ANNUAL REPORT 2015

Coordinating the National Response to HIV and AIDS in Zimbabwe

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MANDATE

To provide for measures to combat the spread of Human Immuno Deficiency Virus (HIV) and management, coordination and implementation of programmes that reduce the impact of HIV and AIDS. (The National AIDS Council Act Chapter 15:14 of 2000)

VISION

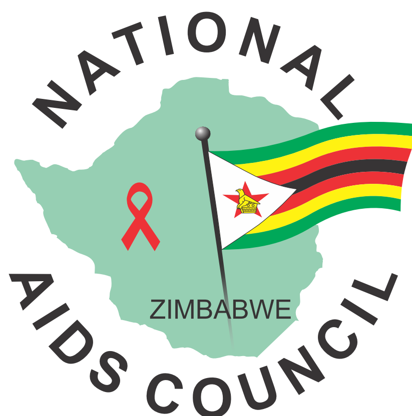
No HIV transmission. Universal access to HIV and AIDS services.

MISSION

To lead and coordinate, with a motivated team, the national strategy in the response to HIV and AIDS in Zimbabwe.

CORE VALUES

- Integrity
- Accountability
- Professionalism
- Pro-action
- Inclusiveness
- Teamwork

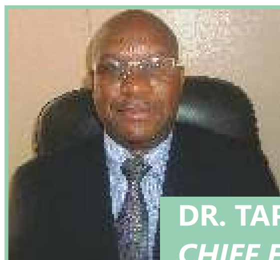


ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Ante-Natal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
ASOs	AIDS Service Organizations
BCC	Behavior Change Communication
BCF	Behavior Change Facilitator
BEAM	Basic Education and Assistance Module
CBO	Community Based Organization
C& HBC	Community and Home Based Care
CSWs	Commercial Sex Workers
CPCPZ	College of Primary Care Physicians of Zimbabwe
DAAC	District AIDS Action Committee
DAAOs	District Accounts and Administration Officers
DACS	District AIDS Coordinators
DBOs	Database Officers
ESP	Expanded Support Program
EID	Early Infant Diagnosis
EMCOZ	Employment
GBV	Gender Based Violence
GF	Global Fund
HIV	Human Immunodeficiency Virus
HLM	High Level Meeting
HTS	HIV Testing Services
IEC	Information, Education and Communication
KYE	Know Your Epidemic
IPP	Integrated Planning Process
MARPs	Most at Risk Populations
MC	Male Circumcision
M&E	Monitoring and Evaluation

MIPA	Meaningful Involvement of People Living with HIV & AIDS
MoHCC	Ministry of Health & Child Care
MOT	Modes of Transmission
NAC	National AIDS Council
NATF	Nation AIDS Trust Fund
NGO	Non- Governmental Organization
OI	Opportunistic Infections
OVC	Orphans Vulnerable Children
PACs	Provincial AIDS Coordinators
PEP	Post-Exposure Prophylaxis
PITC	Provider Initiated Testing & Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
PSS	Pyscho-social Support
SGBV	Sexual and Gender Based Violence
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TWG	Technical Working Group
UNAIDS	United Nations Joint Program on HIV and AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WAAC	Ward AIDS Action Committee
WAD	World AIDS Day
YFCs	Youth Friendly Centres
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZNNP+	Zimbabwe National Network of People Living with HIV
ZIMPHIA	Zimbabwe Population based HIV Impact Assessment

CEO'S SUMMARY STATEMENT



DR. TAPUWA MAGURE
CHIEF EXECUTIVE OFFICER

Welcome to the National AIDS Council's annual report for 2015!

The year 2015 was history defining for the national response to HIV and AIDS in a number of ways. When the decision for Zimbabwe to host ICASA was announced in June 2015, many people were sceptical about our ability given the short period for preparations.

Zimbabwe went on to successfully host the 18th edition of the conference, which brought 4700 delegates from around the world, including scientists, health workers, policy makers, people living with HIV (PLHIV), community leaders and activists working in the fields of HIV and AIDS, sexually transmitted infections, as well as Tuberculosis, Malaria and Ebola.

The conference whose theme was HIV and AIDS in Post 2015 Era: Linking Science, Leadership and Human Rights, was animated by high quality plenary and satellite sessions, exhibitions by big pharmaceuticals and implementing organisations, and the community village, which featured people living with HIV, among other activities.

After hosting a successful continental World AIDS Day in 2014 at the Victoria Falls, Zimbabwe once again commemorated WAD together with visitors from various nations during the ICASA. The Minister of Health and Social Services for Namibia, Honourable Dr Berhard Haufiku was the guest of honour at the event that was truly rainbow, in terms of representation of states.

The central focus of the national response in 2015 was on achieving the 90x90x90 target by 2020 as a key milestone in ending AIDS by 2030.

Evidence has shown that new HIV cases increased from 0.8 % to 1% between 2008 and 2014. This immediately raised fears that if HIV

prevention was not significantly funded as a result of the increased focus on ART, HIV might resurge as has been seen in Botswana and Uganda in similar circumstances. In this regard, the National AIDS Council decided to revitalise HIV prevention interventions at community level and allocated $5 million in 2015, with each province accessing $500, 000.00. This initiative, which was decentralised to districts, enabled them to prioritise interventions central to addressing key drivers of HIV and target hot spots in specific districts. The decentralization strengthened and enlarged community initiatives by our partners on the ground to ensure that they have more meaningful impact on HIV incidence over the years. The funds were utilised to support community initiatives such as mobilisation for prevention of mother to child transmission, voluntary medical male circumcision, HIV awareness, testing and counselling and others.

By the end of the year, 83% of HIV positive pregnant women had been initiated on ART during ANC. Although there was an increase in the percentage of male partners who were tested in PMTCT from 2011 to 2015 (10% to 20%) the achievements are still below the set targets. NAC will continue to mobilise the community for early booking, testing and ART initiation for effective Option B+ outcomes. This will be done through, among others, community sensitisations, awareness meetings and the behaviour change door to door campaigns as well as male partner testing.

HIV Testing Service campaigns were conducted in all districts with more extensive campaigns conducted in the Matabeleland region. The main focus of the Matebeleland campaigns was the hard to reach key populations which include children, adolescents, mobile workers and gold panners. Over 77% of tested clients received their results.

The number of new STI cases has been declining from 203,921 in 2013 to 180,127 at the end of 2015. This could be due to expansion of community mobilizations that were supported by NAC focusing on equipping communities with information on prevention and appropriate referrals to clinical services. In 2015, forty percent of

clients newly treated for STIs were tested for HIV and 15% tested HIV positive. Contact tracing was done for 24% of the clients newly treated for STIs.

