



Government of Zimbabwe

EXTENDED ZIMBABWE NATIONAL HIV AND AIDS STRATEGIC PLAN (ZNASP) 2015 – 2020

*COMMITMENT TOWARDS FAST TRACKING 90 90 90 TARGETS BY 2020 AND
ENDING AIDS BY 2030*



Ministry of Health and Child



National AIDS Council

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.

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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.

Dr T. Magure

Chief Executive Officer

National AIDS Council (NAC)

Preface

While Zimbabwe is still seized by a severe AIDS epidemic with unacceptably high HIV prevalence and incidence, it is one of the first countries that has experienced a sharp decline of new infections and HIV related deaths over the past decade due to a comprehensive set of interventions that have been implemented through a highly multi-sectoral approach.

The AIDS Levy that the country introduced in 2000 and that comprises of 3% of taxable income from PAYE and corporate tax has been herald regionally and internationally as an innovative mechanism and best practice for domestic financing of the national response to HIV and AIDS. However, the resource needs to deal with the HIV and AIDS challenges far outweigh the capacity of the AIDS Levy and hence the continued heavy reliance on external funding for HIV and AIDS programing.

With a rapid reduction of new HIV infections through mother to child HIV transmission (MTCT), Zimbabwe is one step closer to eliminating MTCT. In addition, more people living with HIV know their status and are receiving most efficacious HIV medicines as lifesaving treatment while relatively fewer people are dying of AIDS-related illnesses in the country. The number of men who opted for medical male circumcision in has tripled in the past two years and TB-related deaths among people living with HIV have also declined by three fold.

More evidence in the country is also showing that service delivery in terms of antiretroviral therapy (ART) and PMTCT increased by up to five times between 2004 and 2013. The majority of the PLHIV also live within 10km radius from an ART site which shows generally good highly decentralized service coverage. Therefore more efforts should be placed to increase the functionality, quality and laboratory capacity of the existing service delivery centres. The epidemic still remains largely feminized with women and girls bearing most of the burden and risk of HIV.

The third Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III 2015-2018) is a successor of the ZNASP II (2011-2015) and aligns the national response to the ZIMASSET (2013-2018) priorities. ZNASP III is taking advantage of the experiences and lessons learned from the implementation of the ZNASP II and addressing emerging evidence about the epidemic. There are positive indications that the country can begin ending AIDS epidemic.

ZNASP III proposes strategies of sustaining the gains made to date as well as changing the emerging dynamics of the epidemic positively. It is designed to promote smart investment for more focused and high impact interventions targeting especially children, adolescents, young people, girls, key populations and women as well as prioritized geographical locations while building on the successes of the last five years and commitment to bridging identified gaps.

The Government of Zimbabwe remains committed to achieving Zero new HIV infections, Zero HIV related deaths and Zero HIV related stigma and discrimination. Among many of our success stories, the country is on track to achieving the HIV related MDG goal by 2015 and beyond. Zimbabwe has made formal commitment towards fulfilling international obligations including the United Nations General Assembly Special Session Declaration of Commitment on HIV and AIDS (UNGASS 2001; the Maseru Declaration on HIV and AIDS; the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW); the UN Convention of the Rights of the Child; the Universal Human Rights Declaration; and commitment to attain the Millennium Development Goals. The plan has also domesticated global instruments and commitments such as 90 90 90 and fast tracking, post 2015 Sustainable Development Goals (SDG), Africa Union roadmap on domestic sustainable financing and, ending AIDS by 2030 .

The National AIDS Council (NAC) 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. Over the years NAC established decentralized coordination structures and systems necessary to mobilize an effective HIV and AIDS response. With the response achieving over 50% of reduction of new HIV infections over the last decade, the focus of this strategy is taking the response to the grass-root and communities with emphasis on the most high risk populations, geographical location and hotspots and this will use the investment framework which promotes efficiency, effectiveness and sustainability of collective efforts.

The Government of the Republic of Zimbabwe renews and pledges its continued highest commitment to the cause of the HIV and AIDS epidemic. All local and international partners and stakeholders are urged to continue to work together even harder, smarter and faster so that the 90 90 90 targets are attained by 2020 and Ending AIDS by 2030 will become a reality.

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 15.2% among adults aged 15 to 49 years by 2011 (17.7% among females and 12.3% among males).

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 in an advanced stage and the next four years are critical as the country further intensifies and fast tracks actions towards attainment of 90 90 90 targets and ending AIDS in Zimbabwe by 2020 and 2030 respectively. This third Zimbabwe National HIV and AIDS Strategic Plan for 2015-2018 (ZNASP III) 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. ZNASP III 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 has registered over 50% reduction of new HIV infections among adults and 80% in children born to HIV positive mothers. Similarly HIV related deaths have also been reduced by over 60% as a result of highly successful prevention, treatment and support programme. However, such achievements cannot be said about provision of treatment for HIV positive children whereby the coverage is merely 45%. ZNASP III therefore offers the opportunity to bridge this gap and 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 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 ZNASP III and identify with its ambitious targets and goal to prevent new HIV infections and reduce HIV related deaths towards ending AIDS in the country.

Dr. Evaristo Marowa

Board Chairperson

National AIDS Council (NAC)

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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.

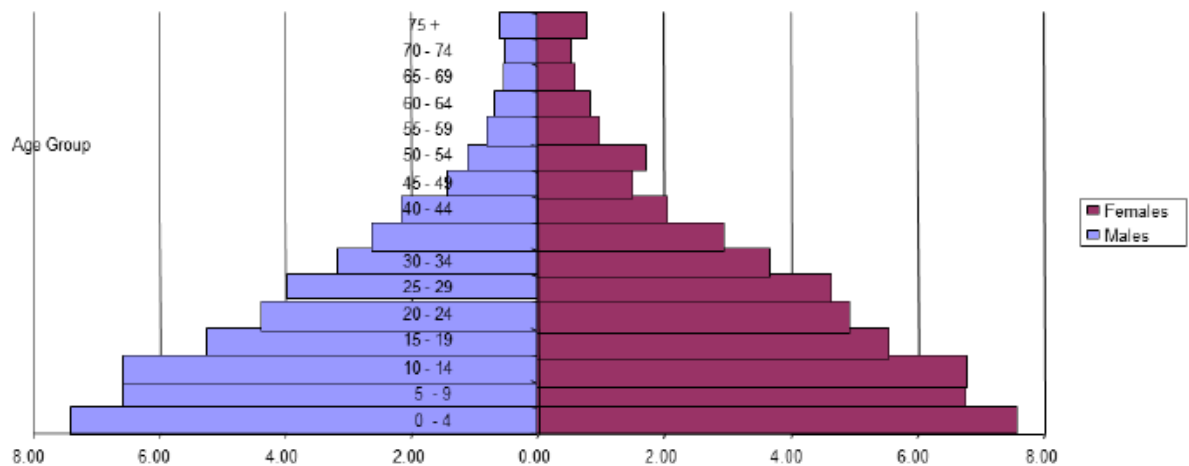
Stakeholders Participation: Stakeholder consultations were done throughout the 10 provinces and stakeholders consultation meeting was held to gather information on the HIV epidemic, needs and challenges in accessing HIV services. Government ministries, traditional leaders, informal sector, civil society, 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 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 1: Population pyramid percent (Zimbabwe 2012 Census Report)



