# ZIMBABWE
# NATIONAL HIV AND AIDS STRATEGIC PLAN
# (ZNASP)
# 2006-2010

National AIDS Council of Zimbabwe

Ministry of Health and Child Welfare

Joint United Nations Programme on HIV/AIDS

**July 2006**

National AIDS Council, Harare, Zimbabwe
ISBN: 0-7974-3201-9

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## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| ABC | Abstain, Be faithful, Condomise |
| AIDS | Acquired Immuno-Deficiency Syndrome |
| ANC | Ante-Natal Care |
| ART | Antiretroviral Treatment |
| ARVs | Antiretrovirals |
| ASOs | AIDS Service Organizations |
| BC | Behaviour Change |
| BEAM | Basic Education Assistant Module |
| BFHI | Baby Friendly Hospital Initiative |
| CBD | Community Based Distributor |
| CBO | Community Based Organization |
| CCM | Country Coordinating Mechanism |
| CHBC | Community Home-based Care |
| CRIS | Country Response Information System |
| CSO | Central Statistical Office |
| CSWs | Commercial Sex Workers |
| C&T | Counselling and Testing |
| CTX | Cotrimoxazole |
| CZI | Confederation of Zimbabwe Industries |
| DAAC | District AIDS Action Committee |
| DCT | Data Collection Tool |
| EMCOZ | Employers Confederation of Zimbabwe |
| FBO | Faith Based Organization |
| FP | Family Planning |
| GBV | Gender Based Violence |
| GFATM | The Global Fund to fight AIDS, Tuberculosis and Malaria |
| HBC | Home-based Care |
| HIV | Human Immunodeficiency Virus |
| ICASA | International Conference on AIDS and Sexually Transmitted Infections in Africa |
| IDU | Injecting Drug Users |
| IEC | Information, Education & Communication |
| ILO | International Labour Organization |
| M&E | Monitoring and Evaluation |
| MCH | Maternal and Child Health |
| MDGs | Millennium Development Goals |
| MIPA | Meaningful Involvement of People living with HIV and AIDS |
| MNCH | Maternal Neonatal and Child Health |
| MoESC | Ministry of Education, Sport and Culture |
| MoHCW | Ministry of Health and Child Welfare |
| MoPSLSW | Ministry of Public Service, Labour and Social Welfare |
| MSM | Men who have Sex with Men |
| MTP1 | First Medium Term Plan |
| MTP2 | Second Medium Term Plan |
| NAC | National AIDS Council |
| NACP | National AIDS Control Programme |
| NAP | National ART Programme |

| | |
|---|---|
| NATF | National AIDS Trust Fund |
| NBTS | National Blood Transfusion Service |
| NGO | Non Governmental Organization |
| NPA | National Plan of Action |
| NPA-OVC | National Plan of Action for Orphans and Other Vulnerable Children |
| NPF | National Partnership Forum |
| NSF | National Strategic Framework |
| OI | Opportunistic Infections |
| OVC | Orphans and Other Vulnerable Children |
| PAAC | Provincial AIDS Action Committee |
| PCCs | Primary Care Counsellors |
| PEP | Post Exposure Prophylaxis |
| PER | Public Expenditure Review |
| PLWHA | People Living With HIV and AIDS |
| PMTCT | Prevention of Mother To Child Transmission |
| PSI | Population Services International |
| SADC | Southern African Development Council |
| SRH | Sexual and Reproductive Health |
| STD | Sexually Transmitted Disease |
| STIs | Sexually Transmitted Infections |
| STP | Short Term Plan |
| TB | Tuberculosis |
| TBAs | Traditional Birth Attendants |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Programme |
| UNGASS | United Nations General Assembly Special Session on HIV/AIDS |
| UNICEF | United Nations Children's Fund |
| UNFPA | United Nations Population Fund |
| VAAC | Village AIDS Action Committee |
| VCT | Voluntary Counselling and Testing |
| WAAC | Ward AIDS Action Committee |
| WASN | Women and AIDS Support Network |
| YAS | Young Adult Survey |
| ZAN | Zimbabwe AIDS Network |
| ZBCA | Zimbabwe Business Council on AIDS |
| ZCTU | Zimbabwe Congress of Trade Unions |
| ZDHS | Zimbabwe Demographic Health Survey |
| ZNASOP | Zimbabwe National HIV and AIDS Strategic Operational Plan |
| ZNASP | Zimbabwe National HIV and AIDS Strategic Plan |
| ZNFPC | Zimbabwe National Family Planning Council |
| ZNHIF | Zimbabwe National Health Indicator Framework |
| ZNNP+ | Zimbabwe National Network of People Living with HIV |
| ZUNDAF | Zimbabwe United Nations Development Assistance Framework |

## FOREWORD

It is now two decades since the first AIDS case was reported in Zimbabwe. Southern Africa remains the epicentre of the global HIV epidemic. I am heartened by the fact that Zimbabwe is the first in our region to have recorded a decline in HIV prevalence from 26.0% to 18.1% during the past 5 years. My government, through the National AIDS Council with the support of local and international organizations, has managed to sustain efforts to fight and mitigate the impact of HIV and AIDS. Our decentralized NAC structures provide a foundation upon which as a country we can build. Let me however reiterate that at 18.1%, our HIV prevalence is still unacceptably very high and therefore we need to redouble our efforts to reduce it further to single digits by the turn of the decade.

The Zimbabwe HIV and AIDS Strategic Framework of 2000-2005 and The HIV and AIDS Policy of 1999 have guided us in the implementation of HIV and AIDS programs over the past years. A review of both tools has shown that there are new emerging issues, which need to be taken on board in the fight against HIV and AIDS. Our commitments to international and regional goals such as The Millennium Development Goals, the UNGASS declaration of 2006 and the Brazzaville Declaration of 2006 call for us to put in place measures to ensure that we attain the MDG goals in a sustainable manner. As we move towards **Universal Access** to HIV prevention, care and treatment, we must ensure accessibility and affordability of HIV and AIDS services to the majority of community members. While I acknowledge that knowledge levels in relation to HIV are now very high, it has to be noted that awareness does not necessarily translate to behaviour change. Our focus should therefore be behaviour change at individual, family and community levels.

We need to take note of the emerging challenges posed by the rising number of orphans and vulnerable children in our country. My government has put in place the National Plan of Action for Orphans and Vulnerable Children as our commitment to mitigate the impact of HIV and AIDS on children and other vulnerable members of the society.

As we enter a new policy dispensation guided by the Zimbabwe National HIV and AIDS Strategic Plan 2006-2010, it is necessary to focus on specific measurable and achievable set targets in line with regional and international principles that we ascribe to. The new framework calls for commitment both at policy and at operational levels to ensure that everyone has a role to play in the fight against HIV and AIDS.

We have already adopted a multi-sectoral approach to fighting HIV and AIDS to ensuring that all sectors play a synergistic role in the fight against the pandemic. In this regard, we will remain guided by the **Three Ones initiative.** The National AIDS Council as the only coordinating body in Zimbabwe will continue to give guidance to the nation in the implementation of the Zimbabwe National HIV and AIDS Plan 2006-2010.

This strategic plan is our road map that the country has adopted in the fight against AIDS over the next 5 years and will guide us to meet the set targets.

Let me recognize the contribution of International Partners, NGOs, Faith Based Organisations, Traditional Leaders and the community in the spirit of oneness that we have shown over the past decades. I hope the spirit of cooperation that exists will take us through as we implement this plan so that by the turn of the decade, Zimbabwe will have further success to reflect upon. In line with the theme of ZNASP, let us turn our commitments into action.

**R.G. MUGABE**
**PRESIDENT OF THE REPUBLIC OF ZIMBABWE**

## ACKNOWLEDGEMENTS


The development of the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) covering the period 2006-2010 involved the participation of stakeholders at different stages of the consultative process, following recommendations made at the first national HIV and AIDS Conference in June 2004 that the old strategic framework be reviewed and a new framework be developed.

The first stage was the review of:

- *National HIV/AIDS Strategic Framework* (2000-2004).
- Current policies and strategies, including the *National HIV/AIDS Policy* (1999).
- Behaviour change situation analysis and response analysis.
- HIV and AIDS epidemiology in Zimbabwe.

The second stage was the Stakeholders' Strategic Planning Consultative Seminar conducted in Kadoma over the period 10-11 November 2005. A draft of the ZNASP was circulated to stakeholders in December 2005 and also at the consultative meeting to prepare the country report on universal access to HIV and AIDS prevention, treatment, care and support 2010 held in Harare on 7 February 2006. Comments on the draft were received from many stakeholders and these were taken into account in the preparation of this document. The revised draft was further circulated to members of the Partnership Forum at their meeting on 4 April 2006. Comments from the members were also incorporated into this document.

The theme of the ZNASP is: **From Commitment to Action.** This theme reflects the thrust of both the Government of Zimbabwe and all stakeholders in the national multi-sectoral fight against HIV and AIDS, that while commitment is important, the HIV and AIDS situation in the country calls for concerted, coordinated action.

The following stakeholders who all played important roles in the process leading to the realization of the ZNASP are warmly acknowledged:

- Non Governmental Organizations (NGOs), civil society, Faith Based Organizations (FBOs), Community Based Organizations (CBOs), People Living With HIV and AIDS (PLWHA), the private sector, and institutions of higher learning are acknowledged for, among other contributions, ideas, inputs they made from the vantage point of their wide-ranging experiences and practice in the area of HIV and AIDS, and working with communities.

- Government Ministries, Local Authorities and the National AIDS Council (NAC) structures for bringing into the process, among other contributions, awareness of strengths, constraints and gaps in the national response.

- Development partners for their support, resource provision and participation in the process that led to the production of the ZNASP.

- Researchers and consultants who prepared working documents and analyses that helped stakeholders focus on key issues at various stages of the strategic planning process.

- Our neighbours in Southern and Eastern Africa who shared views, ideas and their policy and strategic frameworks with us, and from whom we have borrowed some ideas in the compilation of the ZNASP. We acknowledge in particular Kenya and Malawi in this respect.

# SECTION ONE
## INTRODUCTION

### 1.1 BACKGROUND

Southern Africa, of which Zimbabwe is a part, is the epicentre of the HIV and AIDS epidemic, with countries of the region registering the highest HIV and AIDS prevalence rates in the world. According to UNAIDS (2005), an estimated 11.4 million people are living with HIV in nine countries of Southern Africa including Zimbabwe. This is almost 30% of the global number of people living with HIV in an area where only 2% of the world's population resides.

In response, Zimbabwe is implementing a comprehensive multi-sectoral response to HIV and AIDS. The Government declared HIV and AIDS a national emergency in 2002. The overall HIV prevalence in Zimbabwe's adult population has decreased from an estimated 24.6% in 2003 to an estimated 20.1% in 2005 of the adult population (ages 15-49). Nonetheless the declaration of a national emergency remains equally valid today. Through successive initiatives and time-bound plans from 1987 to the present (following the reporting of the first HIV and AIDS case in Zimbabwe in 1985), the Government has put in place a multi-sectoral response coordinated by the National AIDS Council (National AIDS Council Act 1999). The response must be urgently intensified to sustain this decline, and to address the sharply rising impacts of increasing AIDS-related OVC, and morbidity and mortality in all economic and population sectors.