Against a target of 100, 000, 000 male and 5,500,000 female condoms, uptake reached 109,402,154 and 5,573,786 respectively. The Condomise campaign during ICASA and others throughout the year, including the Buy- One- and- Get –One- free campaign for wholesalers and stockist as well as the Condom Nights in liquor outlets contributed in part to the increased performance in this area.
The Public Sector Condom Acceptability among Youth in Zimbabwe Study was conducted in the year and revealed that uptake for males was at 83% compared to 23% for females.

The brother to brother and sister to sister programmes were piloted across the country. These programmes seek to enhance the self-efficacy of young boys and girls differently to access and utilise integrated HIV prevention, SRH and GBV services by empowering them to make responsible reproductive health decisions.

Youth remain a key at risk group that NAC is focusing on in an effort to prevent new infections. During the year, the Guidance and Counselling Syllabus which covers HIV education from Early Childhood Development (ECD) to "A" level was developed and adopted. As part of the response in the education sector, NAC supported the HIV and AIDS Quiz competitions at district, provincial and national levels. Ngwalongwalo Primary School from Bulawayo and Marist Nyanga High School won the first prizes for the respective levels.

In order to realign treatment strategies to achieve the 90-90-90 targets, the country has adopted viral load monitoring and is in the process of rolling out and equipping health facilities. The National AIDS Council supported the ART programme through procurement of medicines and equipment, funding outreach programmes and decentralization of services. The number of people in need of ART services in Zimbabwe stands at 1,254,579. Of these, 879,271 were on

ART by the end of 2015. The ART coverages for children, adolescents, young people and adults stand at 42.8%, 58.1%, 66.6% and 54.8% respectively.

Mashonaland West, Mashonaland East, Mashonaland Central and Masvingo provinces reported ART stock outs during the year. Medicines reported out of stock in these provinces were Kaletra for pediatric formulations and Efavirenz, Combivir, Lamvudine, Nevirapine, Zidolum, and Abacavir for the adults. The stock outs which were site specific, were as a result of challenges in ordering and stock control by the sites.

In support of orphans and vulnerable children's education, the National AIDS Council contributed $1,207,000 towards the Basic Education Assistance Module (BEAM) in 2015. The number of orphaned and vulnerable children receiving any type of support however declined in the year due to a variety of reasons, chief among them the limited funding commitments by donors and implementing partners.

Recognising the assistance Zimbabwe has received from the international community in support of the national response, the National AIDS Council donated USD100,000.00 to the UNAIDS for its global operations. A cheque of this donation was handed over to the UNAIDS Director, Mr Michel Sidibe during his visit to Zimbabwe in 2015.

Evidence is very crucial for planning and programming. In this regard, we are pleased that Zimbabwe is currently undertaking two population based surveys, the Demographic Health Survey (DHS) and the Zimbabwe population based HIV and AIDS (ZIMPHIA) survey, which were initiated in 2015, with results expected in 2016. With funding support from the Global Fund, NAC initiated steps for an ART outcomes study, whose findings will also be available in 2016.

In conclusion, we made considerable progress in 2015, but there is still

much to be done to deliver fully on the mandate of NAC and the objectives of the national response. We are confident that operational and financial performance will improve further during 2016 enabling us to achieve our targets for the year. As we pursue our mission and vision, we are confident that the strategic decentralised funding for HIV prevention we have invested in will start to bear positive fruits in the shape of reduced new infections.

On behalf of the NAC Board and management, I wish to thank our employees for their commitment to our mandate and hard work in 2015. I also wish to thank the community of the national response, our donors, implementing partners and the entire nation of Zimbabwe for being part of an enduring effort to tame HIV and AIDS. We can end AIDS by 2030 if we continue and strengthen our spirit of hard work and collaboration.

Enjoy the end of year's break and best wishes for 2016!

I thank you!

Dr. Tapuwa Magure
CHIEF EXECUTIVE OFFICER

CHAPTER 1: PREVENTION

In pursuit of the goal of ending AIDS by 2030, Zimbabwe intensified the implementation of various HIV prevention interventions in line with Combination Prevention Strategy. In 2015, the country prioritized interventions in the areas of behaviour change, condoms promotion and distribution, prevention of mother to child transmission, HIV testing services, voluntary medical male circumcision, and control of sexually transmitted infections as well as treatment as prevention. In addition, on the strength of NAC funding, there was emphasis on community driven HIV prevention interventions. The National AIDS Council set aside US$5 million for these interventions. This chapter presents performance of these and other HIV prevention activities implemented in the national response in 2015.

1.1 Prevention of Mother to Child Transmission

Zimbabwe continued to make concerted efforts towards the elimination of mother child transmission through the provision of comprehensive PMTCT services in all health facilities. To date the option B+ programme has been decentralized to 1560 health facilities with the aim of maximizing elimination by offering life-long ART to pregnant women, regardless of their CD4 count, in addition to the prophylaxis given for the unborn child.

The annual performance of the PMTC programme is summarized in the table below.

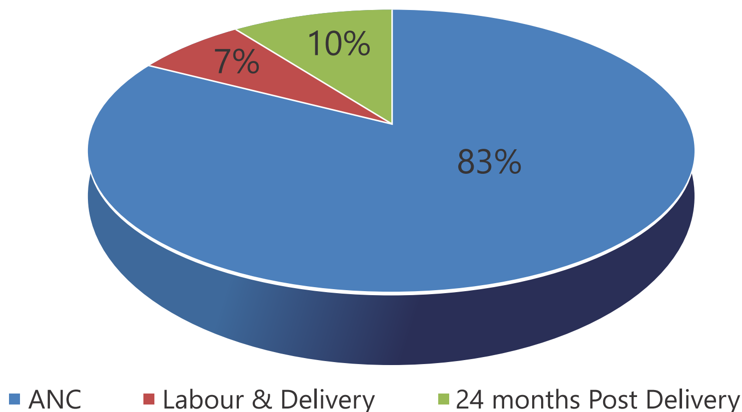
Table 1: PMTCT Outcome Indicators

Indicator	2014		2015	
	Target	Achievement	Target	Achievement
Percentage of Pregnant Women Attending ANC	94%	94.40%	95%	95%
Percentage of infants born to HIV infected pregnant mothers who receive ARV for prophylaxis for PMTCT	85%	80.10%	83%	74.6%
Percentage of HIV infected pregnant mothers who receive ARVs to reduce the risk of mother to child transmission	89%	99%	97%	99%
% HIV exposed infants provided with DNA PCR test within first 2 months of life	65%	74.70%	65%	71%

The proportion of pregnant women attending ANC decreased and exposed infants who received ARV prophylaxis also decreased between 2014 and 2015. This might have been as a result of possibilities of mother-baby pair loss to follow-up.