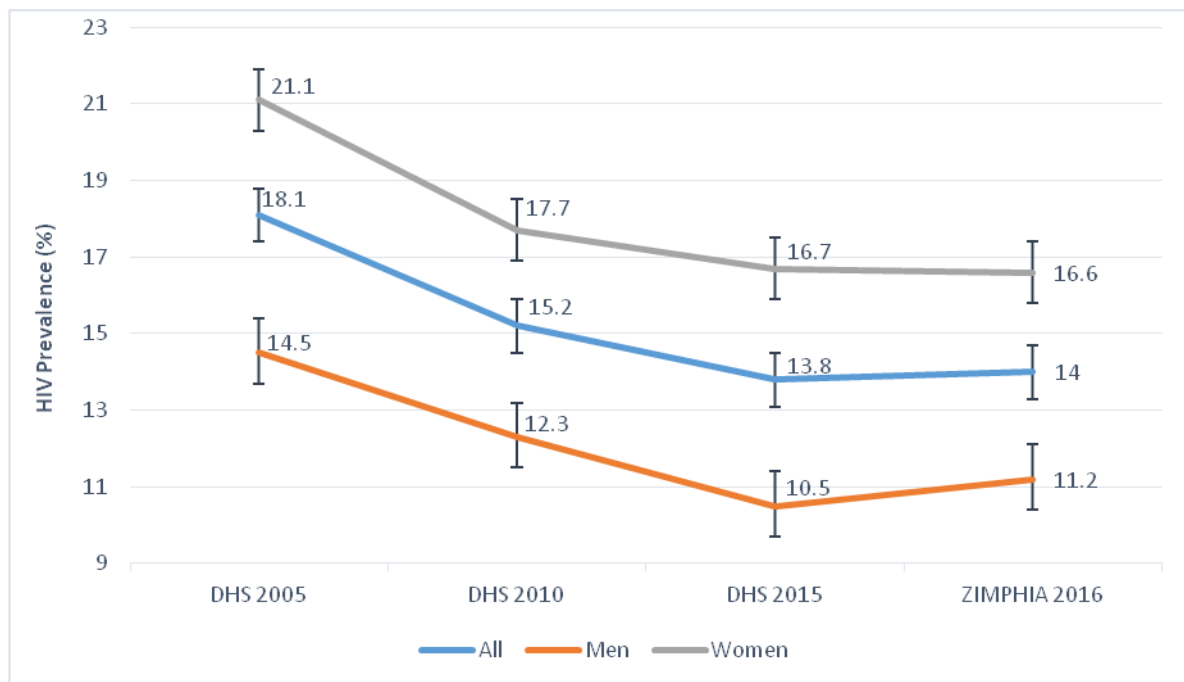
Zimbabwe has an estimated 1.4 million people living with HIV (PLHIV), 1.2 million of whom are between the ages of 15 and 64². Adult HIV prevalence has steadily decreased by 24% over the last ten years, from 18.1% in 2005 to 13.8% in 2015². Prevalence among children (0-14) is estimated at 1.6%. While the epidemic has 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

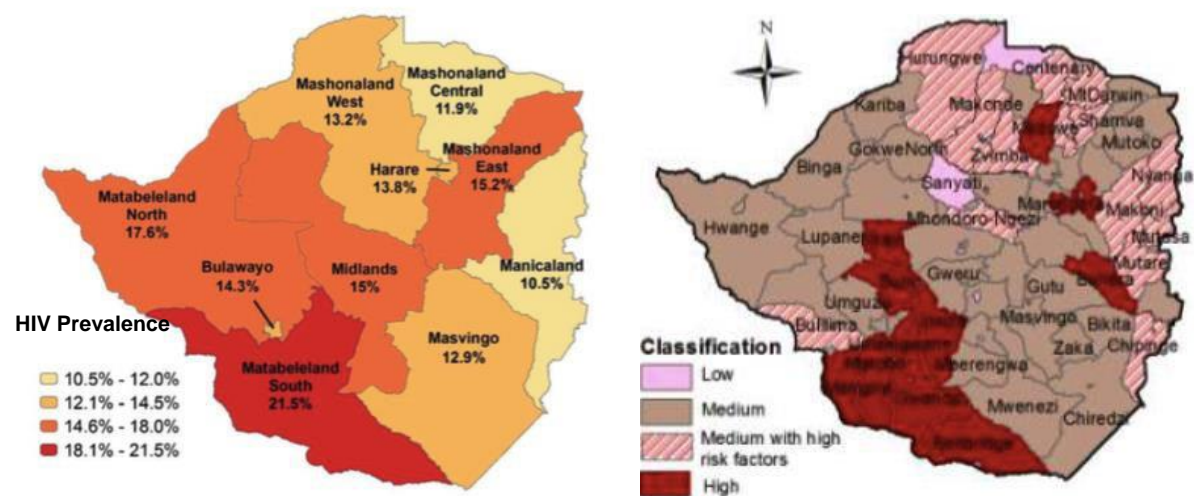
Figure 2: Prevalence of HIV among adults (15-49) in Zimbabwe



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.