At a stakeholder consultative meeting conducted over the period 10-11 December 2005 as part of the process that produced this Strategic Plan, stakeholders agreed that notwithstanding the declining prevalence rate, the prevalence rate was still much too high. Zimbabwe still faces enormous challenges in the fight against HIV and AIDS in all the key programme areas of prevention, care and treatment and mitigation. The majority of Zimbabweans do not know their status. Only 7% of those in need of treatment are able to access treatment and only about 20-30% orphans and vulnerable children receive some form of assistance. About 3,000 people are dying every week in Zimbabwe as a result of HIV and AIDS.

Many sections of the ZNASP therefore call for improving and scaling up specific programmes to meet the growing demand for services, while at the same time calling for an intensification of efforts to attain normative and behaviour change.

### 1.2 ZIMBABWE'S COMMITMENT TO THE "THREE ONES"

Zimbabwe is committed to the "Three Ones" principle which originated from a series of meetings between countries, donors and UN agencies, facilitated by UNAIDS, and discussed at ICASA (Nairobi, September 2003).

The "Three Ones" are:

- one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners;
- one national AIDS coordinating authority with a broad-based multi-sectoral mandate; and
- one agreed country-level monitoring and evaluation system.

Zimbabwe has already made significant efforts to strengthen adherence to these principles. NAC as the coordinating body is being strengthened, and this framework calls for further strategies to continue this strengthening. A national M&E framework has been launched; it needs operationalization and linkage to the national surveillance system and research.

The Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2006-2010 set out in this document constitutes the "one agreed HIV/AIDS action framework" specified in the "Three Ones."

**TABLE 1: KEY FEATURES OF THE "ONE AGREED HIV/AIDS ACTION FRAMEWORK"**

An agreed upon national HIV/AIDS Action Framework is a basic element for coordination across partnerships and funding mechanisms, and for the effective functioning of a National AIDS Coordinating Authority. Such a framework calls for:

- **Priorities:** Clear priorities for resource allocation and accountability, making it possible to link priorities, resource flows and outcomes/results.
- **Reviews and consultation:** Systems for regular joint reviews and consultation on progress that include all partners.
- **Commitment to consult and coordinate:** All stakeholders to commit themselves to coordinate within the Action Framework consistent with their own mandates.
- **Linkages:** Recognising the connections between the HIV/AIDS Action Framework and poverty-reduction and development frameworks, as well as associated partnership arrangements.
- **Managing the public/private partnership in service delivery:** Affirming and optimising the growing drive to engage civil society organisations and the private sector in service delivery.

## 1.3 THE PURPOSE OF THE ZNASP

The ZNASP is the policy and strategic framework that both operationalizes the "Three Ones" principle and provides the national framework for all HIV and AIDS interventions in Zimbabwe implemented by all stakeholders; Government, civil society, the private sector and development partners.

The ZNASP is not intended to replace or duplicate sectoral HIV and AIDS strategies, nor does it include detailed operational or implementation plans attributable to any one sector, or detailed budgets for specific interventions. Rather, the ZNASP provides the framework and context within which sectoral and other strategic plans and budgets should be formulated, monitored and coordinated.

In more specific terms, the purpose of ZNASP 2006-2010 is to:

- Articulate the shared sense of direction and targets for the national response over the period 2006-2010; and
- Provide the basis for advocacy, resource mobilization and programming during this period, in particular the elaboration of operational plans.

## 1.4 TIME PERIOD FOR THE ZNASP

The ZNASP covers the five-year period 1 January 2006 to 31 December 2010. Implementation of many of the ZNASP's provisions is already underway pending the formal launching of the Plan in August, 2006.

Annual reviews will be conducted and an Annual Operational Plan will be produced at each review. The ZNASP Operational Plan (ZNASOP) for January-December 2007 will be produced before December 2006. The ZNASOP will provide in more specific and greater detail frameworks for the operationalization of the ZNASP by various stakeholders, including strategies, responsibility, interim targets and resource allocations.

A mid-term review is planned at the beginning of 2008, following which official modifications and amendments will be made, as necessary.

## 1.5 STRATEGIC PLANNING PROCESS

The need to review the old framework and start developing a new framework was first widely discussed at the First National HIV Conference in June 2004.

The process that then led to the development of the strategic plan included four major steps: the review of the framework and of existing policies; a stakeholder consultation to supplement and refine these reviews, resulting in a series of recommendations; the drafting of the plan, and its finalization following further consultations.

The first step consisted of four sub-reviews carried out by consultants under the leadership of NAC throughout 2005: a comprehensive review of epidemiological and behavioural data and trends, a review of behavioural change and behavioural change approaches, a review of the national policy of 1999 and of sector and topic-specific policies developed since then, and the review of the framework itself. Their findings were presented and discussed at three national partnership forums.

These reviews were supplemented at a stakeholder meeting on 10-11 November 2005, with information from programme areas in which reviews, evaluations and planning processes had already taken place previously, including Prevention of Mother To Child Transmission (PMTCT), Antiretroviral Treatment (ART) and Orphans and Other Vulnerable Children (OVC). The national conference recommendations and NGO and PLWHA perspectives were also presented and discussed at that meeting.

The key recommendations from the stakeholder meeting report, the various presentations and the four original reviews were then consolidated into one document that served to guide the drafting team. One key finding was that both the framework and the policy had been unwieldy and the two documents easily confused, resulting in a recommendation to combine, for the coming years, the strategic framework and key policies into one, simpler document.

The writing team, consisting mainly of NAC and UNAIDS staff and an Organizational Development Consultant, met on 24 and 25 November 2005 to produce the first draft of the new strategic plan. After further consultations with key stakeholders over the following six months, the ZNASP was modified and officially launched.

## 1.6 OUTLINE OF THE ZNASP

The ZNASP 2006-2010 is divided into 5 sections:

Section 1 provides the background to the ZNASP and describes the strategic planning process that gave birth to the national strategy.

Section 2 describes the HIV and AIDS situation in Zimbabwe, the national response and the challenges.

Section 3 outlines the eight guiding principles that underpin the ZNASP.

Section 4 describes the four agreed strategies for the National Response in the next five years.

Section 5 lays a framework for Monitoring and Evaluation of various aspects of the National Response, including programming.

The last part of the ZNASP describes the two annexes that will be attached to the ZNASP once they have been developed and agreed on: Annex 1: The ZNASP Operational Plan (ZNASOP) for 2007; Annex 2: Costing of the ZNASOP 2007.

# SECTION TWO

## HIV AND AIDS IN ZIMBABWE SITUATION AND RESPONSE ANALYSIS

### 2.1 EPIDEMIOLOGICAL SITUATION

An estimated 1,610,000 (2005 National Estimates) Zimbabweans out of a population of 11.6 million are living with HIV and AIDS. 115,000 of them are children under the age of 15. Although Zimbabwe is the first Southern African country to record a significant drop in the HIV and AIDS prevalence rate in the adult age group (15-49) (from 24.6% in 2003 to 20.1% in 2005), attributed to, among other possible reasons, change in sexual behaviour, the rate was described at a stakeholders' consultative meeting in November 2005 as "still unacceptably high."

**TABLE 2: NATIONAL HIV AND AIDS ESTIMATES FOR ZIMBABWE IN 2005**

| | New HIV infection | New AIDS cases | Number living with HIV and AIDS | Number of deaths |
|---|---|---|---|---|
| **Adults (15-49)** | 135,000 | 142,000 | 1 390,000 | 140,000 |
| **Women (15-49)** | 78,000 | 82,000 | 780,000 | 81,000 |
| **Children (0-14)** | 27,000 | 29,000 | 115,000 | 29,000 |

**Source: National HIV Estimates, MOHCW 2005 And Zimbabwe National HIV Estimates, 2005**

The main mode of HIV transmission in Zimbabwe is heterosexual contact (heterosexual contact 92%, perinatal transmission 7%, and others 1%). The emphasis must therefore be on prevention of sexual transmission and PMTCT. However, blood safety and safe sharps in under-equipped rural medical settings continue to be essential and controls must be maintained and strengthened respectively.

Fifty-five percent (55%) of those known to be infected by the virus are women. Of the estimated 135,000 new adult (15-49 years) HIV infections during 2005, 58% (78,000), were in women (MoHCW 2005). Young women aged 15-29 years are the most vulnerable to HIV infection. It is estimated, for instance, that the ratio of young women (15-24 years) living with HIV to young men (15-24 years) living with HIV is three times higher. The Young Adult Survey (YAS) 2001-2002 found that overall 18% of youth (15-24) were HIV positive.

Women and girls are particularly vulnerable for a variety of reasons. They may be compromised in their ability to ward off unwanted sexual attention or negotiate safe sex. Increasing levels of poverty lead some women into casual or commercial sex work, while male norms allow for multiple and concurrent sexual partnerships, including casual and commercial sex.

Recent studies have highlighted the high vulnerability of married women to HIV infection. A review of behavioural change approaches revealed that marriage alone is not a protective factor, as extra-marital relationships are frequent, couple communication difficult and the disclosure of one's HIV status is irregular. In addition condom use in marriage and with regular partners is low.

Other biological, behavioural and cultural risk factors include inconsistent condom use in non-regular partnerships, a high prevalence of untreated, in particular, viral STIs, and practices such as widow inheritance, girl-pledging and dry sex.

Gender inequality is therefore noted as one of the key determinants of vulnerability to HIV infection.

HIV prevalence surveys have also shown the very high levels of infections in border areas, growth points, mining towns and commercial farms (ANC survey, 2003), suggesting mobility and spousal separation are major vulnerability factors.

Furthermore, several recent studies have shown that girls who have lost their mother are significantly more likely to become infected with HIV than their non-orphaned peers. Previous studies had shown that school enrolment is a protective factor, and orphans are more affected by school drop-outs.

Additional new and population-based data on HIV prevalence and sexual behaviour will become available before the end of 2006 from the nationally representative Zimbabwe Demographic and Health Survey (ZDHS) 2005-2006.

The epidemic has resulted in a sharp increase in the burden of disease. About 340,000 of the 1.6 million living with the virus need Antiretrovirals (ARVs).

In 2003, United Nations Children's Fund (UNICEF) estimated that the number of orphans were 1.3 million (about 19% of the child population), about 1 million of them orphaned by AIDS. Recent national and sub-national surveys suggest that the number of orphans may even be higher. In 2004, a joint Ministry of Public Service, Labour and Social Welfare (MoPSLSW) and UNICEF OVC Survey 2004 found that 30% of the child population in rural and urban high density Zimbabwe were orphans.

The HIV and AIDS epidemic has impacted strongly not only on families and communities, but also on commerce, industry, education and health services indeed, on all economic and population sectors through increasing AIDS-related morbidity and mortality. Life expectancy has been significantly reduced. Since 1990, mortality amongst under five-year olds has increased from 80 to 129 per 1,000 live births, largely due to AIDS (UNICEF Global Estimate).