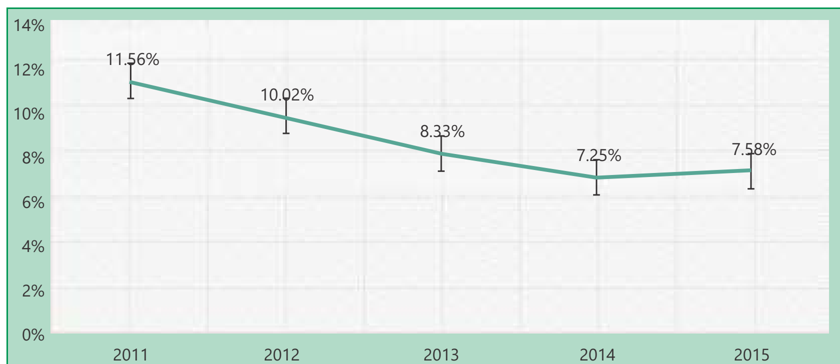
The graph below shows the uptake of PMTCT by stage of pregnancy in 2015.

Figure 1: 2015 PMTCT Uptake by Stage of Pregnancy



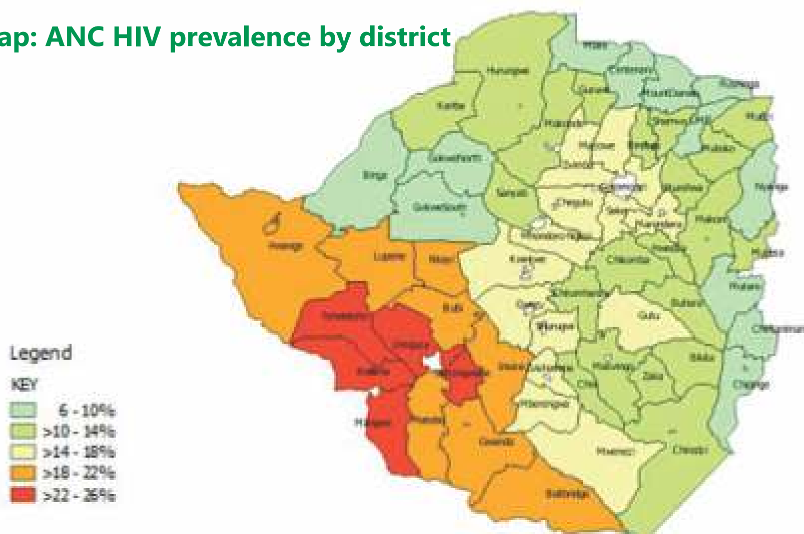
A greater proportion of women were initiated on ART during ANC, compared to other stages as shown above.

Figure 2: PMTCT Positivity Trends



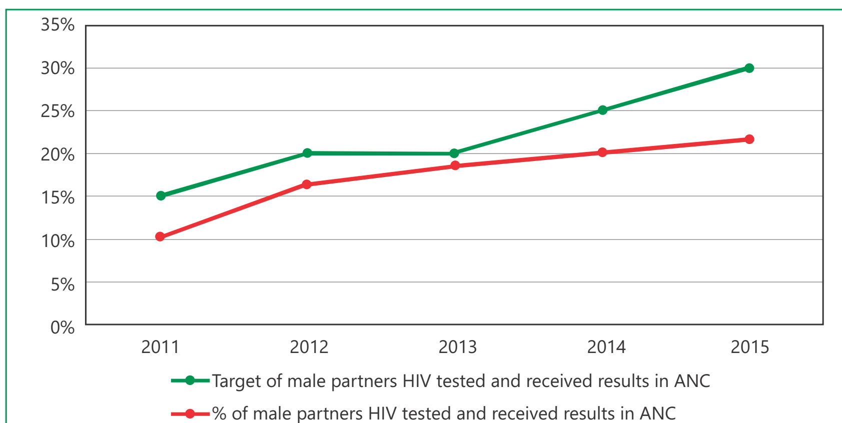
The graph above shows trends of HIV positivity for pregnant women in ANC. There was a slight increase in the PMTCT positivity rate between 2014 and 2015 though the increase is not significant. The following map shows ANC HIV prevalence by district.

Map: ANC HIV prevalence by district



ANC data shows that HIV prevalence is high in Matabeland region, and this is in line with the picture painted by the results of 2010/11 ZDHS.

Figure 3: Male partner testing in PMTCT



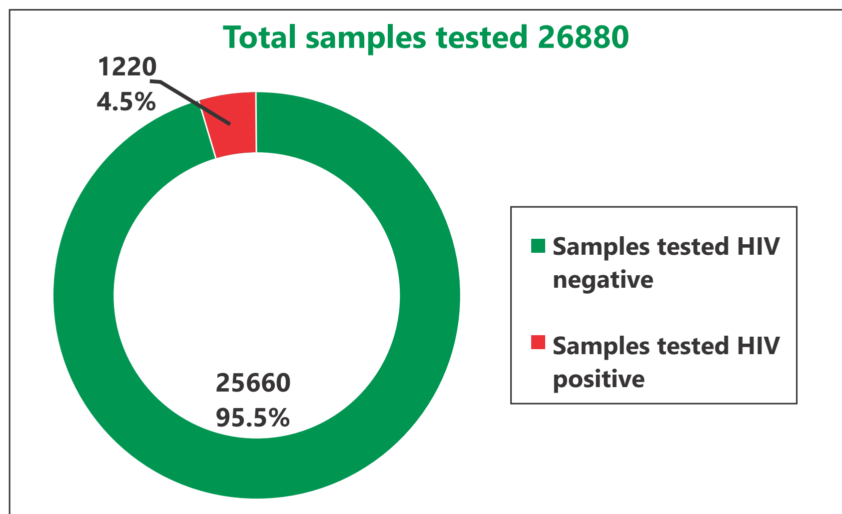
The graph above shows an increasing trend in the percentage of male partners who were tested in PMTCT from 2011 to 2015 which shows the positive effect of male involvement programmes.

