. Programmes are at different levels of integration and several studies have been done to measure the level of programme integration. Weak program integration results in missed opportunities and a fractured continuum of care along the life cycle and across service delivery levels. A recent evaluation recommends that the MOHCC revise existing policies to further address SRHR/HIV linkages and integration and continue to ensure their operationalization.

Strategies

- Strengthen integration of SRH, HIV, TB, FP and MCH services
- Capacity building of health care workers on integration of services
- Set up infrastructure that support integration and linkages of services
- Establish linkage system health services

6.5.6 Quality Improvement and Mentorship

Quality improvement is the combined and unceasing efforts of everyone—healthcare professionals, patients and their families, researchers, payers, planners and educators—to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning). Quality care should be patient centred, acceptable, safe, effective, efficient, equitable and continuous.

The main goal of the National Quality Improvement programme is to provide care that meets or exceeds the expectations of the clients. As such, the emphasis is on patient centred care. Patient centered care is care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions. Core components of quality improvements include: performance measurement, quality improvement, quality management, consumer involvement, coaching and mentoring and peer learning.

Quality Improvement helps to address three fundamental aspects:

- 1) The care provided should be based on the needs of the clients. As such, every health worker should ask the clients the key question: What matters to you today? Instead of "what is the matter with you?"
- 2) The care provided should be consistent with the current national guidelines and standards
- 3) The care provided should be appropriate and have the desired effect /outcome on the client's health

The following are the main gaps in the HIV QI programme:

- i. Organizational assessment results are showing that health facilities do not have structures in place to support quality improvement
- ii. Senior leaders are not visibly engaged in quality improvement initiatives

- iii. Not all of the staff (clinical and non-clinical) are routinely engaged in QI activities and are not provided training to enhance skills, knowledge, theory or methodology or encouragement to identify opportunities for improvement and develop effective solutions
- iv. Formal quality improvement projects have not yet been initiated in the organizational program
- v. There is currently no process to actively engage patients in HIV quality management program activities
- vi. Quality program evaluation is part of a formal process and is integrated into annual quality management plan development, but has not been consistently employed
- vii. There are few facilities with focal persons or functional quality improvement committees
- viii. There are gaps with quality management plans at facilities
- ix. Facility teams are not documenting and completing the registers
 - x. Data is not reviewed and analysed
 - xi. Data is not used for improvement

Strategies

- Orient leaders at national, provincial, district and facility level on quality improvement
- Support the establishment of quality management structures including:
 - National TWG
 - Functional facility QI committees
 - Quality management plans
 - Build coaching for QI capacity
 - Establish platforms for peer learning, including QI forum
 - Establish structures for active consumer involvement/engagement in QI
 - Establish a system for rewarding and recognition of quality
 - Strengthen clinical mentorship
 - Strengthen monitoring of client satisfaction
 - Roll-out quality monitoring

6.5.7 Public Private Partnerships

The private health care system serves most of the affluent community in Zimbabwe. The cost of services are high in the private sector. In order to decongest the public sector there is need to subsidise the cost of services in private sector. NAC lead the initiative by procuring ART medicines for the private sector. The following strategies are critical to improve the public private partnership.

Strategies

- Strengthen public private sector partnership
- Develop policy that compels the private sector to report
- Strengthen monitoring of services in private sector
- Develop standard operating procedure for private sector

6.5.7 Advocacy

In order to strengthen the enabling environment for implementation and uptake of services, advocacy will focus on policy review and support targeting policy makers at all levels and in all sectors.

6.5.7.1 Gaps and Challenges

- Inadequate funding for the response
- Limited participation of some sectors in the national response to HIV and AIDS
- Policies that inhibit uptake and implementation of HIV and AIDS services for key populations.

6.5.7.2 Core Strategies

- Capacity building Policy makers – parliamentarians, chiefs and community and traditional leadership
- Sensitization engagements with Policy makers and community leaders
- Capacity building of faith based leaders
- Capacity building of parliamentarians to move motions on HIV in parliament

6.5.8 Communications

Information dissemination on HIV and AIDS has significantly improved over the years through mass media as well as interpersonal communication. This has led to a marked increase in awareness, which is currently at 95% according to the current ZDHS. There is a need to sustain these efforts.