Over 70% of admissions to medical wards in Zimbabwe's major hospitals are patients with HIV and AIDS-related opportunistic infections such as TB and other pneumonias (MoHCW 2005). The capacity of the health delivery system, in the face of limited financial and human resources, has been severely strained.

The loss of many small-scale and subsistence farmers to AIDS and the high level of AIDS-related morbidity across all productive sectors have contributed to reduced food security at household level and to lower productivity overall. In industry, high levels of sickness-related absenteeism have been reported. Some sectors, such as Education have embarked on specific studies to

determine the impact on their employees, services and constituencies. With the assistance of the International Labour Organisation (ILO), the transport sector has developed an HIV and AIDS policy. A study which will lead to the development of the Zimbabwe Private Sector HIV/AIDS Policy is already underway. Assisted by the ILO, employer organizations such as Confederation of Zimbabwe Industries (CZI), Employers Confederation of Zimbabwe (EMCOZ), and Zimbabwe Business Council on AIDS (ZBCA), trade unions, the Zimbabwe Congress of Trade Unions (ZCTU) and other stakeholders hope to highlight the impact of HIV and AIDS on the world of work and agree on strategies to combat it. The ZNASP strongly encourages such initiatives.

Furthermore, there is a real potential for a long-term reduction in human capital in Zimbabwe if many children are poorly nourished, poorly socialized, and uneducated because of poverty.

## 2.2 THE NATIONAL RESPONSE 1985-2005

### STRATEGIC PLANS AND COORDINATION

In 1985, after the first HIV and AIDS case in Zimbabwe was reported, the Ministry of Health through the National Blood Transfusion Services (NBTS) intensified the screening of donated blood and blood products. In 1987 the National AIDS Control Programme (NACP) was established in the Ministry of Health. A one-year Emergency Short-Term Plan (STP) was formulated to create public awareness of HIV and AIDS. Health personnel were trained in the different aspects of HIV and AIDS interventions to include promotion of appropriate behaviour change among targeted population groups, counselling and caring for people living with HIV and AIDS, surveillance and monitoring the epidemic through epidemiological surveillance. The First Medium Term Plan (MTP1) was launched in 1989 and remained operational until 1994. The MTP1 focused on expanding interventions to promote behaviour change, prevention and treatment of Sexually Transmitted Disease (STD), Care and Support for PLWHA. In 1994, the five-year Second Medium Term Plan (MTP2) was developed to focus on mobilization of non-health sectors to integrate HIV and AIDS issues.

From 1997-1999, the Government of Zimbabwe embarked on a broad-based and multi-level consultative process to develop the National AIDS Policy (1999). To operationalize the National HIV/AIDS Policy, the National HIV/AIDS Strategic Framework (2000-2004) was developed and launched in 2000.

In 1999, Zimbabwe introduced the National AIDS Trust Fund (NATF), commonly referred to as the AIDS levy, which was collected from a 3% tax on all taxable income. Its main purpose is to support HIV prevention efforts and care for those with AIDS. The funds are managed by NAC, which was created through an Act of Parliament in 1999 and started operating in 2000. The Zimbabwe NATF is considered an innovative approach to mobilizing funds in Southern Africa.

NAC has the mandate to coordinate the national HIV and AIDS response. Over the past five years, it has become fully established throughout the country, guided by a multi-sectoral board composed of 13 members, including PLWHA. Provincial, district, ward and village AIDS Action Committees exist, with each of the different levels intended to replicate the multi-sectoral composition and approach of the Board.

These national structures are supported by the NAC secretariat in Harare as well as decentralized structures, with full-time NAC staff, at provincial and district levels.

NAC's partners in the multisectoral response initiative for HIV and AIDS include government sector ministries, local authorities, civil society, CBOs, FBOs, UN and donor agencies. Several Government ministries, including Transport and Mines, and the Public Service Commission have already elaborated their own HIV policies. NAC's role is to provide leadership and coordinate partner responses and initiatives in the response to HIV and AIDS.

Government's declaration of HIV/AIDS as a national emergency in 2003 assisted in the importation of generic drugs into the country. The HIV/AIDS state of national emergency has been extended to December 2008.

Zimbabwe has made progress in establishing a strategic and policy environment for the fight against HIV. However, there are still some gaps, which are described in Section 2.3.

The establishment of ZNNP+ and groups affiliated to it marked great progress in the fight against HIV and AIDS on the national level, as was the establishment of a Meaningful Involvement of People living with HIV and AIDS (MIPA) position at NAC in 2004. The ZNASP stresses the importance of involving PLWHA as implementers and beneficiaries of programmes at all levels, especially in the strategic programme areas of prevention, treatment, care and support.

**PREVENTION OF NEW INFECTIONS**

Zimbabwe has made big strides in prevention, evidenced by the fact that HIV prevalence has started declining. Indeed, prevention has constituted the cornerstone of the national response so far. HIV awareness is high, and behavioural change has started. Several studies have shown that the number of sexual partners among men and women has reduced and that condom use with non-regular partners has increased. Condom distribution, marketing and consumption have steadily expanded since the 1990s, and are the highest in the region, adjusted to size of the population. More than 85 million male condoms were freely distributed and/or sold in 2004, 37 million within the public sector, and 48 million in the social marketing sector. Furthermore, 353 600 female condoms were distributed (ZNFPC 2004) and 750,000 female condoms were sold (PSI 2004) in various outlets such as liquor stores, hair salons, supermarkets and service stations.

In recent years, Zimbabwe has placed emphasis on the maintenance and adoption of safe behaviours among young people. A number of Adolescent Sexual and Reproductive Health programmes have been developed, including community based, peer education, health institutions based (e.g., youth friendly services) and school based-programmes such as Anti-AIDS clubs. These clubs encourage young people to delay sexual relations until marriage. The country's 13 Teachers' and 11 Technical Training Colleges have each either a full time coordinator or a team of trained lecturers to teach the life skills based HIV/AIDS Education Programme in schools which all trainee teachers are required to take as part of their training since 1994.

Major radio and TV programmes have also addressed issues related to HIV prevention. Billboards and posters have been displayed and small print media disseminated to maintain knowledge and awareness.

By the end of 2005, Zimbabwe had 27 stand alone Voluntary Counselling and Testing (VCT) sites mainly in the urban areas, 389 testing and counselling integrated sites in health institutions, mainly rural areas, and some mobile outreach services for the hard-to-reach populations. VCT uptake has increased, reaching nearly 288,000 adults (15-49) in 2004.

In the PMTCT programme, the total number of PMTCT sites has increased from 205 in 2003 and 800 in 2004 to 1369 in 2005, covering many parts of the country.

All blood for transfusion is screened for HIV: this has been the case since 1985 (NBTS 2005). Zimbabwe has one of the earliest and best Sexually Transmitted Infections (STI) control programmes in Africa.

**TREATMENT**

AIDS treatment, including treatment of Opportunistic Infections (OI) and Antiretroviral Treatment (ART) is coordinated by the Ministry of Health and Child Welfare (MoHCW). There have been great strides made in the treatment of OIs. Policies and Protocols for OI management were developed in 2003 and continue to be updated. OI clinical services have been established for both adults and children at national, provincial and district hospitals.

The national ART roll-out plan was launched in April 2004. National guidelines were developed the same year and treatment providers trained. Potential treatment sites were assessed, and by the end of 2005, altogether more than 40 ART sites have been registered and are delivering ART services in Zimbabwe, including the various public sector OI clinics. Procurement and logistics systems are being strengthened.

By the end of 2005, about 25,000 Zimbabweans were receiving ART (about 7% of those in need), including an estimated 6,000 in the private sector.

**CARE AND SUPPORT**

In 2004, the MoHCW launched the *National Home-Based Care Standards*, a critical development to harmonize various training initiatives carried out throughout the country by NGOs. In addition, a Home-based Care (HBC) focal point has been newly appointed in NAC to enhance coordination of HBC activities country-wide. A mapping of the large number of HBC programmes, mostly implemented by NGOs and CBOs, and their coverage country- wide is underway.

Mitigation programmes include programmes to support OVCs with a minimum package of services, and food aid, nutritional support and other assistance to vulnerable households and communities, including women- and child-headed households and those with chronically sick family members.

The launch of the National Plan of Action for Orphans and Other Vulnerable Children (NPA - OVC) by the Vice President in 2005 was a significant milestone with regards to mitigating against the impact of HIV in Zimbabwe. Spearheaded by the Ministry of Public Service, Labour and Social Welfare (MoPSLSW), the NPA aims to reach 25% of OVC through various interventions, including educational, medical, legal and psychosocial assistance by partners in the multisectoral response.

## 2.3 CHALLENGES

While the national response to HIV has significantly expanded over the past years, it still faces a number of challenges which the ZNASP 2006-2010 will need to address.

With regards to **prevention,** the various reviews conducted in 2005 showed that many infections actually occur among married adults, which behavioural change strategies have not sufficiently addressed in the past. Neither has there been a sufficient focus on most-at-risk groups, including young people who are already sexually active, sex workers, orphans and mobile populations. Another gap identified was the need to address not only risk behaviors, but underlying factors of vulnerability such as harmful societal norms, gender inequality and poverty, mobility and stigma. Furthermore, prevention service coverage and uptake, e.g. of Counselling and Testing (C&T) and PMTCT, are not yet satisfactory, especially in rural areas.

For these reasons there is a need to strengthen and scale-up the full range of technological, behavioural, cultural and structural prevention approaches.

With regards to **treatment** the ART roll-out has been slower than hoped for. Originally, a target of 166,000 persons on treatment was identified, but with the 3 by 5 deadline passed, this target was reduced to 60,000. Ultimately and for a variety of reasons, even this reduced target could not be achieved. Only 25,000 persons or 7% of those in need were receiving treatment by the end of 2005. Some of the reasons why the availability of AIDS treatment has been hampered include a shortage of foreign currency to purchase commodities, including ARVs, OI treatments such as TB drugs and co-trimoxazole, and lab reagents, the high prices of ARVs in the private sector, a weakened infrastructure and a critical shortage of trained service providers to treat and follow up patients. Logistics and management systems also need to be strengthened.

Other gaps include paediatric ART, under-nutrition which impedes positive responses to treatment, and insufficient access to counselling and testing for HIV, especially in rural areas. Treatment of paediatric AIDS remains a challenge due to difficulties with early diagnosis, lack of trained staff to administer ART and insufficient paediatric formulations. During the period covered by the ZNASP, 2006-2010, efforts will be strengthened to address these underlying reasons for slow treatment expansion and to strengthen the policy dialogue around rapid scale up of treatment.

**Mitigating the impact** of the epidemic on individuals, households and communities has become increasingly important in recent years, with the number of individuals falling sick increasing, the economic crisis deepening and recurrent droughts threatening livelihoods, in particular of those affected by HIV. The impact of the epidemic will still be felt over many years to come, and therefore there is a need not only to care for OVC, but also to develop strategies for communities and sectors to better cope with the epidemic.