Table 2: Early Infant Diagnosis (EID)

Activity	Achievements					
	2010	2011	2012	2013	2014	2015
Sites collecting DBS for EID	371	895	1500	1440	1489	1630
DBS Samples collected	16352	34660	53848	56572	38672	26880
% positivity rate for the sample collected	14%	10.6%	7%	5.1%	4.6%	4.5%

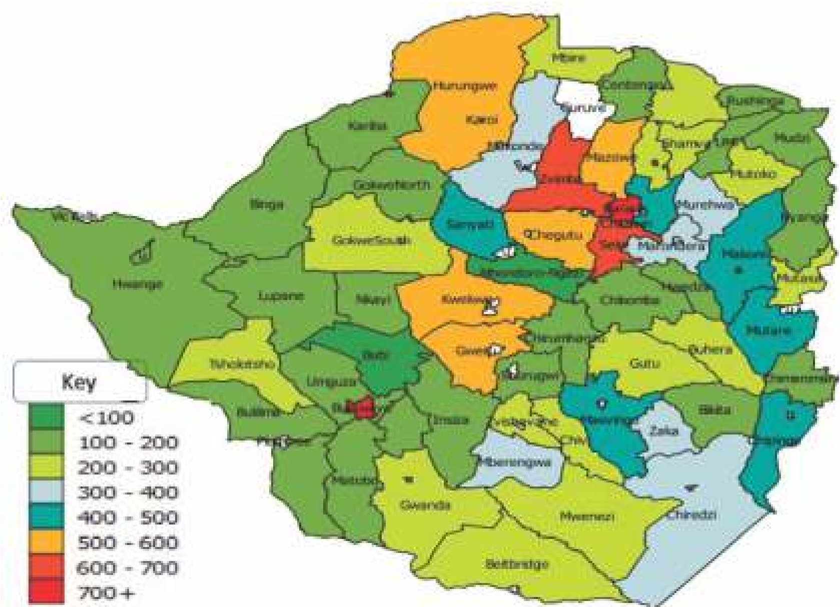
Since 2013, the number of sites collecting DBS has risen from 1440 to 1630 in 2015. The number of actual samples collected however declined from 56575 to 26880 during the same period, while the positivity rate has fallen from 5.1% to 4.5%.

Figure 4: Total DNA-PCR samples tested for all labs



The figure above shows that eMTCT positivity is lower than 5%, which indicates the success of PMTCT programme in Zimbabwe.

Map 2: Exposed infants tested by district



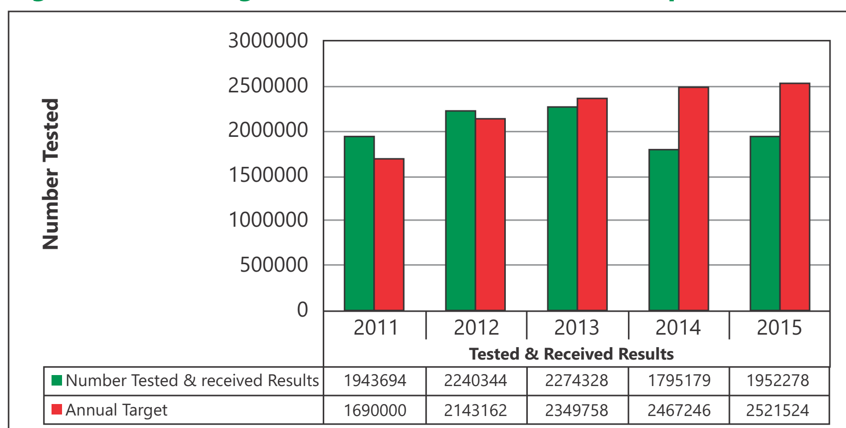
Metropolitan provinces are the ones that tested more samples for EID probably due to the availability of laboratories in the provinces.

1.2 HIV Testing Services (HTS)

HIV Testing Services (HTS) have helped millions of people know their HIV status, and for those testing positive, access long term treatment and care.

The figure on the next page indicates performance of HIV Testing Services from 2011 to 2014.

Figure 5: HTS Programme Performance for 2011 up to 2015



HTS campaigns were conducted in all districts with more extensive campaigns conducted in the Matabeleland region. The main focus of these campaigns was to serve the hard to reach populations which include children, adolescents and workers especially those in the informal sector and artisanal miners. Seventy seven percent (77%) (1,952,278) out of the targeted 2,521,524 clients who were tested received their results.

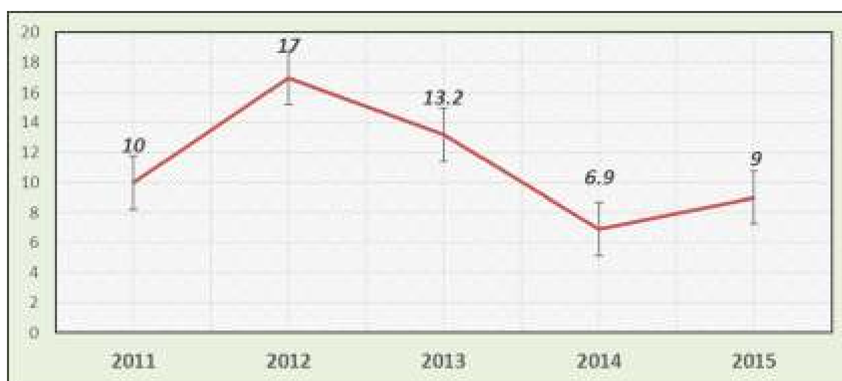
Table 3: HTC Services

	HIV Tests	Clients HIV tested and received results	Clients HIV positive	Clients HIV Positivity rate	Annual Target	% Performance
Bulawayo	92,105	91,492	11,713	13%	126,076	73%
Harare	261,882	257,859	28,885	11%	411,009	63%
Manicaland	256,792	246,743	18,061	7%	337,884	73%
Mash Central	198,733	190,228	14,399	8%	221,894	86%
Mash East	219,285	211,006	19,995	9%	259,717	81%
Midlands	225,463	219,354	20,021	9%	312,669	70%
Mat North	145,253	143,336	9,707	7%	143,727	100%
Mat South	120,094	118,607	12,094	10%	131,119	90%

Masvingo	240,041	232,818	17,918	8%	287,454	81%
Mash West	273,992	264,050	23,107	9%	289,975	91%
Total	**2,033,640**	**1,975,493**	**175,900**	**9%**	**2,521,524**	**78%**

Although only Matabeleland North met its various targets in HIV testing services, all the other provinces recorded positive results towards their targets.

Figure 6: Trend in HTC HIV positivity rate

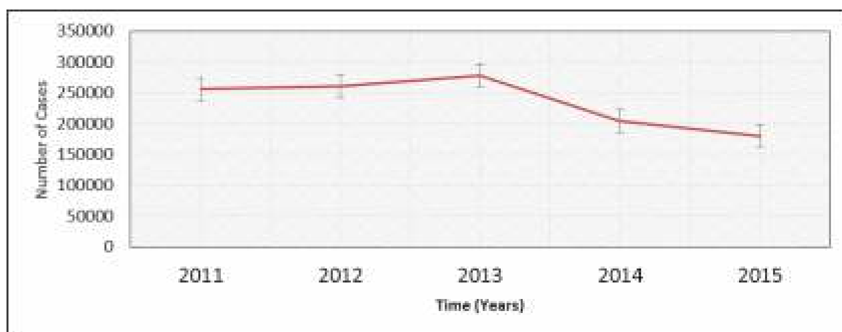


The graph above shows a decreasing trend in HIV positivity rate between 2012 and 2014. An increase was however recorded in 2015, perhaps based on the scale up of HTS.