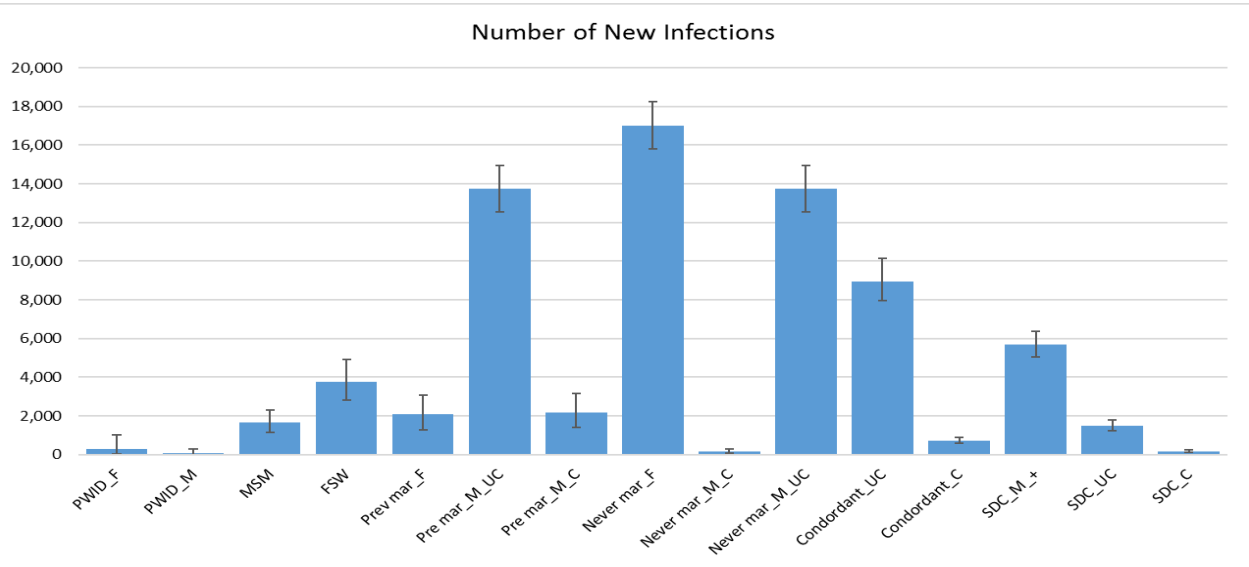
⁴ Hot spot analysis (2015), page 27

Figure 2: Adult HIV Prevalence (Left) and Hot Spot Risk Analysis (Right) (2015)



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 3: New Infections by population groups⁵



⁵ Draft Epidemiological data analysis and MOT survey report 2017

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.

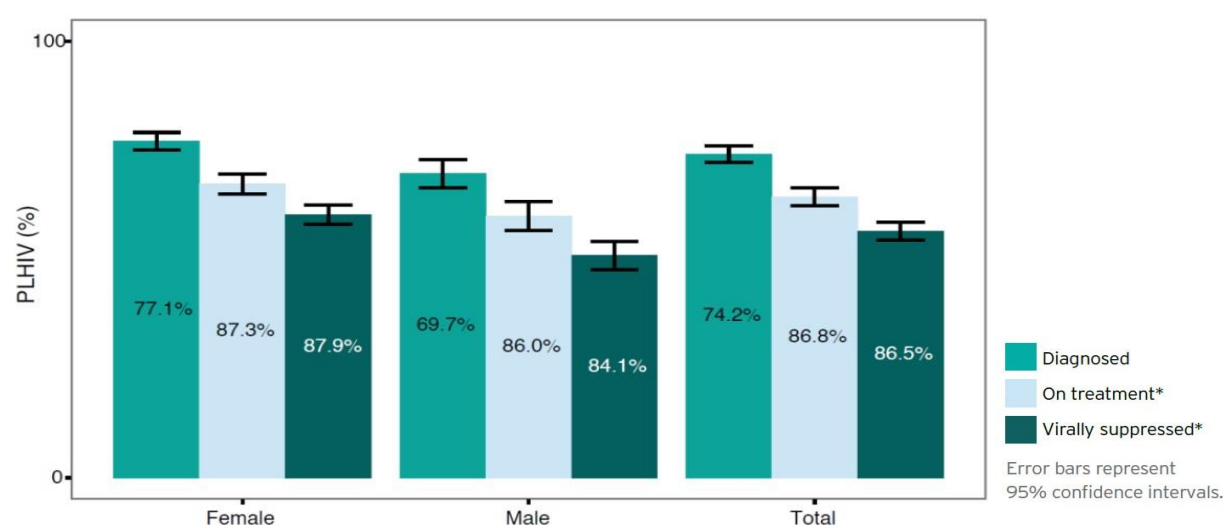
According to 2015 national HIV estimates the final vertical transmission rate was at 7.24%, and this was a significant decline from 30% in 2009. Data suggests that, Zimbabwe has the potential to achieve the international threshold for virtual elimination of vertical transmission (EMTCT) (<5% at 18 months), 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 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.

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

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.

Figure 4: 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.

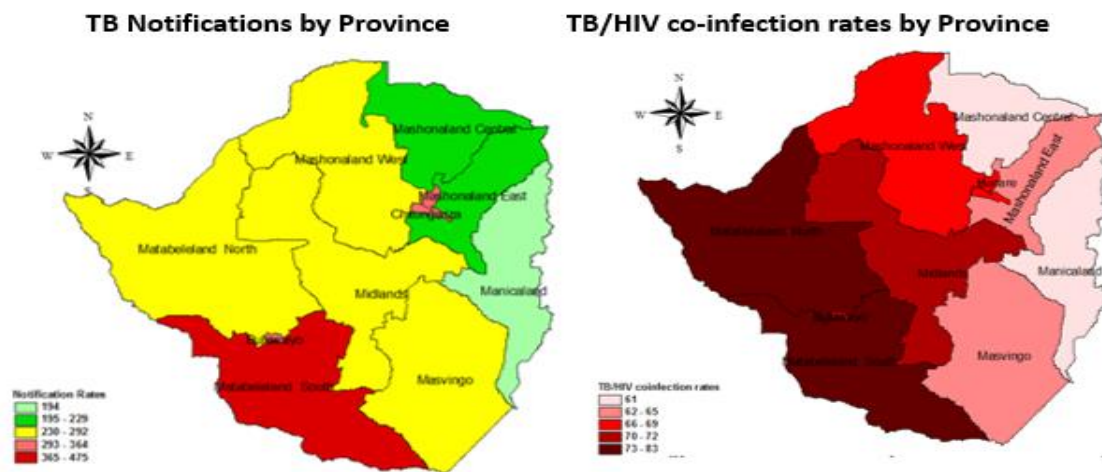
Zimbabwe’s TB incidence has sustained a downward trajectory from as high as 799/100,000 population in 2005⁸ to 242/100,000 population in 2015⁹. TB mortality excluding HIV has declined by 50%, from 22/100,000 in 2005 to 11/100,000 in 2015, and TB mortality including HIV has significantly declined by 75% from 158/100,000 in 2005 to 40/100,000 in 2015. These gains are largely due to increased investment in TB diagnosis and 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).

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

⁸ Global TB Report 2013, page 159

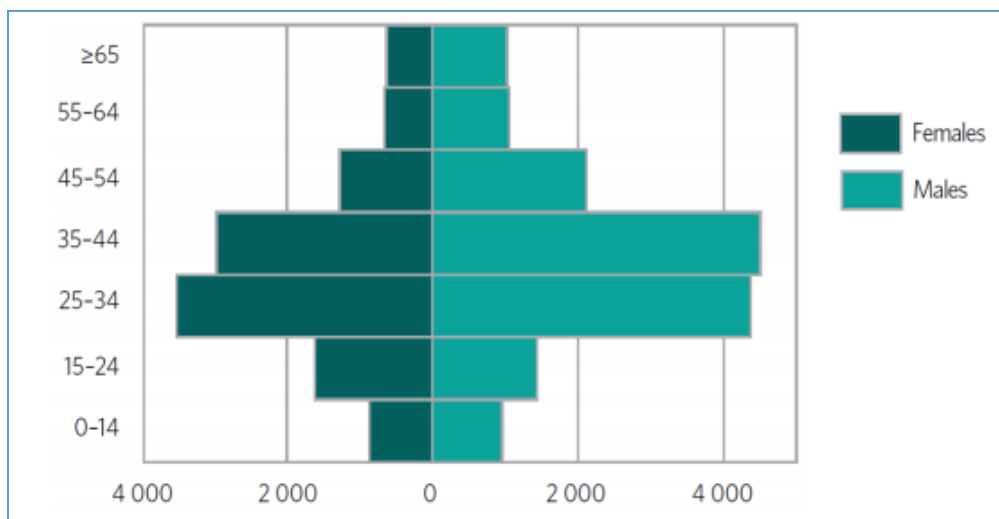
⁹ The Epidemiological review of TB disease and surveillance (May 2016) (As cited in team’s 7 Feb template)