Only a minority of OVC have access to a minimum package of support at present.

While home-based care has been standardized to a large extent, the quality and reach of programmes remain uncertain. The use of volunteers and the level of their remuneration and

incentives for caregivers vary according to the funding organization, and will have to be harmonized. The issue of burnout among caregivers is a major challenge in the face of the enormity of the epidemic. The other major challenge is the shortage of home-based care kits and related supplies. The sustainability of the home-based care programmes needs to be evaluated.

Furthermore, existing mitigation strategies have been too narrow, focusing on the survival of certain categories of individuals and communities such as orphans and child-headed households, while neglecting the needs of other vulnerable population groups, and failing to comprehensively address the human capacity implications resulting from high AIDS morbidity and mortality in various sectors.

Impact mitigation should be extended to elderly caregivers, to the workplace, and in HIV and AIDS hard-hit sectors of the economy such as agriculture, health, education, and among mobile populations.

**Management, co-ordination, monitoring and evaluation** of the national response have improved in recent years, but are not yet satisfactory. In its coordination role, NAC is being strengthened, and coordination forums are now in place, but require a clearer mandate, with accountability of all stakeholders. Both public and non-public sector responses need strengthening. With regards to Government policies and programmes, as already stated earlier, some ministries such as Mines, Transport and the Public Service have HIV policies already in place, while Education and Agriculture are still in the process of developing theirs. The business response remains unsatisfactory in that while a business coalition has been created, many CEOs remain unengaged. Initiatives such as those being taken by the ILO and the business sector to develop a private sector HIV/ AIDS policy and strategy should be encouraged and supported. Civil society needs full support to play its role.

A national monitoring and evaluation system has been instituted at NAC, but is yet to become fully functional.

International donors and the NATF are the two major sources of funding in Zimbabwe. However, Zimbabwe is currently receiving much less international funding than its neighbours, while the AIDS levy is insufficient to cover the increasing financial resource needs, especially with regards to the ART roll-out. National consultations on universal access have resulted in calls for a significant increase in the allocation of both national public and private sector and international funding for the national HIV response, and for more aggressive efforts to attain this objective.

# SECTION THREE

## ZNASP GUIDING PRINCIPLES

Since the promulgation of the *National HIV/AIDS Policy* (1999) and the *National HIV/AIDS Framework* (2000-2004), the Zimbabwe national response has been based on a set of 43 guiding principles, which reflected the desired common values of all stakeholders in the national response.

The new *Zimbabwe National HIV and AIDS Strategic Plan* (2006-2010) consolidates and updates this set of core principles, focusing on pertinent issues of national importance, including HIV as an emergency, the need of all stakeholders to work together in a multi-sectoral response, addressing gender inequality and stigma, the need for adequate resources, Zimbabwe's commitment to international goals and the need to adopt effective and evidence-based strategies to fight the epidemic.

These principles will determine the priorities for and the design of interventions, and the approach to their implementation.

### 3.1 HIV AS AN EMERGENCY

The new strategic plan foresees the expansion of the principle of HIV as an emergency to reflect the Government's and all other stakeholders' full commitment to urgently mobilize all required financial, material and human resources to reduce the impact of the epidemic on Zimbabwean society and to further reduce the rate of new infections.

### 3.2 MULTI-SECTORAL APPROACH

Since the development of the first strategic framework there has been an increased recognition of the importance of a multi-sectoral response to HIV and AIDS. However, some sectors in Zimbabwe have yet to become fully engaged. As mentioned a number of sectoral strategies and policies have been developed while other strategy developments are still underway. Several existing sector policies have remained incomplete and do not address the increasing need for care, support, impact preparedness and mitigation.

This ZNASP will further guide strategic development in the various sectors and assist them to address any deficiencies and encourage the implementation of the policies and the elaboration of specific programmes.

In addition, this strategic plan specifically recognises the important role NGOs, FBOs, the private sector and PLWHA should play in the national response to the HIV and AIDS epidemic in the next five years.

### 3.3 GENDER

This principle provides a framework for integrating gender into the overall HIV and AIDS response, to ensure all prevention and advocacy strategies and programmes are gender sensitive in order to reduce vulnerability and risk.

The National Task Force on Women, Girls, HIV and AIDS has already developed a draft strategy that addresses six key issues, including prevention, equal access to treatment, girl's education, fighting gender-based violence, women's property and inheritance rights and gender equality in addressing the burden of care. The ZNASP embraces this work.

Some of the strategies will use a mainstreaming approach, so that girls' education and men's participation in HBC are fully considered within the education sector and the development and implementation of HBC strategies and policies respectively. Other areas will require a specific effort and the mobilization of extra resources, for example the fight against sexual abuse and the reinforcement of women's property and inheritance rights. The particular relationship between women's vulnerability to HIV transmission, pregnancy and the well being of newborns will require continuing research, policy formulation and service development.

### 3.4 MEANINGFUL INVOLVEMENT OF PEOPLE LIVING WITH HIV AND AIDS (MIPA)

The ZNASP intends to fully operationalize the principles of greater and meaningful involvement of people living with HIV and AIDS (MIPA) throughout all components of the strategy.

Various analyses of the situation have shown that stigma remains very high, persons openly and positively living with the virus are not yet fully represented in political and programme structures and committees, that the capacity of key PLWHA networks needs strengthening and PLWHA are still considered more as victims, or programme beneficiaries, than full partners in the national response.

People living openly and positively with HIV have enormous potential to contribute and drive the implementation of the ZNASP, particularly with regard to prevention messages and interventions, and socio-economic mitigation initiatives. Active engagement of PLWHA in strategic planning, implementation and M&E, or MIPA as it is becoming known, will be sought wherever possible.

### 3.5 VULNERABLE GROUPS

The previous framework highlighted the needs of specific groups at high risk, such as young people, sex workers, and prisoners. Recent reviews have further stressed the particular vulnerability of married women, orphans, the disabled and mobile populations.

Mobile populations in Zimbabwe include sex workers, cross-border traders, uniformed personnel (soldiers, police, game rangers, the militia, customs and immigration officials), truck drivers, the internally displaced and the farming community. The vulnerability and risk factors of mobile populations are caused by long periods of separation from regular partners and social settings, which may result in casual and commercial sex and/or irregular access to HIV prevention and care services.

Other groups that have been identified as particularly vulnerable to infection include the disabled (including the mentally challenged), prisoners, illegal immigrants, men who have sex with men (MSM), and survivors of rape and sexual abuse.

The ZNASP seeks to develop innovative strategies for these groups at high risk, focusing on their empowerment and inclusion in decision-making, the allocation of resources for programmes that address their specific needs, and community strategies, especially with regards to orphan support, ensuring the rights of married women, and prevention of transmission in marriage settings. The life skills education and HIV prevention and care components of the NPA for OVC will be strengthened.

Mobile populations will be reached through intensified programming in specific geographic areas, further mainstreaming of HIV in sectors such as mining, transport, construction, agriculture, uniformed services, informal cross-border trade and sex work.

In addition, research will be carried out and specific strategies will be developed for other groups at risk, which are not yet benefiting from any strategy or programme.

## 3.6 UNIVERSAL ACCESS

As already noted in the earlier sections of this strategy, current programmes and interventions fall short of universal access (only 7% of those in need of treatment are accessing treatment and only about 20-30% of orphans and vulnerable children are receiving any kind of assistance). Furthermore, particular vulnerable and hard-to-reach populations often remain excluded from these services. Children have largely been excluded from the ART roll-out programmes.

While full coverage with prevention, treatment, care and support during the planning period remains unrealistic, the ZNASP aims to scale up services to come as close as possible to universal access by all those in need, while allocating resources and designing programmes equitably according to a transparent and coordinated policy. Scaling up of services will therefore be in stages, gradually covering as many of those in need as possible. The principle of universal access will include deliberate targeting of the vulnerable groups to ensure equity, including gender equity. Monitoring and reporting during the lifetime of this strategy should reflect progress towards achieving equitable distribution of access to services by vulnerable groups.

## 3.7 EVIDENCE AND RESULTS-BASED STRATEGIES

The body of evidence on the impact of the epidemic and the effectiveness of interventions is constantly growing. The ZNASP will be regularly reviewed in light of the best available evidence from monitoring the implementation of the strategy, and from academic and operational research both nationally and internationally.

Some research conducted in sub-Saharan Africa and locally has not yet been fully used in developing programmes in Zimbabwe. Behaviour change programmes, for instance, have over 15 years of accumulated history and knowledge, but despite this body of evidence, most programmes in Zimbabwe have not been research-based. This includes programmes targeting youth which are not tailored to the specific needs of young people as they do not take into account their different ages, sex, and previous sexual experience. Other areas will need new operational research, for example, treatment compliance, PMTCT and the special and changing needs of OVC.

### 3.8 ADHERENCE TO INTERNATIONAL GOALS AND PRINCIPLES

Zimbabwe is not alone in pursuing a multi-sectoral national response to HIV and AIDS, and it is important that the ZNASP is consistent with, and supports, ongoing regional and international HIV and AIDS initiatives. Zimbabwe is a signatory to a number of international and regional conventions which include the *Millennium Development Goals* (MDGs), *United Nations General Assembly Special Session on HIV/AIDS (UNGASS)* and the *Final Communique 2003 SADC Heads of States and Government Summit on HIV/AIDS (The Maseru Declaration).* Zimbabwe is committed to ensuring that the goals set in these declarations are achieved.

At the global level, the ZNASP is consistent with the internationally agreed "Three Ones" approach. The ZNASP also supports Zimbabwe's commitment to achieving the 2015 Millennium Development Goals relating to poverty, gender and HIV/AIDS. At the regional level, the ZNASP is consistent with the *Maseru Declaration on HIV and AIDS*, the *SADC Strategic Framework on HIV and AIDS*, the *SADC Business Plan* and the *Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS prevention, treatment, care and support in Africa by 2010 (Brazzaville Commitment on Universal Access)*.

# SECTION FOUR
## KEY STRATEGIES AND TARGETS

The overall goal of the ZNASP is to reduce the spread of HIV, improve the quality of life of those infected and affected, and mitigate the socio-economic impact of the epidemic in Zimbabwe.

In order to achieve this goal, the following four main strategies have been agreed upon:

- HIV prevention to reduce number of new infections, with a focus on behavioural change promotion;
- Increased access and utilization of treatment and care services;
- Improved support for individuals, families and communities, including orphans and other vulnerable children infected and affected by HIV and AIDS;
- Effective management and coordination of the national HIV and AIDS response (including resource mobilization).

In addition, capacity strengthening of national institutions and gender mainstreaming into all programmes and services have been identified as key cross-cutting themes for the 2006-10 period.

With regards to the first three strategies, the ZNASP has agreed upon overall targets, the reduction of HIV prevalence among 15-24 year olds from the current 17% to single digits (as a proxy indicator for incidence reduction), a coverage of 75% of those in need with OI treatment and ART, and a coverage of at least 50% of OVC and affected households with a basic package of support services. Additional targets are presented at the end of the different sections describing the key strategies.