1.3 Sexually Transmitted Infections (STIs)

The number of new STI cases declined from 2013 to 2015 as shown by the graph below. This could be due to expansion of community mobilization campaigns that were supported by NAC and other organisations focusing on equipping communities with information on STI prevention and appropriate referrals to clinical services.

Figure 7: New STI cases by year



Forty percent of clients newly treated for STIs were tested for HIV and 15% tested HIV positive. Contact tracing was done for 24% of the clients newly treated for STIs.

1.4 Condom Programme

The uptake of male condoms in 2015 was 109,402,154 against an annual target of 100,000,000 and 5,573,786 for the female condom against a target of 5,500,000. Various condom promotional activities such as the "Condomise" campaign during the ICASA, the Buy- One- and- Get –One- free campaign for wholesalers and stockist and the Condom Nights in liquor outlets, in part led to the surpassing of targets. The repackaging and introduction of scented condoms by PSI also contributed to the increase in uptake of condoms.

1.5 Youth Programme

A variety of youth programmes were conducted in-school, out-of-school and in tertiary institution to increase comprehensive knowledge, enhance life skills and improve uptake of Sexual and Reproductive Health (SRH), HIV and AIDS services.

1.5.1 Youth in School Programmes

In partnership with UNICEF, UNFPA and UNESCO, the National AIDS Council supported a number of programs targeting in-school youth. These activities included syllabus review and development, teacher capacity building and AIDS School Quiz competitions. Over 10,000 teachers were trained in delivering HIV and AIDS and life skills lessons to pupils, which has become an examinable subject. The AIDS School Quiz competitions were successfully held at district, provincial and national levels, with lots of prizes being given to winners. The prizes were aimed at motivating schools to take HIV and AIDS education seriously and to capacitate the schools for better delivery of the subject.

Picture 1: National school Quiz Competitions

Guests at the National school Quiz Competitions held at Prince Edward High School in October 2015, from right Dr J S Utete-Masango PEM Sec MoPSE, Dr Gjizen of UNESCO and NAC HR and Admin Director Ms S Mhlanga

A total of 1,129,074 students were reached through Life Skills, Sexuality, HIV and AIDS Education against an annual target of 3,380,955.

Table 4: Youth in School

Indicator	Annual Target	1st Quarter 2015	2nd Quarter 2015	3rd Quarter 2015	4th Quarter 2015
No of pupils taught on Life Skills, Sexuality, HIV& AIDS Education	3,380,955	1,067,053	1,070,113	1,129,074	1,113,709
No of pupils in AIDS Action Clubs		102,975	125,522	159,010	136,089
No of pupils receiving education assistance		121,106	45,996	129,180	128,456

1.5.2 Youth Out of School

The number of youth out of school who were exposed to HIV and AIDS education decreased from 268,018 in 2014 to 131,960 in 2015, most probably due to limitations in funding at implementer level.

Table 5: Youth Out of School

Indicator	Annual Target	1st Quarter 2015	2nd Quarter 2015	3rd Quarter 2015	4th Quarter 2015
Number of youth out-of-school exposed to HIV & AIDS education	180,000	30,414	36,380	28,910	36,256
Number of active peer educators	4,000	3,367	2,381	1,334	1,443

A decrease was also recorded in the number of active peer educators as most organisations programming on youth out of school faced funding challenges. This is however expected to improve as NAC intensifies HIV prevention activities at community level through the decentralized funding mechanism.

1.5.3 Youth in Tertiary Institutions

There was a marked increase in the uptake of HIV and AIDS services for tertiary students, resulting in 104,134 students being reached with related activities. Activities in this category included orientation of new students on HIV and AIDS, HIV prevention dialogues, outreaches, planning and coordination meetings.

Picture 2: STE Campaign

Tertiary level students on an HIV and AIDS campaign in Harare

1.5.4 Other Key Youth Activities

Other key youth activities implemented in 2015 included the Public Sector Condom Acceptability among Youth in Zimbabwe Study and the STEPS videos screening project. Among other findings, the Public Sector Condom Acceptability among Youth in Zimbabwe Study highlighted a higher condom uptake of the male condoms, at 83% compared to 23% for female ones.

1.6 Behaviour Change and Communication

On the strength of NAC's decentralised district funding mechanism introduced at the beginning of 2015, the behaviour change programme recorded increasing numbers of persons reached with services from 86% in the first quarter to 97% in the fourth quarter, against an annual target of 662,400.

Peer reviews, door to door campaigns, community dialogues, sensitization meetings, and video screenings were some of the activities funded by NAC in support of the behaviour change programme in 2015.

Table 6: Annual achievements

Indicator		2015			
	Quarterly Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Total number of persons reached	662,400	86%	90%	95%	97%
No. of new households reached through home visits	220,800	86%	91%	99%	101%
Number of people referred for integrated HIV services		265,075	288,455	208,613	314,713

1.6.1 Brother to Brother (B2B) and Sister to Sister (S2S) Programmes

The Brother to brother (B2B) programme whose aim is to create a safe environment for boys to change their sexual behavior was piloted in Masvingo Province, where 15 male mentors were
trained in dealing with ASRH & HIV for boys. Each mentor established a group of 25 boys and held weekly meetings to share information and experiences in addressing issues affecting boys.

The sister to sister programme on the other hand was also introduced in Matabeleland North (Nkayi, Lupane and Hwange Districts), Manicaland (Nyanga, Mutare and Mutasa Districts) and
Masvingo (Gutu District) provinces. The aim of the sister to sister programme is to enhance self-efficacy of young women to access and utilise integrated HIV prevention, SRH and gender based violence (GBV) services by empowering them to make responsible reproductive health decisions.

1.7 Voluntary Medical Male Circumcision (VMMC)

A total of 188,732 men were circumcised from January to December, which is 78.8% of the annual target of 239,580. Cumulatively, 46.3% (601,303/1,300,000) of the targeted population has been circumcised.

The following table outlines number of people circumcised by age by year to date from 2009.