6.5.8.1 Gaps and Challenges

- Low uptake of certain HIV and AIDS services like Voluntary Medical Male Circumcision and Pre-Exposure Prophylaxis.
- Low risk perception among in certain groups such as young people and people in marriages.

Core Strategies

- Strengthening of social and other innovative media
- Use of mass media communication
- Capacity build media personnel
- HIV media reporting

Annex

ZNASP III Results Framework

Impact Results	Outcome Results	Output Results	Targets						
			2015	2016	2017	2018	2019	2020	
Prevention of New Infections									
Social and Behavioural change									
HIV incidence among adults and adolescents reduced by 30% from 0.54% in 2016 to 0.38% by 2020	Men and women aged 15 - 49 whose personal HIV risk perception improved from 29% by 2015 to 70% by 2018	Increased number of in school youths and out of school youths reached with comprehensive life skills, Sexuality HIV and AIDS education	YIS 50,644 YOS -131960 (NAC Report 2015)	YIS-50,644 YOS – 155,103	YIS-55,000 YOS – 160,000	YIS-60,000 YOS – 165,000	YIS-75,000 YOS – 170,000	YIS-100,000 YOS – 175,000	
	Young people who had sex before age of 15 reduced from 5% in female and 6% in males to 2.5% in females and 3% in males by 2020	Increased proportion of school teachers who have been trained in life skills based HIV and AIDS education	35% (NAC Report 2015)	3,999	4,500	5,000	5,000	80% 5,000	
		Increased number of youth in tertiary institutions exposed to comprehensive life skills, sexuality and HIV & AIDS education	104,134 (NAC Report 2015)	110,000	120,000	125,000	130,000	135,000	
	Men and women 15-49 years who had 2 or more sexual partners in the last 12 months reduced from 14.2% for men and 1.1% for women in 2015 to 10% for men and 0.55% for women by 2020.	Men and women aged 15 – 49 with comprehensive correct knowledge of HIV&AIDS increased from 55% for females and 56% for males in 2015 to 57.5% for females and 58% for males by 2020	F-54.6% M-55.7% (ZDHS 2015)					F=57.5% M=58%	

		Condoms – correct and consistent use		2015	2016	2017	2018	2019	2020
HIV incidence among adults and adolescents reduced by 30% from 0.54% in 2016 to 0.38% by 2020	Female and Male aged 15–49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse increased from Female: 49.6% & Male: 37.1% in 2015, to F: 60% & M: 50% by 2020		Increased condoms distributed annually	109.4m - male 5.6m – female (NAC Report 2015)	110m- male 6m- Female	123m- male 4.7m- Female	128m male 6.4m- Female	132m Male 6.4m Female	137m Male 6.5m Female
			Increased Condom Use among Key populations	SW – 66.8% MSM - TG – PLWD- Prisoners-	SW - MSM - TG – PLWD- Prisoners-	SW - MSM - TG – PLWD- Prisoners-	SW - MSM - TG – PLWD- Prisoners-	SW - MSM - TG – PLWD- Prisoners-	SW - MSM - TG – PLWD- Prisoners-
			Increased young men and women aged 15 -24 who can access condoms	F-48.2% M-86.4% (ZDHS 2015)					
HIV incidence among adults and adolescents reduced by 30% from 0.54% in 2016 to 0.38% by 2020	Women and men in sero-discordant relationships who reported using condoms consistently in the last sexual intercourse increased from 25% in 2013 to 80% by 2018		Increased proportion of sero-discordant relationships / couples who used condoms in the last sexual encounter						