The following chapters describe the four strategies in more detail.

### 4.1 PREVENTION OF NEW INFECTIONS

While treatment, care and support will have to significantly expand by 2010, prevention of new HIV infections will remain the cornerstone of the national HIV response. With infection levels declining, HIV prevention in Zimbabwe can build on already existing successful programmes. Behavioural change approaches will be further refined, and C&T and PMTCT services and their utilization further increased. STI management will be adapted to new realities, and blood safety maintained.

As compared to the previous framework 2000-2004 and the national response so far, the ZNASP promotes the re-focusing and intensifying behavioural change (BC) approaches and programmes in several ways.

- The **promotion of abstinence** and delayed first sex among unmarried young people will continue, and so will the promotion of **condom use** for those young people who fail to abstain and those adults that engage in non-regular and commercial sex while being married. At the same time, **faithfulness** in marriage and stable mutual relationships will be more strongly promoted, and become the new BC focus.

- Programmes and interventions will go beyond awareness-raising and the Abstain, Be faithful, Condomise (ABC) approach to **address underlying factors of vulnerability** and the reasons why people engage in risk behaviours. This includes cultural and religious values and norms that permit men in particular to have multiple relationships; poverty that forces women and girls in particular to engage in casual and commercial sex in exchange for support and subsistence; gender inequality that, among other effects, frequently prevents open discussion, disclosure of HIV status and safe sex negotiation within couples; and mobility and spousal separation that increases both partners' risk of being unfaithful.

- In order to achieve normative and behavioural change, an **enabling environment** for such change will be created by disseminating appropriate messages via mass media, by increasingly enrolling traditional, religious and political leaders to speak out in favour of mutual faithfulness (and the need to use condoms if that fails), their own experiences and HIV status, to become AIDS activists themselves, and by systematically documenting positive role model examples. Risk behaviours rooted in culture, tradition and religion such as polygamy, "small houses", wife inheritance, girl pledging among others, will be openly discussed and addressed at all levels, and open discussions at community level specifically promoted. All relevant sectors will be actively involved in these efforts, including Government ministries, such as Education, Gender, Transport, Information, Health, as well as Churches, NGOs, the Arts, among others. BC Task Forces will be established in individual sectors, institutions and districts, as appropriate.

- Specific efforts will be undertaken **to empower women** to allow them to refrain from risky relationships and protect themselves. Women's representation in AIDS Action Committees at all levels, including in leading positions, will be increased to enhance their decision-making power. Legal support and sensitization programmes will be established to ensure women and girls benefit from property and inheritance rights enshrined in existing legislation. While not pretending to be able to resolve the issue of deepening poverty, especially female poverty, the ZNASP will also make a contribution towards women's economic independence by integrating income-generating components into such programmes as HBC or allow a modest degree of profit-making from such activities as condom distribution. Female-controlled means of prevention, such as female condoms, and educational tools that may assist in safer sex negotiation will be made more widely available. All HIV prevention, care and support projects and programmes will be encouraged to systematically mainstream gender into their design, implementation, data collection and evaluation, and gender will also be integrated into sectoral policies and programmes. Sexual abuse will be fought with a mixture of public monitoring and reporting, awareness-raising, and punitive approaches. The sexual offences law will be amended to increase the protection of individuals. Post Exposure Prophylaxis (PEP) will be made available for victims of sexual and gender-based violence.

- **Spousal separation** is a long-standing practice not only among miners, truck drivers and domestic workers, but many other groups in Zimbabwe, as well as in the diaspora, which has significant implications on marital faithfulness and family life overall, and constitutes a major factor of HIV vulnerability. Policies will therefore be elaborated and implemented that minimize separate living arrangements and spousal separation. As HIV and AIDS is having a major economic impact on the Zimbabwean nation, and spousal separation and consequent multiple partnering contribute to this scourge, all employers, employees and families will be actively encouraged to make it possible for families to live together and to reduce mobility and separations, to the extent possible. Where this is not possible, efforts will be made to mitigate against the impact of separations, through awareness and risk reduction programmes.

- **Persons living openly with the virus** will be encouraged to become strong advocates for prevention, benefiting from full and meaningful involvement in prevention and treatment program and project design, implementation, monitoring and evaluation. The representation of PLWHA in AIDS Action Committees at all levels, including in leading positions, will be increased. Where possible, public awareness programmes including treatment literacy should be led by PLWHA who are willing to share their experiences. At the same time, stigma and discrimination will be more closely monitored through the definition and integration into the national M&E framework of appropriate stigma and discrimination indicators, and the public dissemination of reports. Efforts will be made to reinforce existing anti-discrimination legislation, or if this proves difficult, new laws will be passed.

This new BC focus will be supported by increased access to and availability of prevention commodities and services, including Information, Education & Communication (IEC) materials, condoms, C&T, PMTCT and STI treatment. As mentioned, blood safety will be increased, including through an adequate allocation of funds.

- **Condom programming** has been relatively successful, but requires some adjustments, both with regards to supply and distribution chains and promotion among target groups. Both re-branded public sector and socially marketed condoms will be made more widely available in rural and remote areas, including through new and innovative outlets, such as newly trained CBDs (where there are too few), other village-based condom holders, and HBC providers, among others. Arrangements will be made to allow limited for-profit sales, in addition to traditional free distribution for such groups as prisoners and displaced people that cannot afford even subsidized prices, and social marketing. Condom promotion through mass media, print and interpersonal means will ensure targeting only to those who need them. This should include the promotion of consistent condom use among the minority of unmarried youth that are already sexually active and among those adults and couples that are either not faithful, do not know their status, or are HIV test discordant. Public misunderstandings regarding efficacy versus effectiveness of condoms will need to be addressed. A major effort will be made to make female condoms available to certain segments of the population, including married women at risk and sex workers. Current procurement and supply systems, dominated by externally supported supplies, will be strengthened, with a buy-in from Government, and more systematic forecasts of consumption needs will be carried out.

- **Counselling and testing** will develop from largely urban-based VCT programmes to nationwide provider-initiated C&T. The challenge is to maintain quality counselling and testing services in urban areas, while scaling up C&T and post test support services in rural

areas. It is anticipated that such increased coverage can be achieved through a significant increase in the number of static clinics registered to provide C&T, in combination with mobile service delivery in some areas with limited access to static clinics. The training of primary counsellors and cadres certified to perform rapid testing will significantly expand. Persons openly living with HIV will be encouraged to enrol in Primary Care Counsellor (PCC) training. Increased efforts will be made to offer C&T services to youth and pre-marriage couples. As with condoms, currently existing test kits procurement, supply and dissemination systems will be periodically reviewed and strengthened, as necessary.

- The national **PMTCT** programme will be further strengthened through geographical expansion, improved quality of services and an increase in the package of services provided. All the four prongs of PMTCT will be strengthened:

    - primary prevention;
    - prevention of unplanned pregnancies;
    - prevention of mother to child transmission; and
    - care and support for mothers and babies.

    HIV testing will be routinely offered in all PMTCT relevant settings, including Ante-Natal Care (ANC), Family Planning (FP), and MCH clinics, with priority given to establishing new sites in currently underserved areas in the south of the country. The use of more effective ARV prophylactic regimes will be considered. PMTCT services will be further integrated in, linked with and supported by the training of health service providers and community-based cadres, including Traditional Birth Attendants (TBAs) and CBDs, in safe delivery practices, post-test follow-up and where necessary treatment for OIs of HIV positive mothers and exposed babies, and nutritional support in case of food insecurity. Health workers will be trained in comprehensive PMTCT, including rapid testing and infant and young child feeding counseling. A major focus will be the prioritization of pregnant women and mothers in the ART roll-out. The uptake of PMTCT will be promoted among men, and PMTCT services fully utilized for couple counselling and behavioural and normative change promotion. Support will be increased for the promotion of optimal and safer infant feeding practices and to ensure HIV and infant feeding is prominent in PMTCT scale-up (including Baby Friendly Hospitals Initiative or BFHI scale-up). Tracking of children born to exposed mothers will be instituted so that they can be tested as early as possible, using, preferably, detection of the virus, not antibodies, so that children can access treatment as soon as they need it. New research may require adjustments to PMTCT policy and services over time.

- Another potentially important service-based HIV prevention intervention is male circumcision. The feasibility and acceptability of its implementation at a larger scale will be investigated (also see below: Research), and depending on the results, pilot initiatives in some geographic areas may be considered.

    A third prevention focus of the ZNASP will be addressing the specific needs of most-at-risk populations, through comprehensive programmes aiming at informing, protecting and caring for them.

- While the mainstay of prevention efforts will be aimed at unmarried young people and married couples generally, specific programmes will be developed targeting such at-risk and minority groups as young people who start having sexual relations below the age of 17, adolescent orphans and street children, sex workers, injecting drug users (IDU), MSM, prisoners, among others.

- Young people belong to different subgroups, and the national BC review has shown that a minority of young people is at a particularly high risk of infection. These are young people who start having sex very early, often come from a poverty-stricken or otherwise difficult family background; many are orphans, many drop out of school early, and some are already suffering from the negative consequences of early unprotected sex, such as unwanted teenage pregnancies and STIs. Rather than assuming that such young people would benefit from abstinence-only messages and programmes, it is accepted that these youngsters need practical support and a comprehensive package of services, including peer support, access to counselling and testing, condoms and STI treatment. Existing programmes will be modified to specifically recruit particularly vulnerable young people themselves as peer supporters and educators, and to provide the specific services needed in both urban and rural areas.

- There is need to consolidate and expand the in-school life skills program. *The HIV/AIDS and Life Skills Strategic Plan* for the period 2006-2010 is being finalized by the Ministry of Education, Sport and Culture (MOESC). Its provisions will need to be widely operationalized to reach as many in-school young people as possible.

- A mapping of commercial sex settings and populations is currently being conducted, and the results will be used to develop policies and programmes. Current laws and legislation will be reviewed, and amended, if necessary. Periodically occurring round-ups and arrests of street and hotel-based prostitutes in urban sites and border areas will be replaced by longer-term regulation of the sex work scene and more predictable planning and programming. Sex work-related interventions and programmes will be agreed upon on a consensus basis between the Ministries of Home Affairs, Health and the Department of Social Welfare, in collaboration with humanitarian NGOs. Areas of significant sex work such as border towns, growth points and the main urban centres will be targeted, and a minimum service package provided through peer support programmes, including IEC, male and female condoms, STI treatment and where feasible and appropriate legal advice, child care and other social support.

- While homosexuality remains illegal in Zimbabwe, there can be no doubt that there are men who have sex with other men. They are at risk of HIV infection and passing on the virus to their partners, including female partners. Furthermore, international experience has shown that ignoring this group or adopting punitive approaches will only serve to drive MSM underground and reduce opportunities to dialogue with this group. An assessment of MSM patterns, meeting points and behaviours will therefore be carried out, and adequate public health interventions developed based on the findings.

- The ZNASP will strengthen linkages of HIV prevention services (C&T, PMTCT) in high volume child care settings, including paediatric wards and therapeutic feeding units.