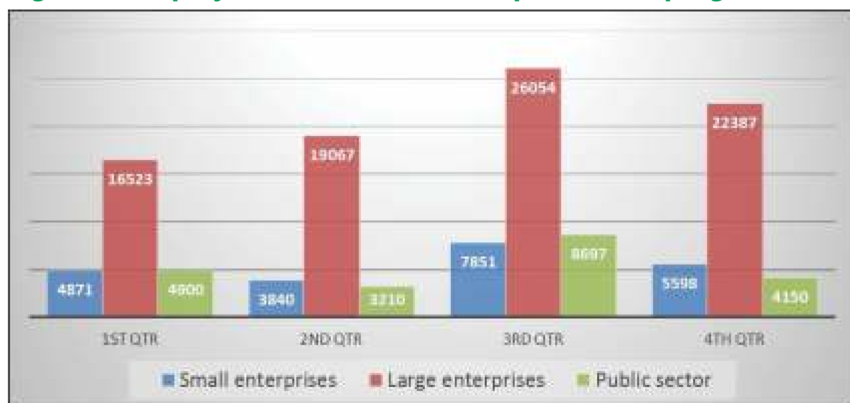
Table 7: Circumcision procedures done from 2009 to 2015

Year	(<1Yr)	(1-9Yrs)	(10-12Yrs)	(13-14Yrs)	(15-19Yrs)	(20-24Yrs)	(25-29Yrs)	(30-49Yrs)	(50Yrs+)	Total
2009	-	-	-	17	216	765	794	994	15	**2,801**
2010	-	-	-	1,792	1,954	2,626	2,069	2,506	229	**11,176**
2011	-	-	-	8,771	11,403	6,502	4,382	5,207	477	**36,742**
2012	-	-	-	11,087	12,572	6,916	4,503	5,150	484	**40,712**
2013	-	-	-	46,471	35,324	13,173	7,949	8,327	840	**112,084**
2014	-	-	-	97,687	62,533	23,067	11,699	12,748	1,322	**209,056**
2015	46	3,777	38,804	39,819	54,011	25,027	14,294	11,788	1,166	**188,732**
Total	**46**	**3,777**	**38,804**	**205,644**	**178,013**	**78,076**	**45,690**	**46,720**	**4,533**	**601,303**

1.8 Workplace

NAC in partnership with implementing partners supported companies and institutions to develop and implement workplace HIV and AIDS policies and programmes through sensitization and training of company managers and focal persons. Road shows and dialogues were also conducted with the informal sector to create awareness and enhance their capacity to prevent new HIV infections.

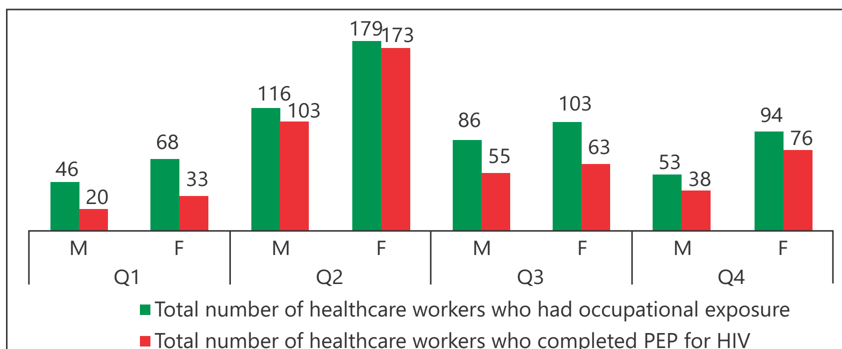
Figure 8: Employees reached with HIV prevention programmes



A total 127,148 employees were reached with HIV prevention programmes with the majority of those being reached by large enterprises (84,031). The performance of the workplace programme has remained subdued due to limited investment by companies and organisations in their HIV and AIDS workplace programmes as a result of challenging economic environment. Some companies have scaled down on their operations resulting in the demise of the HIV programmes. Only those companies with a significant profit margin have been able to sustain the programmes.

1.9 Infection Control

Figure 9: Infection Control



A total of 745 healthcare workers were occupationally exposed to HIV and of these 561 completed their post exposure prophylaxis (PEP).

1.10 Sexual Violence

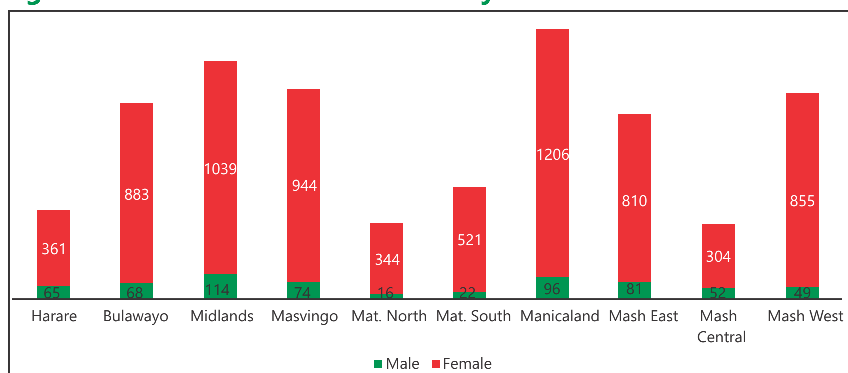
Sexual violence remains a major concern within the country with policy makers continuously discussing how the implementation of existing legislation can be improved. NAC supported engagement of traditional and community leaders as advocates for eliminating gender based and sexual violence. This was achieved through community dialogues and sensitization meetings which also further encouraged reporting cases of sexual violence within communities.

Table 8: Sexual Violence Indicators

	1st Quarter		2d Quarter		3rd Quarter		4th Quarter		Total
	Male	Female	Male	Female	Male	Female	Male	Female	
Number of clients sexually abused	138	1677	126	1603	182	2247	129	1873	7975
Number of sexually abused clients HIV tested	136	1519	116	1506	171	2051	84	1631	7214
Number of sexually abused clients tested HIV positive	1	77	9	63	4	103	6	78	341
Number of sexually abused clients who received PEP for HIV	28	295	32	286	30	378	23	362	1434

Cases of gender based violence significantly increased during the third compared to other quarters. A total of 7,975 people were sexually abused in 2015 with women constituting the majority. Of the 7,975 people, 1,434 received PEP, while 341 tested HIV positive.

Figure 10: Cases of sexual violence by Province



The above graph shows cases of sexual violence by province with more cases recorded in Manicaland, Midlands, Masvingo Bulawayo, Mashonaland East and Mashonaland West. There are a number of factors contributing to sexual violence among them religion and culture.

1.11 Key Populations

Prisoners constituted the majority of key populations reached with HIV and AIDS interventions. Categories of various groups and the extent to which they were reached are given on the next page.

Table 9: Key populations

INDICATOR	2014	2015
Number of sex workers reached with HIV prevention programmes	7320	10129
Number of truck drivers reached with HIV prevention programmes	5684	6407
Number of prisoners reached with HIV prevention programmes	10542	13583
Number of fishermen reached with HIV prevention programmes	1464	1850
Number of small scale miners reached with HIV prevention programmes	3494	4610
Number of migrants reached with HIV prevention programmes	2492	1421

A general increase in the numbers of key populations reached with HIV prevention programmes was recorded in the quarter except for migrants. The increase in number of sex workers has been attributed to the opening of more clinical sites for sex workers, both mobile and static by partners such CeSHHAR. CeSHHAR also initiated a size estimation exercise for sex workers in the year, meant to inform planning and programming.

City of Harare in partnership with NAC, MOHCC with technical assistance from UNFPA opened a 24 hour GBV clinic at Wilkins Hospital to offer timely and quality service to survivors of sexual and gender based violence (SGBV). The clinic is targeting sex workers, sexually abused children and any other GBV survivor from the community at large.