Figure 5: TB notifications and TB/HIV co-infection by province



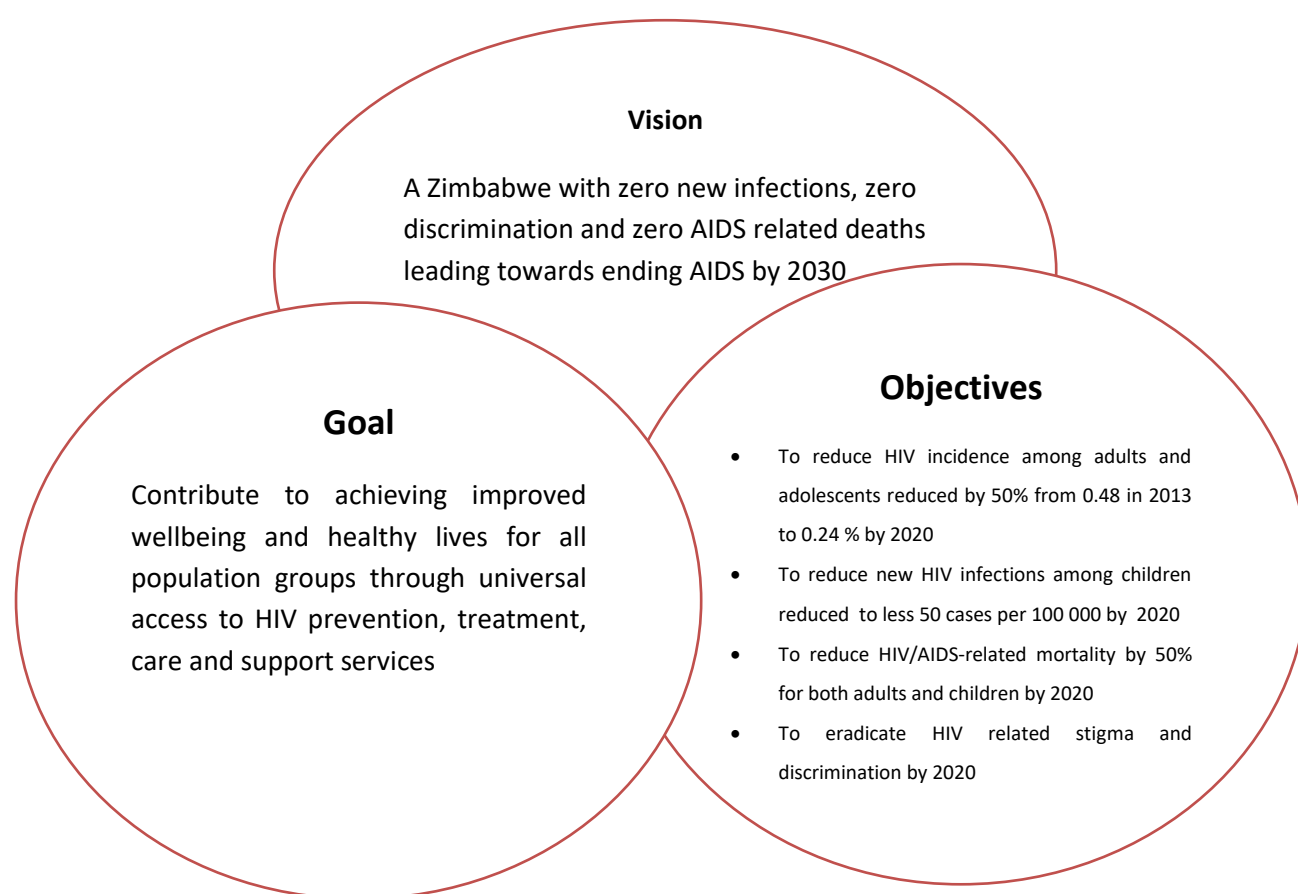
The figure 5 shows that the TB epidemic in Zimbabwe is predominantly driven by HIV

Figure 6: 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 with 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 generalized epidemic, a common mistake is to invest in national response programmes that generally 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.
- **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

3.5.1 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 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.

3.5.11 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 has been prioritized in ZNASP II (2011-2015) and consistently so in previous strategic plans. Data indicating that incidence of HIV in both adults and children have declined by more than 50 percent over the past fifteen years testifies 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 has drastically fallen from a peak of about 5% in 1994 to 0.98% in 2013. Adoption and implementation of a combination prevention strategy has 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 do 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 avert new HIV infections.

Relatively low uptake of VMMC, HCT and other HIV prevention services is attributable to demand and supply-side challenges that should be prioritized to address through 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 25582 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.

11.3% of married/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 aforementioned areas. Behaviour change interventions have been classified as high impact programs under the Combination 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 model of delivery includes a range of communication channels, including mass media, social media, interactive materials, and interpersonal communication that includes home visits.

4.3.1 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.

4.4.1 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.

4.5.1 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 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.

4.6.1 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.