**TABLE 3: TARGET STATEMENT: PREVENTION**

| **Strategy:** Prevention of new infections | | |
|---|---|---|
| **Objective:** To reduce the number of new HIV infections in both vulnerable groups and the general population | | |
| **Target Area** | **Target for 2010** | **Baseline** |
| Prevalence (15-24) | Reduced to below 10% in women and by 50% in men | 17% women (YAS 2002);<br>17% ANC attendants (MoHCW 2004); 5% men (YAS 2002) |
| Proportion of married men reporting non-regular partners<br><br>Normative and behavioural change regarding faithfulness | Number of national level leaders speaking out against multiple partners disclosing they are living with the virus<br><br>Number of districts with at least one traditional/religious/political leader who has spoken out against multiple partners disclosing he/she is living with the virus | |
| Condom consumption | 150 million per year | 80 million (UNFPA, PSI 2005) |
| Counselling and Testing (C&T) | 75% of persons (15-49) tested | 15% of persons (15-49) ever tested |
| PMTCT | 100% of ANC tested; 90% uptake of PMTCT services amongst tested ANC women | 73% tested; 42% uptake of PMTCT services |
| Most-at-risk populations | 50% of all groups and sites Covered | Less than 10% |

- Other particularly vulnerable groups include mobile populations not captured in previous sections, persons with disabilities, IDU and prisoners, among others. Where this is not already the case, specifically tailored programmes will be developed to address their HIV risks and vulnerabilities.

The stakeholders in the national HIV response, led by NAC, will closely follow developments in research on HIV prevention and commission relevant research themselves, as appropriate.

Topics proposed for further investigation include the meaning and patterns of multiple parallel relationships; factors related to correct and consistent condom use; the impact of ART roll out on behaviour change; sexual practices of PLWHA; the acceptability and feasibility of large-scale male circumcision; and specific risks and vulnerabilities of marginalized and most-at-risk groups. Educational materials and programmes will be systematically pre-tested and their impact evaluated.

## 4.2 TREATMENT AND CARE

The overall objective for this strategy is to reach access and utilization of treatment and care services by 2010 for up to a minimum of 75% of those who need them, including eligible children for whom the 2010 national target is 100%. The principle of free treatment in the face of the country's economic challenges will continue to be vigorously pursued.

The ZNASP strategy for treatment focuses on the following:

- **Accelerate enrolment of patients at already registered sites.** Current bottlenecks at sites which should be ready to rapidly increase the number of patients on treatment, as drugs are available and providers have been trained, will be identified and addressed. If necessary, existing admission policies and eligibility criteria, focusing on WHO clinical staging and previous enrolment in HBC programmes will be reviewed.
- **Basic laboratory services** that are in a state of disrepair will be strengthened nation-wide to allow for a rapid roll-out. Funding that is becoming available will be specifically earmarked to allow the strengthening of laboratories.
- **The affordability of AIDS treatment,** especially the cost of diagnostic and treatment services and admission procedures will be reviewed with the aim of coming as close as possible to free public sector AIDS treatment in principle. As for the private sector, efforts will be made to negotiate drug prices as low as possible. This may involve review of trade barriers and tariffs, if any; full use of already existing agreements, such as with the Clinton Foundation; encouraging the business sector to engage in insurance schemes that include AIDS treatment for their employees and open up their own procurement channels and do bulk purchases; further strengthening of local manufacturing capacity with the aim of facilitating local companies to pre-qualify according to WHO and other standards.
- **The regular supply of adequate ARVs, including paediatric formulations, and drugs for OIs,** including TB drugs and co-trimoxazole for the expanded AIDS treatment program in both urban and rural health centres will be pursued aggressively. This will involve sustainable funding (see strategy 4) and the strengthening of procurement and logistics systems. Procurement bottlenecks will be resolved through the establishment of an integrated, comprehensive national HIV commodity procurement, warehousing and distribution system. The ZNASP thus provides for the establishment of a National HIV and AIDS Commodity Security Committee dealing with forward planning and forecasting of needs, a National HIV and AIDS Procurement System and a National HIV and AIDS

Commodities Warehouse. This system will be led by Natpharm, but given the specificities of AIDS diagnosis and treatment, it will initially function differently from other Natpharm essential drugs procurement and dissemination operations, and be strengthened independently.

Lessons learnt from the Global Fund Procurement System already in operation in association with NAC will be used to provide guidance.

In addition, policy research aimed at understanding and improving the larger health systems environment in which the HIV response is taking place will help to ensure that the public-private mix is appropriately balanced, that resources can be channelled efficiently for the achievement of equity goals as stated in this strategy and to ensure that the health system is able to gear up to universal access without unduly harming other important health priorities in Zimbabwe as identified by the MoHCW.

- **Human resource shortages** for the roll-out of the ART programmes at all levels will be addressed through a number of initiatives that, in the face of the emergency nature of the HIV and AIDS situation in Zimbabwe, will be implemented concurrently, as part of a comprehensive human resource capacity strengthening strategy. Urgent steps to retain local health services personnel currently working in the system and to recruit new staff will be taken through a comprehensive improvement of conditions of service and training at all levels. Health workers need the skills to administer and monitor ART, and paediatric AIDS requires additional expertise. Improvement in conditions of service will entail improved remuneration, non-remuneration benefits such as provision of resources staff need in health centres and institutions, child education incentives and postgraduate training opportunities following rural attachment. At the same time, the recruitment of expatriate doctors, nurses and lab technicians, including volunteers from neighbouring and donor countries will be encouraged, and the registration of expatriate health service personnel facilitated by removing unnecessary bureaucratic barriers. In order to ensure as many people as possible are able to be treated and monitored by the available health staff, there will be a constant review of tasks and responsibilities by different level of health worker. This review will aim to ensure efficiency in the distribution of care responsibilities with the intention of devolving as much as possible away from the medical profession.
- **Issues of stigma and fear of discrimination** that deter people from taking the necessary steps to seek care and treatment will be addressed through targeted IEC materials (which are also essential for the treatment literacy programme) and the review of policies and legislation to ensure the protection of the rights of those who make personal disclosures, especially in work places. Leaders at all levels will be encouraged to lead by example and operationalize the motto of the ZNASP, "From Commitment to Action," by being personally tested for HIV and by those who live with the virus openly disclosing that fact.
- Research and development initiatives will include expanding studies into the effectiveness of **alternative therapies,** what they offer and how they can be utilised. A Research and Development Office to harness, motivate and network so as to promote ongoing and targeted research and development initiatives among the various stakeholders will be established at NAC.
- Efforts to **expand HBC coverage** will build on the already ongoing assessment mapping exercise. The aim is to expand HBC programmes to cover the whole of Zimbabwe, and to include several new elements and lessons learnt from areas where the programmes are

operative. These will include more systematic nutritional support to HBC clients (see strategy 4), better access and more widespread use of co-trimoxazole by HBC providers and clients, and more frequent referrals to ART services. **Volunteer burn-out** will be addressed through a needs-based national volunteer motivation and training program that will address both the material and the psycho-social needs of volunteers. The programme will also address issues of gender equity so that more men take an interest in becoming care givers than is currently the case. To enable HBC volunteers to do their work effectively, HBC kits will be regularly replenished through a decentralized commodities distribution system coordinated by NAC or another designated agency.

The notion that PLWHA are placed on the HBC program as preparation for their death should be dispelled.

- One of the recommendations of the National HIV/AIDS Conference of 2004 was that "nutrition must be mainstreamed and become an integral part of the HIV and AIDS agenda". Nutrition can affect medication efficacy, nutritional status and adherence to drug regimes. The ZNASP will therefore strengthen linkages between ART programmes and food security and nutrition programmes.

**TABLE 4: TARGET STATEMENT: IMPROVE QUALITY OF LIFE OF PEOPLE INFECTED AND AFFECTED BY HIV AND AIDS**

| **Strategy:** Improve quality of life | | |
|---|---|---|
| **Objective:** Improve treatment and care, protection and rights and access to effective services for infected and affected people | | |
| **Target Area** | **Targets for 2010** | **Baseline** |
| Treatment coverage | 75% of eligible persons on ART; 100% of eligible children on ART & psycho-social support | 7% (2005) |
| Private sector and insurance treatment | 30,000 | 6,000 |
| Treatment providers | All districts have two full-time medical doctors, registered as ART providers | To be determined |
| Prices of imported ARV first line | US$12 | US$20 |
| AIDS commodity procurement and logistics system | Fully functional | Being designed |
| HBC | Full coverage, includes nutritional support and CTX where appropriate | To be determined |

## 4.3 MITIGATION AND SUPPORT

Mitigation approaches will be broadened to address the impact of HIV on individuals, households, communities, the public, workforce and specific sectors.

- **Support to PLWHA and HBC clients.** Mitigation at individual level seeks to provide support to those infected with HIV and suffering from AIDS-related illnesses. Strategies to care for those chronically sick have already been described in the previous section. Comprehensive support strategies will include not only health care, but also nutritional support, access to clean water and sanitation, among other services. Nutritional support will be achieved through a combination of strategies to ensure food security at family and community level (see below) and direct food assistance to those chronically sick, as needed. Nutritional support will be systematically provided to those enrolled in ART. Community-based counselling to help PLWHA and their families cope with the impact of their status will be strengthened. HBC and other community volunteers need to develop counselling skills to raise awareness on ART and support adherence.

- **The specific needs of orphans and other vulnerable children** will be addressed through equitable accessibility of OVC to Basic Education Assistant Module (BEAM) and NATF funds as well as external funds becoming available for the implementation of the National Plan of Action for OVC. Programmes will include the provision of basic health and social services, including schooling, shelter as well as activities to enforce existing laws to protect OVC from disinheritance by greedy relatives, and from sexual offences especially in case of girl OVC. In order for OVC to realize their rights, birth registration will be facilitated and legal and administrative assistance provided.

- The **livelihoods of affected households and communities** will be secured through sustainable community initiatives and programmes, including water and sanitation activities, nutrition gardens, communal granaries and appropriate income-generating activities. Woman- and child-headed families and households with chronically ill people will be prioritized with the assistance provided. Volunteer service providers from the communities will be trained to lead these activities and programmes, and the volunteer motivation measures mentioned under HBC implemented. Measures to enable HBC volunteers to benefit from livelihood programmes they are asked to lead will be put in place as a concrete way of addressing the recurring problem of volunteer motivation.

- **Emergency assistance** (food, care and livelihood support, etc.) during times of crisis will be provided to most vulnerable AIDS-affected households, coordinated and facilitated by the decentralized NAC structures. NAC structures will institute early warning signals for such crises needing urgent emergency assistance.

- The ongoing review of the **impact of HIV on the agricultural sector** will lead to the development of a comprehensive framework of action for mitigation within this sector. Programmes will be developed to address the impact of HIV on agricultural extension services. Agricultural practices will be reviewed in the light of a weakened labour force and the increasing number of households that are unable to feed themselves using traditional farming methods. Modified less labour intensive methods will be promulgated as needed. Reviews of a similar nature will be undertaken in other sectors.