1.11.1 NAC and ZPCS Partnership

Having identified prison inmates as part of the key populations in the response to HIV and AIDS in Zimbabwe, the National AIDS Council (NAC) supported the Zimbabwe Prison and Correctional Services (ZPCS) with inputs worthy $100,000.00 for production of maize for inmates on ART's nutrition. Inmates provided labour for the production, which was piloted at various ZPCS farms in Bindura. The Vice President and Minister Of Justice, Legal and Parliamentary Affairs, Honourable Emmerson Mnangagwa was the Guest of Honour at the handover ceremony of the 500 tonnes of maize harvested at Bindura Prison Farm. Additional maize input support was also extended to Ridigita prison farm in Marondera. Gwanda prison farm received 83 goats for an inmates nutrition support project.

Insert 1

From the right: Vice President of the Republic of Zimbabwe, Hon. E.D. Mnangagwa, and theCommissioner of the Zimbabwe Prison and Correctional Services, Mr Zimondi during the handover of the Bindura Prison Maize production project (May 2015) that was funded by NAC to augment nutrition for prisoners.

Insert 2

Part of the maize crop and produce at Bindura Prison Farm

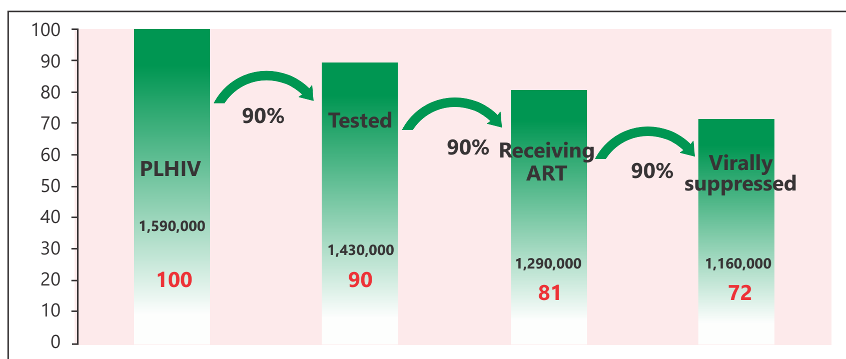
CHAPTER 2: TREATMENT AND CARE

This chapter presents performance of treatment, care and support programme activities implemented in 2015. These include the provision of antiretroviral services (ART), HIV and TB collaboration, community and home based care (CHBC), as well as orphans and vulnerable children.

2.1 The ART Programme

The objective of the ART programme is to reduce morbidity and mortality due to AIDS through provision of antiretroviral treatment. In order to realign treatment strategies to achieve the 90-90-90 targets the country has adopted viral load monitoring and is in the process of rolling out and equipping health facilities. The following figure shows a schematic cascade of the pursuit of the 90 x 90 x 90 programme targets in Zimbabwe.

Figure 11: 90-90-90 Cascade

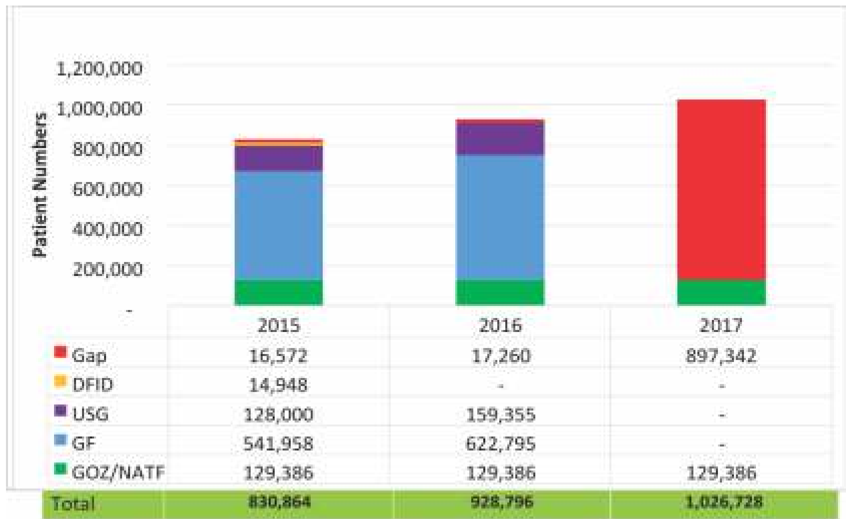


The National AIDS Council supported the ART programme through procurement of medicines and equipment, funding outreach programme and decentralization of services.

2.1.1 Projected ART Support by Different Partners

As shown below, the ART programme has been supported by the NATF, GF, USG and DFID. The figure on the next page shows projected ART support by the major partners.

Figure 12: ARV Funding Commitments and Gap for 2015



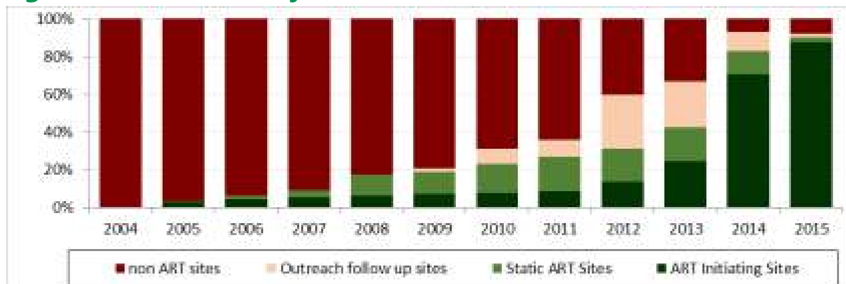
	2015	2016	2017
Gap	16,572	17,260	897,342
DFID	14,948	-	-
USG	128,000	159,355	-
GF	541,958	622,795	-
GOZ/NATF	129,386	129,386	129,386
Total	830,864	928,796	1,026,728

Most of the donor commitments towards provision of ART end in 2016 thereby leaving a major gap in 2017. Discussions have been ongoing on how this gap would be tackled to avoid disaster. Forecasts of contribution of the National AIDS Trust Fund have remained constant as a result of performance of the local economy.

2.1.2 ART Sites

Against an annual target of 1450 ART sites, 1545 both initiating and follow up were functional by the end of the year. The graph below outlines the growth of the ART sites by year.

Figure 13: ART Sites By Year



2.1.3 ART Medicines and Equipment Procurement

The following table shows the ART medicines and equipment procured in the year under review.