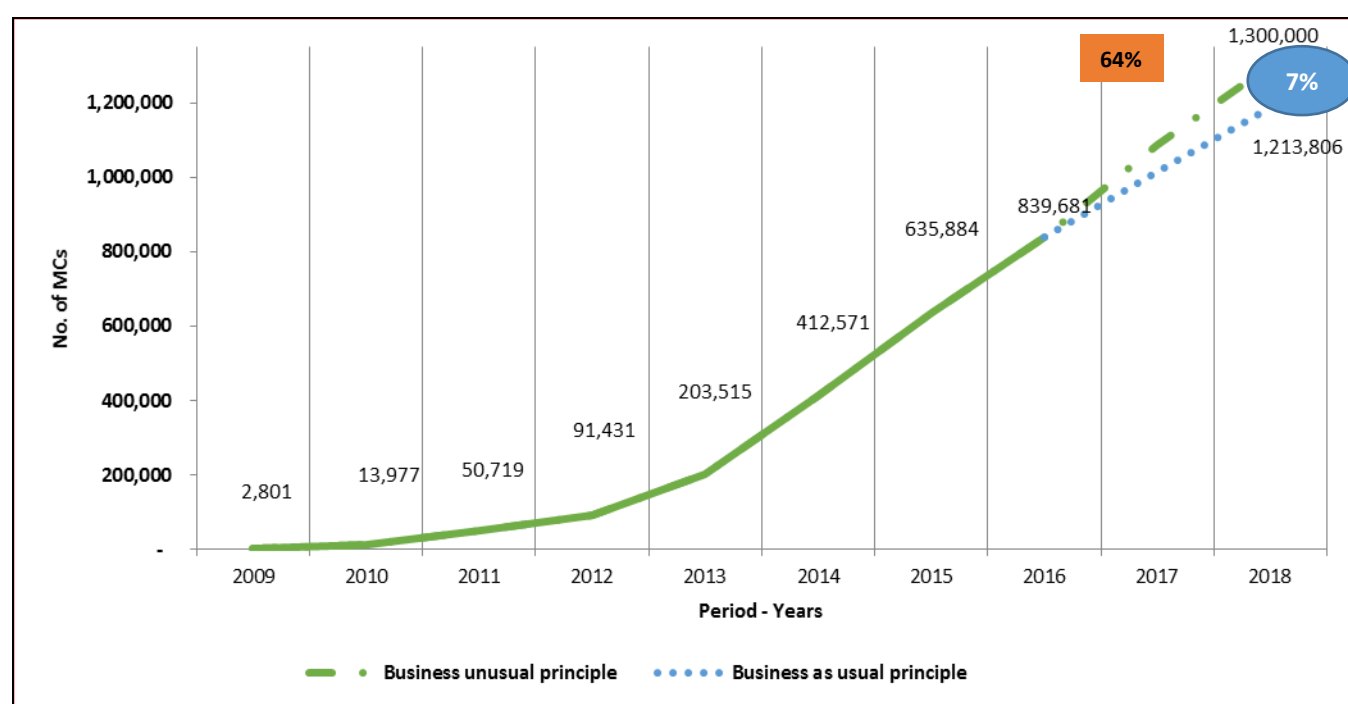
- Sustained and robust condom distribution appropriate to settings where high risk sexual activity occurs
- Re-enforce the benefits of consistent and correct use of condoms
- Enhanced advocacy for policy that allows access to condoms for sexually active adolescents and youths
- Strengthen marketing and 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 xxc: 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

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

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.

4.8.1 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

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

¹¹ OPTIONS Country Situation Analysis Interim Findings: Zimbabwe December 2016

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. 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.

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

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.

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.

4.I0.I.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.I0.I.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

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)

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

- 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.

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.

- 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

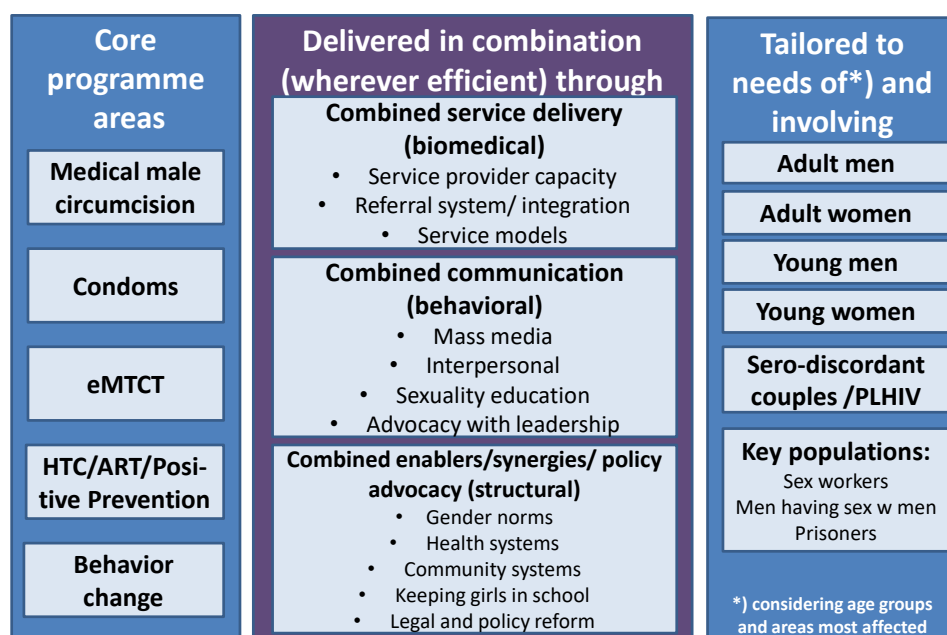
Sexual Reproductive Health (SRH) and HIV integration

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.

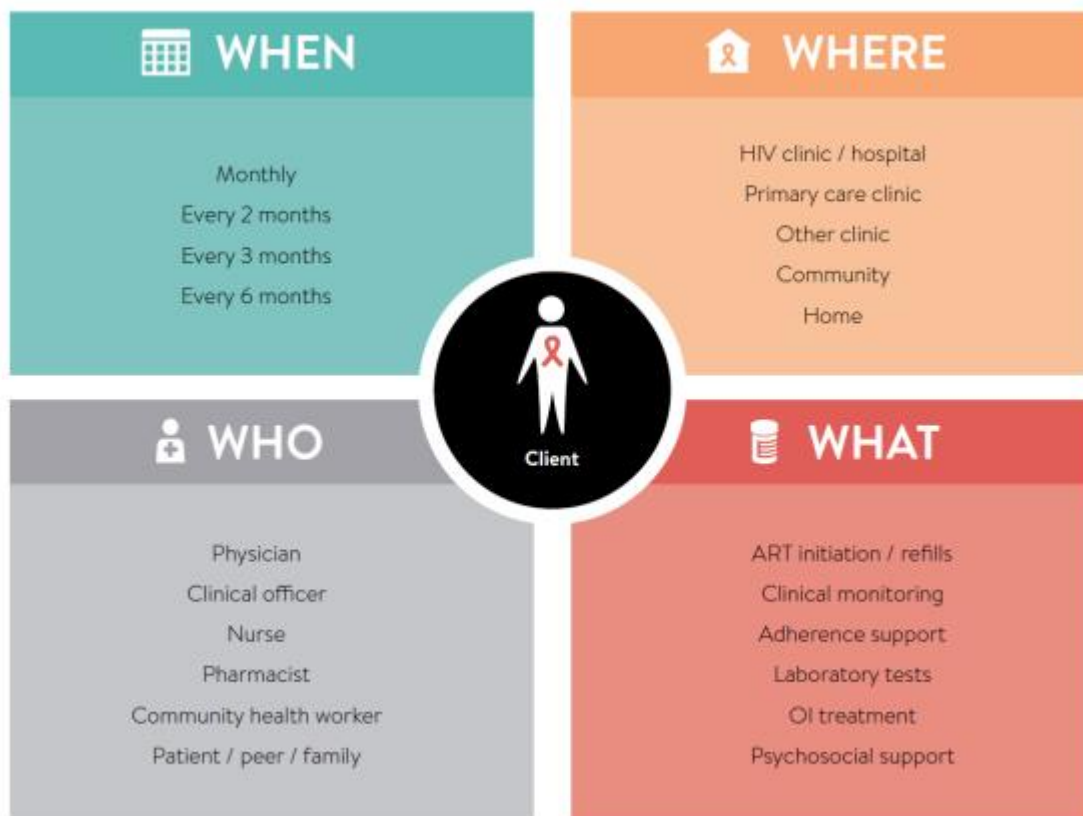
Focus of Zimbabwe Combination HIV Prevention Strategy