- Efforts will be made to systematically strengthen **mitigation of the impact of the epidemic on social sectors,** such as Education and Social Welfare, as well as the Public Service itself. Building on existing work, such as the 2005 *HIV and AIDS Policy (Zimbabwe Public Service Implementation Strategy)* and impact studies in the education sector, new human resource policies and programmes will be developed so as to allow for planning for effective service delivery in the near, medium- and long-term future.

- **The impact of HIV on other productive sectors,** such as manufacturing and mines will be given increased attention during the ZNASP period. The very high impact of HIV on productivity and profits, and the economic benefits of investing in HIV prevention and treatment, will be more systematically documented. On the basis of this documentation, sector ministries and business leaders will develop their own responses and programmes to address the immediate, medium- and long-term consequences of the epidemic.

**TABLE 5: TARGET STATEMENT: REDUCE ADVERSE EFFECTS OF THE HIV AND AIDS EPIDEMIC**

| **Strategy:** Reduce adverse effects | | |
|---|---|---|
| **Objective:** Reduce the adverse effects of the HIV and AIDS epidemic on orphans, PLWHA, communities, and sectors | | |
| **Target Area** | **Targets for 2010** | **Baseline** |
| HBC and ART clients | 80% receiving nutritional support | |
| OVC receiving free external basic support | 50% of those eligible | 20-30% (2005) |
| HIV policy for agricultural sector | Fully developed and implemented | Being developed |
| Impact on other sectors | Impact studied and mitigation strategies in public and private business sectors | Being developed |

## 4.4 EFFECTIVE MANAGEMENT AND COORDINATION OF THE NATIONAL HIV AND AIDS RESPONSE (INCLUDING RESOURCE MOBILIZATION)

The 'Three Ones' ones principle of coordination will be continued and strengthened during the 2006-2010 period. Translating the general orientation of this strategic plan into concrete and effective plans, programmes and interventions will require strong leadership, coordination and partnerships between a wide range of actors at national and local levels. During the planning period, NAC will be further strengthened, especially in its coordination, partnership and strategic information functions.

## COORDINATION FORUMS AND COORDINATION

The *National AIDS Council Act of 1999* makes the provision that NAC be the coordinating body of the multi-sectoral response to the HIV and AIDS epidemic in Zimbabwe. Efforts will be made to ensure that all sectors, including those traditionally less involved, identify their specific comparative advantage and the contribution they can make to the fight against HIV and AIDS, actively engage in national HIV policy-making and planning at high level, and integrate HIV and AIDS into their own planning and programming. In order to further strengthen this multi-sectorality, Memoranda of Understanding between NAC and sector ministries will be elaborated to outline the specific roles and responsibilities of these sectors in the response. The NAC Act itself will be reviewed in order to further strengthen NAC, as necessary.

**National Coordination** will also be further strengthened by formalizing the composition, *modus operandi* and terms of reference of the **National Partnership Forum** (NPF) that has started to meet on a two-monthly basis, chaired by NAC. All stakeholders, including key sector ministries, the private sector, donors, NGOs and PLWHA will be represented, with representatives providing regular feedback to their constituencies. Technical working groups and task forces, for instance those on M&E, treatment and behavioural change, will report to the NPF and be accountable to it. With its role and mandate strengthened, the NPF will gradually develop from an information-sharing function into Zimbabwe's key coordination forum.

The ZNASP advocates for coherence and close collaboration between the NPF, the main national-level coordination forum, and **other national-level HIV fora** such as the Country Coordinating Mechanism (CCM), project-specific fora, the United Nations Theme Group on HIV and AIDS, and HIV donor coordination groups, among others, with the aim of further aligning and harmonizing these to the NPF. Whenever possible, the same staff will represent their constituencies on the various fora, to ensure consistency and continuity. NAC will designate full-time staff to specifically deal with fostering partnerships.

The ZNASP 2006-2010 also encourages the further **strengthening of NGO, FBO and private sector HIV umbrella organizations** so that the potential of their members and the comparative advantages of the networks can be fully harnessed. The participation of young people, women and PLWHA in all coordination bodies, including in leading and decision-making positions, will be systematically strengthened.

At sub-national, in particular district levels, NAC decentralized structures will work closely with local authorities, sector ministry representatives, NGOs, FBOs and traditional leaders to share information and jointly map and plan, monitor and evaluate local responses. District HIV planning processes will be further strengthened during the ZNASP period. To enable effective coordination at grassroots level, there is need for all structures to be capacitated to enable a holistic approach. As at national level, women and PLWHA will be fully represented in planning and coordination processes, including in decision-making roles.

## STRATEGIC INFORMATION AND NETWORKING

NAC will be provided with the capacity to play its designated role as a hub of all HIV and AIDS strategic information. Excellent publications such as policy documents, reviews, best practice documents and IEC materials have been produced in and about Zimbabwe. To this purpose, a national HIV and AIDS information collection and dissemination policy will be developed.

This policy will seek to ensure that all HIV and AIDS related publications produced in Zimbabwe are systematically collected. To this effect the policy will encourage all partners and stakeholders to:

- Acquire International Standard Book Numbers (ISBN) for their publications on HIV and AIDS.
- Comply with their legal depository obligations and deposit copies of their HIV and AIDS publications with the National Archive.
- Lodge at least one hard or electronic copy of all forthcoming HIV and AIDS related publications (IEC materials such as posters, flyers, pamphlets, music cassettes and CDs, DVDs and videos, etc.) which do not necessarily fall under legal depository obligations with the NAC resource centre.
- Systematically archive digital copies of publications (ideally captured at the at the point of desktop publishing) so as to facilitate the development of HIV and AIDS content management systems.

The HIV and AIDS information collection and dissemination policy would facilitate the development of a vital national resource which would help to provide an overall national overview of what is being produced so as to complement other areas such as BC reviews and M&E. The resources would be available and accessible to implementing partners and the general public.

To this purpose a national HIV Resource Centre will be established and housed in an appropriate organization, preferably in NAC itself. The establishment of the centre will imply the strengthening the human resource capacity of NAC.

NAC will continue to support the establishment of decentralised resource centres in the provinces. Existing NGO networks will be encouraged to maintain and strengthen their own information networking functions. Coordination and collaboration between the NAC resource centres, the 120 Parliamentary Constituency Information Centres and district based resource centres being developed by NGO networks such ZAN will be encouraged.

This policy will support the development of a NAC web portal so that HIV and AIDS related strategic information can be collected and distributed electronically using new digital technologies. For example, cross portal searching can digitally unite online HIV and AIDS materials relevant to Zimbabwe.

The policy will also:

- help to develop an editorial policy and style manual of NAC publishing efforts, including the website so as to maintain consistent and quality;
- develop a controlled vocabulary on HIV and AIDS related terminology and an agreed acronyms standard; and
- establish terms of reference for the NAC bulletin and its editorial board.

## RESOURCE MOBILIZATION

Resource mobilization is critical to the implementation of the ZNASP. A number of concurrent strategies will be undertaken.

The systematic tracking and efficient allocation of existing resources is the first step for the identification of funding gaps and successful resource mobilization to fill these gaps. A national HIV resource tracking system will be established, building on already existing work, capturing all external and internal HIV allocations and expenditure, and providing for an analysis of expenditure by strategy, geographic area, target population and source of funding.

Secondly, annual operational plans of the ZNASP, ZNASOPs, will be costed to give an indication of the additional financial resources that need to be mobilized for the Plan to be successfully implemented together with a plan for resource distribution across priorities, geographic areas and sectors. NAC will facilitate the establishment of a national HIV and AIDS Resource Mobilization Committee which, together with partners, will aim to raise funds as per the costed ZNASOPs, and hopefully result in a significant increase in local and external resources.

Such a comprehensive resource mobilization strategy will include the stronger involvement of the Reserve Bank and the Ministry of Finance in HIV decision-making and advocacy for the prioritization of adequate foreign exchange for the procurement of ARVs (including paediatric formulations), drugs for OIs and other HIV and AIDS care commodities including nutrition; regular accounting by NAC on how Government HIV allocations have been spent; increased commitment by the business sector to provide funding for the welfare of their own employees and their families; the monitoring of effective implementation of existing funding schemes, such as The Global Fund To Fight AIDS, Tuberculosis and Malaria (GFATM); the documentation of funding gaps as well as best practices to attract the interest of external donors not yet engaged in Zimbabwe; the design of new funding modalities, including basket funding; and the establishing of a fund-management unit in NAC through which new funding may be channelled.

The ZNASP places a lot of importance on good financial practices. The ability to raise further resources will be severely undermined if good financial practices are not followed. With regard to all resources made available to the HIV and AIDS response, and regardless of their source, public accountability, openness, a commitment to international standards of financial management, audit and expenditure tracking will be actively pursued in order to maintain a rigorous system of resource management that will build the confidence of users, providers, implementers and funders.

## TABLE 6: TARGET STATEMENT: EFFECTIVE MANAGEMENT AND COORDINATION

| **STRATEGY:** Effective coordination and management of the national response, including resource mobilization | | |
|---|---|---|
| **OBJECTIVE:** To effectively coordinate all national HIV programmes and strategies and ensure their high quality and full funding | | |
| **Target Area** | **Targets For 2010** | **Baseline** |
| NAC | Fully operational<br>Coordination, partnership, resource tracking, M&E and strategic information functions<br>Costed annual operational plans including all funding streams | M&E department functional<br>NAC work plans |
| National Partnership Forum | Agreed Terms of Reference, quarterly meetings, with feedback from Working Groups<br>Regular minute-taking, follow-up on action points | Two-monthly meetings<br>Minutes |
| Strategic Information | Resource centre<br>Information management system, including regular reports on strategic issues | NAC bulletin, website |
| Resource mobilization | US$8-10 million national resources (National Budget, AIDS Levy); around US$65 million dollars external funding | As per costed ZNASOPs |
| M&E | See below | See below |

# SECTION FIVE
## MONITORING AND EVALUATION

The Zimbabwe National AIDS Strategic Plan presents a expanded national response to HIV and AIDS in Zimbabwe. Its implementation will involve many implementing agencies and stakeholders. The government of Zimbabwe and several development partners will commit an increased amount of resources for its operationalization. It is therefore imperative to demonstrate the effectiveness of programmes through achievement of strategic results, outcomes and impact at all levels of NAC coordination structures. A multi-level approach to Monitoring and Evaluation of programmes and activities is therefore required that will facilitate inter and intra-level M&E particularly for cross-cutting issues such as policy, resource mobilization, programme design and implementation.

Monitoring and Evaluation (M&E) is a critical and integrated task of the National Response on HIV and AIDS. In order to comply with the "Three Ones" principles, there will be one single monitoring and evaluation system in place to which all stakeholders and implementing organizations will be required to adhere to. The "Three Ones" principles that must be adopted by Zimbabwe to build a stronger national Monitoring and Evaluation system include:

- Country level alignment of Monitoring and Evaluation needs around the indicators linked to the United Nations Declaration of Commitment (DOC) on HIV and AIDS and additional core elements that emphasize performance and accountability.
- Agreement among stakeholders for a core national monitoring and evaluation system that provides high quality data for analyzing Zimbabwe's performance on the national AIDS action framework.
- National and external investment in building essential capacity and infrastructure to meet national monitoring and evaluation needs.