		Voluntary Medical Male circumcision		2015	2016	2017	2018	2019	2020
HIV incidence among adults and adolescents reduced by 30% from 0.54% in 2016 to 0.38% by 2020	Men aged 15-49 who are circumcised increased from 14% in 2015 to 80% by 2020.	Increased number of males 10 - 29 reported to have been circumcised	171955 (Programme data 2015)	Ann-203,797	Ann -322,436	Ann- 353,706	Ann- 315,543	Ann – 248,258	
	HIV Testing and Counselling (HTC)		2015	2016	2017	2018	2019	2020	
HIV incidence among adults and adolescents reduced by 30% from 0.54% in 2016 to 0.38% by 2020	90% of all PLHIV know their HIV status	Targeted HIV testing and counselling functioning sites increased	1545 (Prog data 2015)	1,578	1,578	1,578	1,578	1,578	
	Women and men aged 15-49 who received an HIV test in the last 12 months and know their results increased from 48.8% for women and 35.9% for men in 2015 to 90% for both by 2020	Males and Females tested for HIV and received results annually increased	2,210,246 (Prog data 2015)	2,664,844	2,458,374	2,788,913	3,285,552	4,014,037	
		Blood units screened for HIV	100% (NAC Report 2015)	100%	100%	100%	100%	100%	

		Prevention and control of sexually transmitted Infections (STI)		2015	2016	2017	2018	2019	2020
HIV incidence among adults and adolescents reduced by 30% from 0.54% in 2016 to 0.38% by 2020	Women and men aged 15-49 who reported having STI in the past 12 months reduced from 2.2% in 2015 to 2% for both in 2020		Reduced number of new STI cases	180127 (NAC Report 2015)	142,502	145,000	130,000	118,000	106,000
		Key population							
HIV incidence among adults and adolescents reduced by 30% from 0.54% in 2016 to 0.38% by 2020	90% of the Key Populations know their status Condom use in paid sex among 15 - 49 increased from 89.8% in 2015 to 95% in for men in 2020		Increased proportion of Key Populations reached with HIV combination prevention and SRH programs (Young People, Sex Workers, Prisoners and People living with disabilities, MSM)	YP SW – 72% Prisoners PLWD MSM	60 % 85% 60% 60%	60 % 85% 60% 60%	60 % 90% 60% 60%	60 % 90% 60% 60%	60% 90% 60% 60%
			Increase proportion/number of individuals who have received ART pre-exposure prophylaxis (PrEP) to prevent HIV infection (MSM, Transgender (TG), Sex workers, Prisoners, Migrates	MSM TG SW Prisoners PLWD					90% 90% 90% 90%
			Increased proportion/number of key population reporting use of condoms	SW 66.8% (RDS Survey 2015)	SW-70%	SW-80%	SW-90%	SW-90%	SW-90%

		Prevention of Mother to Child Transmission (PMTCT)		2015	2016	2017	2018	2019	2020
New HIV infections among children reduced to less 50 cases per 100 000 by 2020	Infants born to HIV positive mothers who are infected reduced from 7.24% in 2015 to less than 5% by 2020	All Health facilities providing ANC services provides PMTCT	100% (Prog data 2015)	100%	100%	100%	100%	100%	100%
		Increased proportion of women who attend at least one ANC visit	93% (DHS 2015)	93%	94%	95%	96%	97%	
		Increased proportion of pregnant women who know their HIV status	99% (Prog Report 2015)	99%	99%	99%	99%	99%	
		Increased male partners testing in ANC	23% (Prog Report 2015)	23%	25%	27%	30%	35%	
HIV related maternal deaths reduced by 50% from 10.4% in 2010 to 5.2% by 2020	Proportion of HIV positive pregnant women who are put on ART increased from 82% in 2015 to 95% by 2020	HIV-positive pregnant women who received ARV medicines to reduce MTCT increased	82% (Prog Report 2015)	87%	88%	90%	93%	95%	
		Increased HIV-positive pregnant and lactating women who received ARV medicines to reduce MTCT	84% (Prog Report 2015)	89%	9%	92%	95%	97%	
	Reduced unmet need for family planning among women of child bearing age from 10% in 2015 to 6.5% by 2020 -	Increased proportion of women using contraception	67% (ZDHS 2015)						68%