4.II.2 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



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.I Antiretroviral therapy

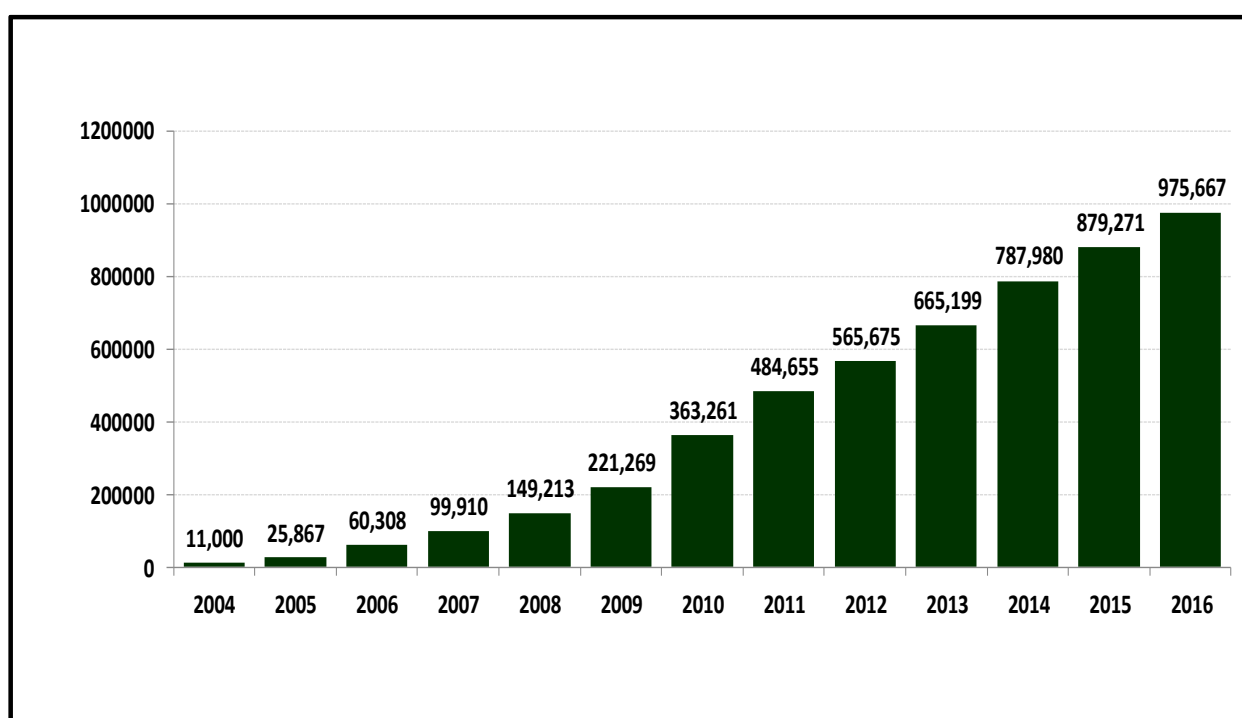
Zimbabwe is committed to providing antiretroviral therapy for all PLHIV. The overall goal of the ART programme is to reduce HIV-related morbidity and mortality among people living with HIV. The ART programme will continue to initiate strategies that link clients to enrolment for early treatment and enhance 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.I.I 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 28: 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% (Figure xx) 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.I.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

Outcome	Follow-up time (in months)							
	3 months		6 months		12 months		24 months	
	(N = 3807)		(N = 3807)		(N = 3807)		(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)

Figure 29: Overall Retention Rates by time of follow up

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.