### 5.1 M&E GOAL AND OBJECTIVES

The overall goal of the national M&E system is to provide a comprehensive tracking system to collect, enter, analyze and share information on HIV and AIDS that will enhance decision making at all levels in the implementation of interventions under the multi-sectoral response to HIV and AIDS in Zimbabwe.

Specific objectives include the following:

- To measure the progress in implementing the ZNASP.
- To track inputs and results of the national response to HIV and AIDS epidemic in Zimbabwe.
- To track epidemiological trends over time.
- To compare and improve the cost-effectiveness of different types of HIV and AIDS interventions.
- To provide programme data to meet global and donor reporting requirements e.g. UNGASS, GFATM, etc.
- To continuously identify and resolve any problems arising in the course of implementing the national response.
- To ensure greater transparency, effective coordination and communication among different groups involved in the national response to HIV and AIDS.
- To promote the importance of M&E, the need for systematic data collection and utilization of M&E results.

- To strengthen M&E capacity of NAC, MOHCW and other stakeholders in the public, private and civil society sectors i.e. NGOs, FBOs and CBOs to collect, analyze and utilize data.
- To provide guidance on national HIV reporting requirements.
- To make available user-friendly data summaries and key trends to all stakeholders throughout the country.

## 5.2 ZIMBABWE NATIONAL M&E SYSTEM

The Zimbabwe HIV M&E system consists of the following components (Fig. 1) which will be further strengthened during the ZNASP period:-

- A-Indicators, i.e., National Core Output Indicators (COI) and internationally defined outcome and impact indicators.
- B-Data Sources for indicators:
  - **Population based** surveys- ANC Surveillance, DHS, BSS, and census.
  - **Special** surveys- health facility, school-based, community-based and high risk surveys
  - **Academic research work**
  - **Programme and project reports**
  - **National Programme Monitoring System *branded* the NAC Activity Reporting System- for service statistics generated from programme implementation**
- C -National M&E Database System
- D-Information Products
- E-Stakeholders /Implementation organizations and at all levels
- F-HIV Interventions, i.e., Strategic and Programme Areas

NAC will continue to have overall responsibility for and oversee the national monitoring and evaluation system. A multi-sectoral and multi-disciplinary National M&E Technical Working Group (TWG) will continue to provide technical advice in the development and operationalization of the national M&E system. Specific work will continue to be undertaken by Taskforces on IT, OVC, GIS, UNGASS Country Report, CRIS and National M&E Framework and Roll Out. The M&E department in NAC, which operates as the Secretariat to the Task Force, will be further strengthened, and sufficient financial and logistical resources allocated.

A national M&E work plan that clearly states agreed indicators and M&E activities during the ZNASP period will be developed in collaboration with all partners and disseminated to all sectors. The plan will state the responsibility of different stakeholders and will also contain components that require international reporting such as surveillance results and prevalence estimates, UNGASS, Country Response Information System (CRIS), MDGs, and specific projects such as the Global Fund.

## 5.3 NATIONAL PROGRAMME MONITORING

A National Programme Monitoring System (NPMS) branded as the NAC Activity Reporting System (NARS) has been developed through a consultative and participatory process led by the National M&E Task Force. It is made up of the following features:

- A set of national Core Output Indicators (COI) for each programme area that is supported by an Indicator Guide.
- A National Activity Report Form (NARF)-a standardized core data collection and reporting tool supported by a Reporting Guide.
- A list of all implementing organizations (from civil society, public and private sectors) registered through an Organization Details Form (ODF) implementing HIV and AIDS programmes at district level and reporting monthly to the District AIDS Action Committee (DAAC) through the NARF.
- An M&E Database System to capture COI data, to process and produce a report at district level linked to Province and National levels, and to provide data for the Country Response Information System (CRIS).
- An M&E data dissemination programme at all levels.

While various elements are still being refined, it is envisaged that the NAC Activity Reporting System will be rolled out to all districts and adopted by all implementing organizations and partners. For effective roll out of the National M&E System NAC and implementing organizations, staff will be trained in M&E.

The national M&E system is decentralized at all levels. While all implementing organizations or AIDS Service Organizations (ASOs) are expected to report to the District AIDS Action Committee (DAAC) on nationally agreed core output indicators on a regular basis, they are encouraged to continue to use their primary data collection tools to record programme output data from which they will extract, summarize and report on NARF Programme Area core output indicators (COI) for which they are registered and are implementing. Regular joint review and planning sessions will be conducted at district level where all implementing organizations and stakeholders participate and share experiences, qualitative and quantitative data on additional indicators, and at the same time contribute in shaping HIV and AIDS programme direction in the district. Reports from districts will be consolidated at provincial and national levels where feedback should be given to all levels. Nationally agreed indicators will be clearly defined and described in the existing indicator manual.

A national database that captures who is doing what and where has been developed. The database captures the core output indicators for each programme area. This database feeds into other international databases such as CRIS.

## 5.4 FINANCIAL MONITORING

As part of the monitoring of the National Response, the monitoring of financial provisions is crucial and will be a key task of national coordination, monitoring and evaluation. Building on existing tools and efforts, the main instrument will be a yearly Public Expenditure Review (PER) for HIV and AIDS involving all stakeholders. Together with annual inventories of external assistance to the national response to HIV and periodic private sector and out-of-pocket expenditure surveys, the PER will provide a full overview of HIV expenditure in Zimbabwe.

The purpose of financial monitoring includes the following:

- The constant review and discussion of Government and NAC budgets, allocations and

expenditures for HIV and AIDS to ensure efficiency and effectiveness in resource utilization.
- Tracking and reviewing externally available funds and ensuring they are sufficiently synchronized with the priorities of the National Response.
- Identification of bottlenecks and resource constraints by programmatic and geographic area (expenditure rates).
- Identification of shortfalls of national and/or external funds and making the necessary recommendations.
- Transparency and accountability of public funds as well as donor funds and the decisions about allocation of funds.

## 5.5 SURVEILLANCE AND EVALUATION

In order to measure the impact of the various interventions, routine epidemiological data on the trend of the epidemic will be collected through the MOHCW (ANC surveillance, drug resistance) and other sources such as the ZDHS. Other surveys and research will be commissioned as needed. Behavioural surveillance of HIV and AIDS activities will be strengthened to ensure that decisions are based on data.

NAC and its partners will commission periodic formative and summative evaluations to measure impact and document lessons learnt from implementing the interventions in the strategic framework.

## 5.6 MID-TERM REVIEW 2008 AND END-OF-TERM REVIEW 2010

In 2008, the implementation of the ZNASP will be reviewed. The review will involve a desk review including M&E data generated by the national system, key informant interviews, the compilation of any other relevant information, and the organization of a review workshop where findings are presented and discussed. ZNASP priorities and strategies will be modified as necessary following the review, for instance through an amendment attached to the ZNASP document. By mid-2009, NAC will define the process of reviewing the ZNASP and consult stakeholders with the objective of arriving at a new ZNASP for the period following 2010 by the end of that year.

## 5.7 RESEARCH

The ZNASP places great importance on evidence-based interventions to ensure initiatives are demand-driven and relevant. All stakeholders in the multi-sectoral response, led by NAC, will contribute to studies, reviews, assessments and research that will become necessary from time to time in all areas of HIV and AIDS work, particularly the priority areas of prevention, treatment, care and support. The Zimbabwe Demographic Health Survey 2005-2006 will provide data on which further research will become necessary. As mentioned in the Prevention priority area section of this Strategy, some topics proposed for further research or investigation include the following:

- The meaning and patterns of multiple parallel relationships.
- Factors related to correct and consistent condom use.
- The impact of ART roll-out on behaviour change.
- Sexual practices of PLWHA.
- The acceptability and feasibility of large-scale male circumcision.
- Specific risks and vulnerability of marginalized and most-at-risk groups.
- The relationship between women's vulnerability to HIV transmission, pregnancy and the well being of newborns.

**Goals of National AIDS Council**
1 Reduce HIV incidence
2 Improve quality of life for infected and affected

National HIV/AIDS M&E System

**A**

G.Indicators
- **Global Level**
- **National level**
- **District level**
- **Project level**

Impact → **Fewer new persons infected. Better quality of life for those infected.**

Outcomes → **Less risky behaviour, improved knowledge, less stigma, less discrimination.**

Population-based Surveillance
- Sentinel surveillance
- Behavioural surveillance
- DHS
- Other surveys

Programme Outputs → Increased Coverage for:
HIV prevention
HIV treatment and care
HIV impact mitigation and support
Sectoral mainstreaming
Capacity building and partnership

HIV intervention data
NAC activity report system

**B**

**Data Sources**
Surveillance
Programme Monitoring Data
Research
Other sources, Public sector, civil and private sector

**F**

HIV interventions as per the Zimbabwe National Health Indicator Framework (ZNHIF)

Strategic Priority Area
1. HIV prevention
2. HIV/AIDS Treatment and Care
3. HIV impact Mitigation and Support
4. Sectoral Mainstreaming
5. Capacity Building
6. Others

Data collection Tool/DCT Form
- Primary DCT Activity site/village level
- Summary DCT at Ward level
- Summary DCT at District level
- Summary DCT at Provincial level
- Summary DCT at National level

**C**

National AIDS Council (NAC)

**D**

Information products
Annual HIV/AIDS M&E report
Quarterly statistical report
NAC Website Periodic updates

**E**

Stakeholders at National, Provincial, District, Ward and Village level
Private sector, Public sector, Civil society, Local Authorities


UNAIDS

# ANNEX 1:
## ZIMBABWE NATIONAL HIV AND AIDS OPERATIONAL PLAN (ZNASOP) 2007

One of the shortcomings of the *National HIV/AIDS Strategic Framework* (NSF) 2000-2004 as seen by stakeholders in the process leading to the formulation of the ZNASP 2006-2010 was that the NSF did not allocate specific responsibilities to sectors and implementing agencies. Obviously, a national framework cannot prescribe one action plan for all sectors as different sectors have different needs and may need different approaches to meet those needs. As noted already in the discussion on the challenges of implementing the national strategic plan, different sectors and stakeholders have been carrying out different interventions in different ways over the past five years when the NSF was in force.

For these reasons, annual operational plans will be developed on the basis of the ZNASP 2006-2010 providing a framework for the allocation of responsibilities. These action plans comprise of a narrative and matrices containing the following information:

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

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

# ANNEX 2:
## COSTING OF THE ZIMBABWE NATIONAL HIV AND AIDS STRATEGIC OPERATIONAL PLAN (ZNASOP 2007)

*** NB:** The costing of the ZNASOP 2007 will be undertaken as soon as the ZNASOP 2007 has been developed from the ZNASP 2006-2010 and approved during the course of 2006.

# Notes

# Notes