50% reduction of under-five HIV related child mortality from 21% in 2009 to 5% by 2020	Proportion of HIV-infected under-five children initiated on ART before the age of 5 years increased from 80% in 2015 to 95 by 2020	Increased infants born to HIV-positive women receiving ARV prophylaxis for prevention of MTCT	76% (Prog Report 2015)	71%	73%	75%	77%	80%
		Increased infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	54% (Prog Report 2015)	69%	70%	72%	75%	75%
		Increased infants born to HIV-positive women started on cotrimoxazole prophylaxis within 2 months of birth	60% (Prog Report 2015)	61%	63%	65%	67%	70%
	Reduction/maintenance of congenital syphilis to ≤ 50 per 100 000 live births	Increased proportion of pregnant women tested for Syphilis	93% (Prog Report 2015)	93%	94%	95%	96%	97%
		All syphilis sero-positive pregnant women treated	90% (Prog Report 2015)	90%	92%	93%	94%	95%

Treatment Care and Support				2015	2016	2017	2018	2019	2020
Antiretroviral Therapy (ART)				2015	2016	2017	2018	2019	2020
HIV/AIDS-related mortality reduced by 50% for both adults and children by 2020	81% of the HIV positive received ART 90% of the people on ART have viral load suppression PLHIV still alive at 60 months after the initiation of ART increased from 74% in 2013 increased to 75% in 2020	Proportion of Adults on ART	60% (HIV Est Report 2015)	66%	72%	76%	79%	81%	
		Proportion of Children on ART	82% (HIV Est Report 2015)	84%	87%	90%	92%	95%	
		Proportion of Key populations on ART	SW - MSM - TG - PLWD- Prisoners-	SW - MSM - TG - PLWD- Prisoners-	SW - MSM - TG - PLWD- Prisoners-	SW - MSM - TG - PLWD- Prisoners-	SW - MSM - TG - PLWD- Prisoners-	SW - MSM - TG - PLWD- Prisoners-	SW - MSM - TG - PLWD- Prisoners-
		Children enrolled in HIV care and eligible for CTX prophylaxis according to national guidelines increased	59% (HIV Est Report 2015)	70%	75%	80%	85%	90%	
		Health facilities dispensing ART based on the national accreditation guidelines	100% (Prog Report 2015)	100%	100%	100%	100%	100%	
		TB patients who are HIV positive enrolled on ART	83% (Prog Report 2015)	87%	91%	95%	98%	100%	
		PLHIV on ART tested for viral load	5% (Prog Report 2015)	10%	30%	50%	75%	80%	
		Orphans and Vulnerable Children				2015	2016	2017	2018
		OVC whose household received at least one type of free basic external support ¹⁸ increased	147,251 (NAC Report 2015)	147,251	200,000	270,000	300,000	340,000	

¹⁸ External Support refers to assistance from outside their household (not necessarily donor support)

		HIV & TB Collaboration and Nutrition		2016	2016	2017	2018	2019	2020
	Reduced TB/HIV Mortality from 40 to 29 per 100,000 population	PLHIV with new smear positive TB has increased access to ART and TB treatment.	PLHIV in care screened for TB during their last clinical visit	93% (Prog Report 2015)	100%	100%	100%	100%	100%
			Increased proportion of PLHIV diagnosed of TB who are put on TB treated.	78% (Prog Report 2013)	100%	100%	100%	100%	100%
		PLHIV who are malnourished reduced from 9.03% in 2013 to 5% by 2020	PLHIV receiving nutritional care and support increased (Put the severely malnourished)	21089 (Prog Report 2015)	26,176	30,000	34,000	38,000	42,000
		Response Management		2015	2016	2017	2018	2019	2020
		Key institutions from government and civil society have improved capacity to effectively and efficiently manage a multi-sectoral AIDS response	Increased amount of public and donors funds mobilized and spent efficiently	25% domestic and 75% donor (NASA report 2015)	25% domestic and 75% donor	30% domestic and 70% donor	30% domestic and 70% donor	30% domestic and 70% donor	30% domestic and 70% donor
			Improved availability of timely, coherent, and relevant data and strategic information disaggregated by gender and appropriate age group for development	80% NAC Performance Measurement Report	85%	90%	93%	95%	98%
			Policies and strategies that provides enabling environment for the multi-sectoral response		100%	100%	100%	100%	100%