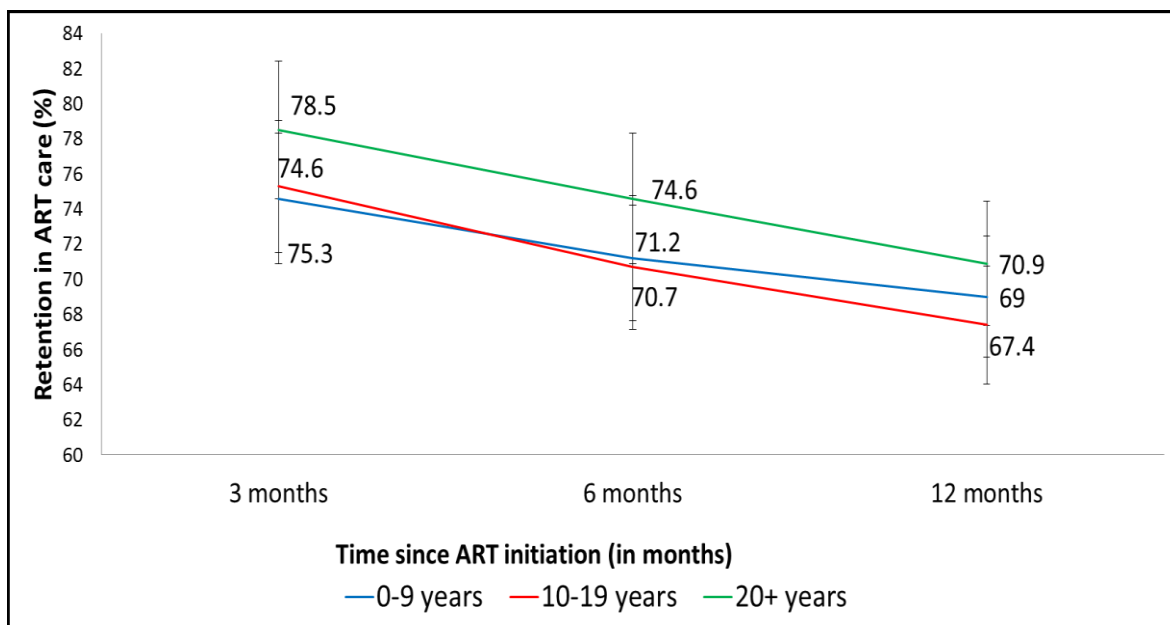
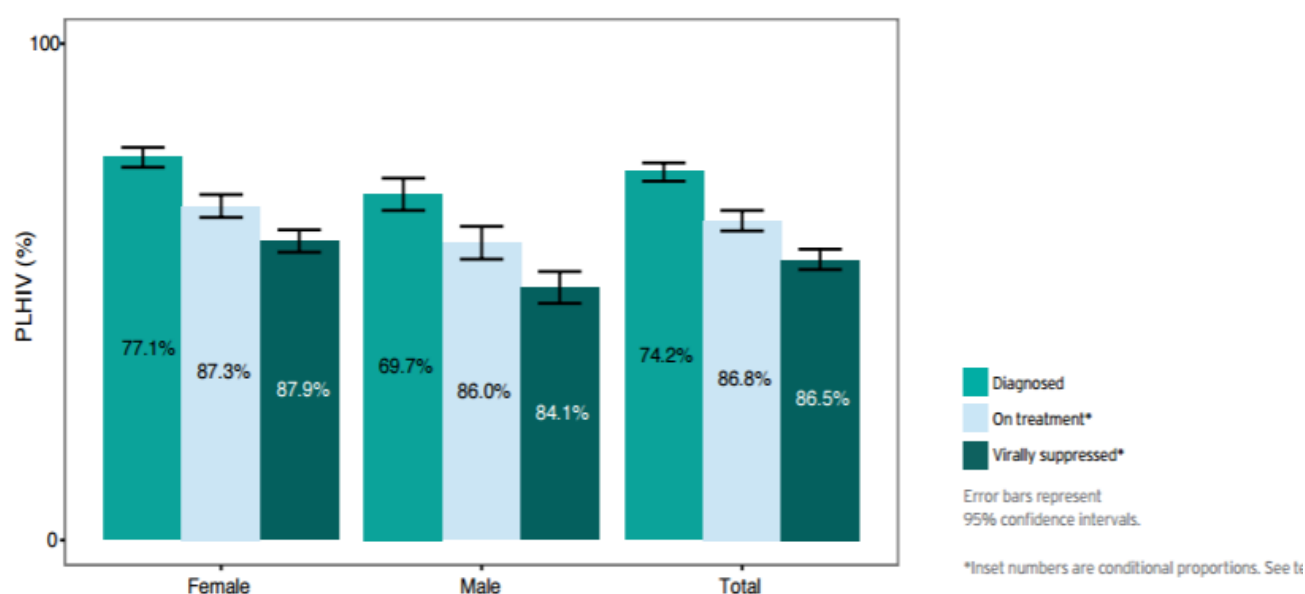
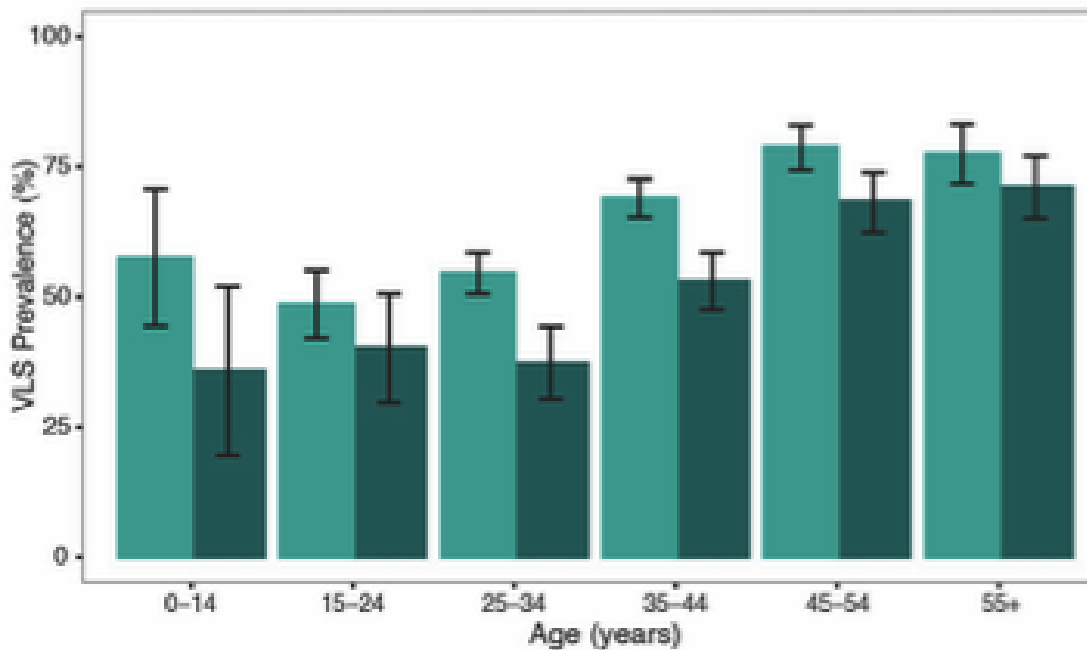


Figure 30: ART retention among adolescents & young people

5.I.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%.





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	Innovative supporting mechanisms to integrate TB/HIV services to maximize impact Facilitate co-location of TB and HIV services to support one stop service delivery
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
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	Procurement of TB and preventive medicines, laboratory

medicines (INH/CPT) and laboratory reagents including Gene Xpert cartridges	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
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 t ypes 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

6.0 Strategic Direction 3:

Resilient Sustainable Systems for Health (RSSH)

6.I 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

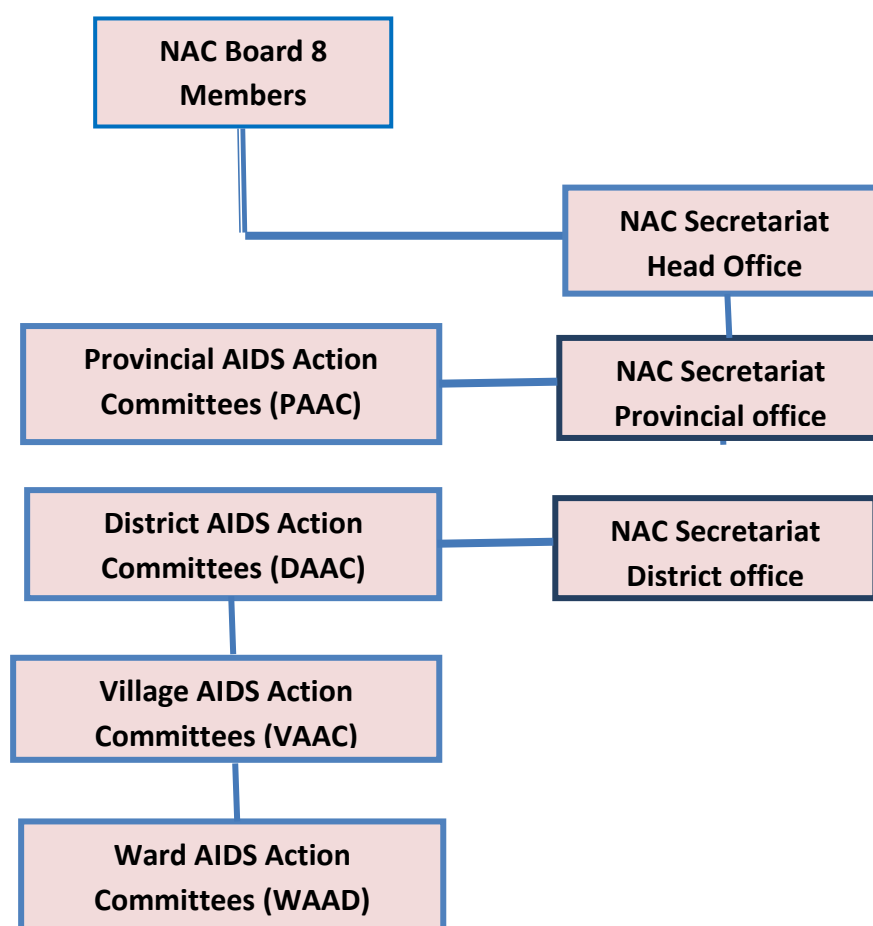
The institutions and structures are briefly highlighted below.

6.I.I 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.

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.

6.1.2 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

6.1.3 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
- 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

6.2 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	<p>Improve, broaden and sustain staff retention allowances</p> <p>Broaden performance-based financing for HRH</p>
Inadequate resources	Innovative strategies in resource mobilization
Lack of baseline data	Evidence based staff needs in line with disease burden and catchment populations
Inadequate staff capacity for integrated service delivery	<p>Capacitate, mentor and monitor staff</p> <p>Strengthen task shifting to enable health providers to provide comprehensive care</p>
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	<p>Identify bottlenecks to referral system and feed-back between health facilities</p> <p>Strengthen and monitor referral and feedback systems between health facilities and community health workers</p>
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
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	
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

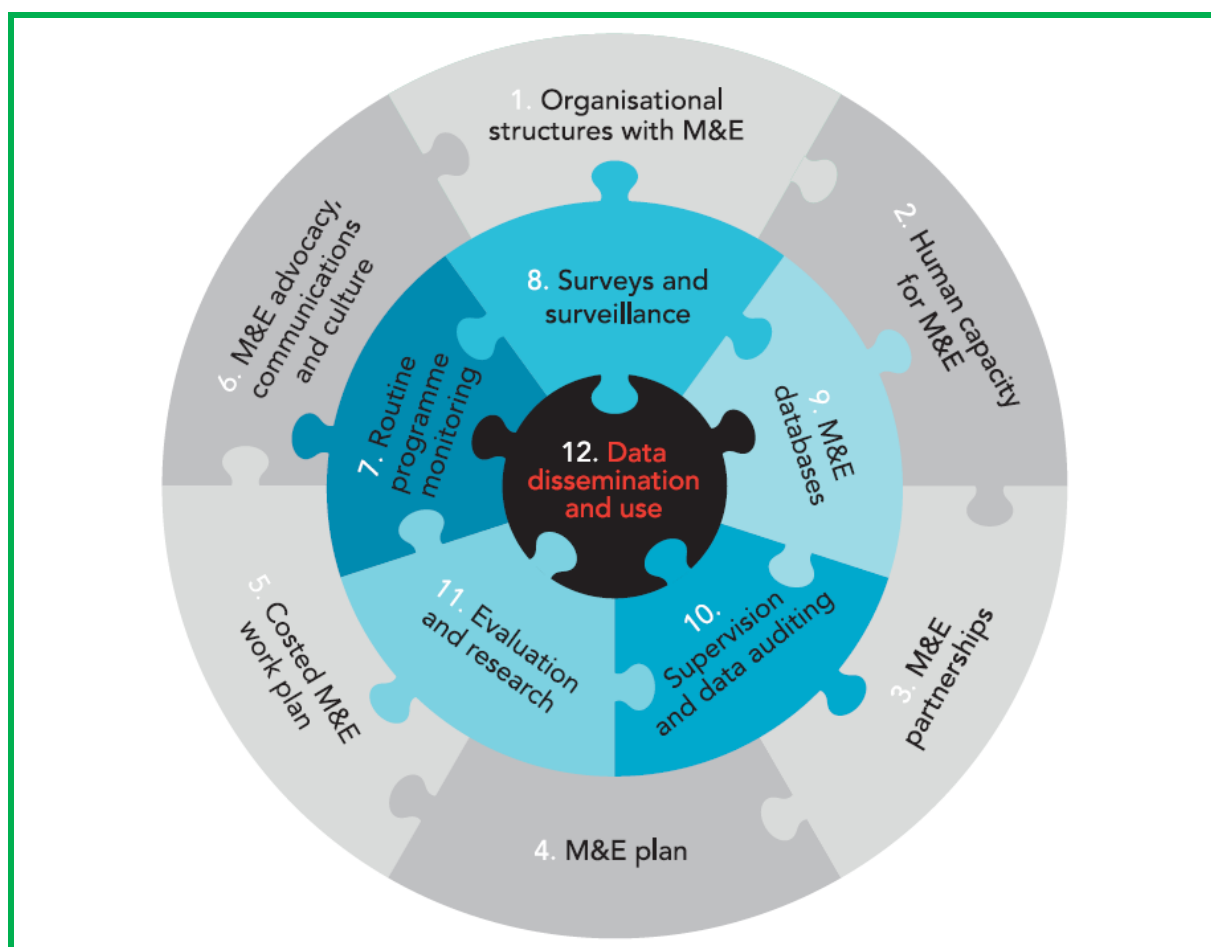
Outputs	Core Strategies
Improved capacity of communities to adequately and effectively contribute to the response	Strategic inclusion of CSOs in the response
Proportion of CSOs with improved governance	Capacitate and strengthen CSOs governance structures and accountability
Improved CSO in data collection 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’ “12 Component Framework for Developing a Functional National M&E 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 Strengthen support for data quality for the DHIS II
Lack of nationally recognised unique patient identifier.	Strengthen data management
Weak patient level information system in the coordination of these systems	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.	Strengthen data capture across all target groups in the response

Outputs	Core Strategies
Improved capacity of M&E units with qualified staff	Increasing staff establishment across all critical professional grades within M&E
Improved linkage between health information (data generation point) and the directorate of	Strengthen linkages between health information (data generation point) and the directorate of

M&E in the Ministry	M&E in the Ministry
Proportion of facilities reporting to a centralised data collection points	Strengthen and capacitate nationwide data collection
Lack of nationally recognised unique patient identifier.	Strengthen patient data management
Weak patient level information system in the coordination of these systems	Strengthen patient level information system in the coordination of these systems

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.	Improve paper based patient record supports quality and continuity of health records
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	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

6.5 Cross Cutting Issues

6.5.1 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

6.5.1.1 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 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.

6.5.2.1 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

6.5.2.2 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.

6.5.3 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.

5.3.3.1 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.

6.5.3.2 Core Strategies

- Capacity building activities with Policy makers and community leaders
- Sensitization engagements with Policy makers and community leaders

6.5.4 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.

6.5.4.1 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