Table 10: Reagents and Diagnostic Equipment

Item Description	Value
Haematology controls	322,555.68
Viral load reagents	187,000.00
Servicing of Diagnostic Equipment (Haematology, CD4 Machines and Chemistry analysers)	160,000.00
Breast Cancer Screening Mammography package	250,000.00
CD4 reagents	300,080.00

Table 11: ARVs

Item Description	Cost
Tenofovir DF/ Lamuvidine / Efavirenz 300/300/600mg	9,700,000.00
Atazanavir/ Ritonavir 300/100mg	2,475,970.00

Table 12: Test Kits

Item Description	Cost
HIV Test kits – Determine	617,000.00
Syphilis Test kits – SD Bioline	559,000.00
HIV test kits- First Response	400,020.00

2.1.4 Stock outs

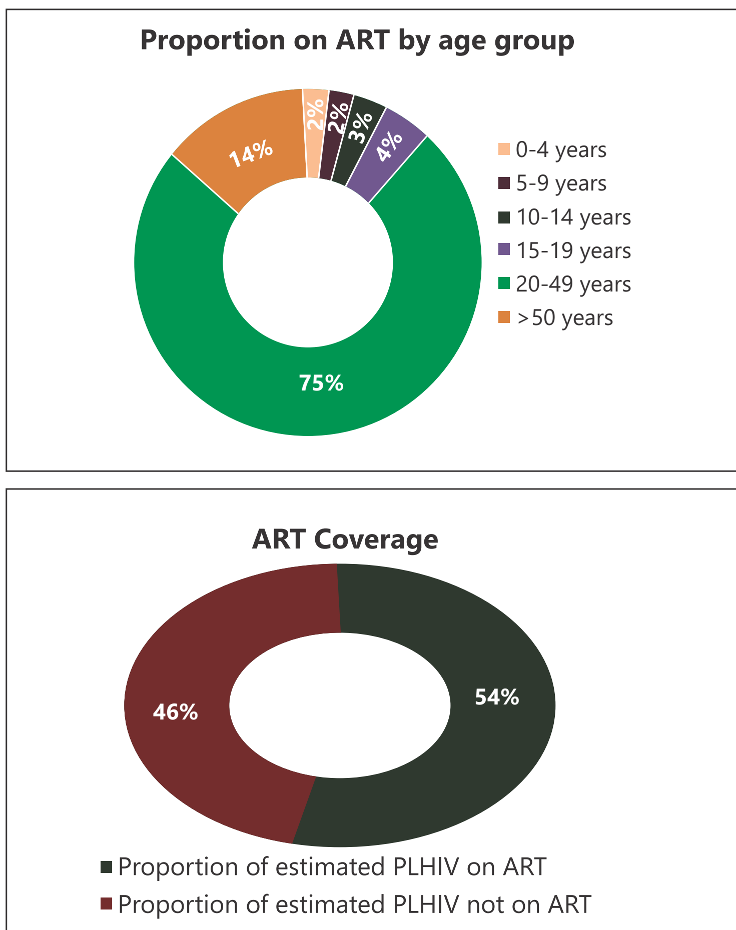
Stock outs of Kaletra (paediatric formulation), Efavirenz, Combivir, Lamvudine, Nevirapine, Zidolum, and Abacavir for adults were experienced in Mashonaland West, Mashonaland East, Mashonaland Central and Masvingo. The stock outs did however not disrupt service delivery.

2.1.5 Clients on ART

The number of people in need of ART services in Zimbabwe stands

at 1,254,579. Of these, 879,271 were on ART by the end of 2015. The following figure shows the coverage of ART services and the proportion of those on ART by age group.

Figure 14: ART Coverage



The ART coverages for children, adolescents, young people and adults stand at 42.8%, 58.1%, 66.6% and 54.8% for respectively.

Zimbabwe National HIV Estimates 2014

Map 3: ART Coverage by age

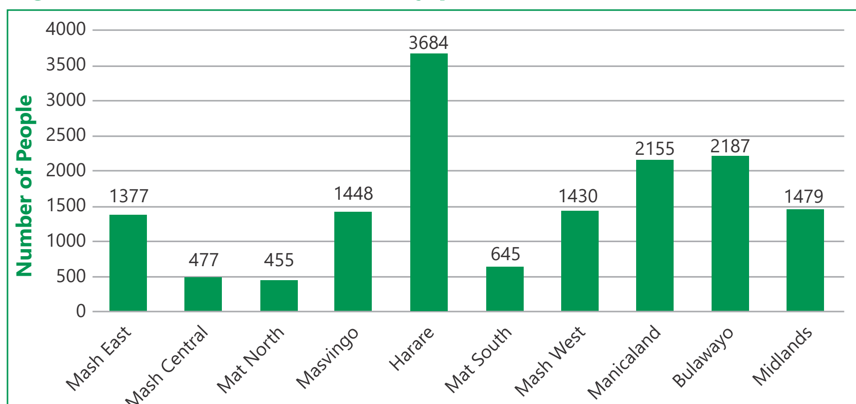
Although ART coverage is above 50% for adults in nearly all provinces, it is below half for children in all provinces except for Matebeleland North and Matebeleland South. It is however important to note that coverage is based on the estimated 1,254,579 in need of ART although some of them have not presented for HIV testing. The majority of those tested have actually been initiated on ART.

2.1.6 Second line ART

The proportion of clients on second line ART increased from 1.7% in 2014 to 1.8% in 2015.

The following figure shows clients on second line by province.

Figure 15: Second line clients by province



Harare province has the highest proportion of people on second line ART probably as a result of availability of specialist services in Harare, which are not readily available in other provinces.

2.1.7 AIDS deaths

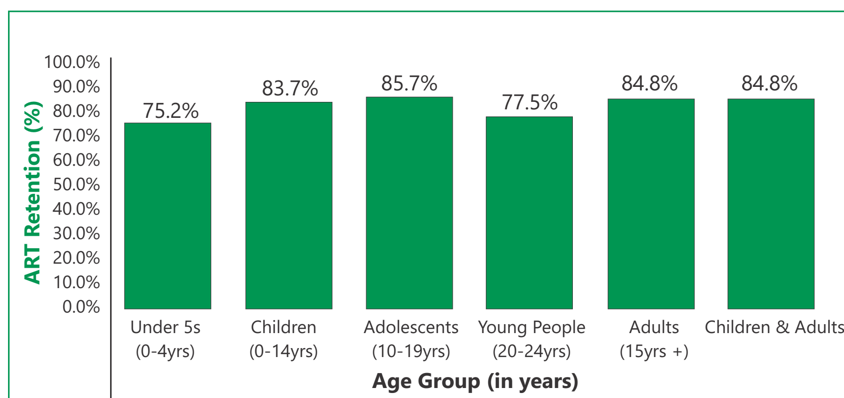
The case fatality rate was 2 patients per 1000 for the year under review

2.1.8 Retention on ART

Retention of children and adolescents on ART is fairly high probably due to adult supervision. Compared to the ART Outcomes Study results from the 2012 investigation, retention has increased from 78% to 85% after 12 months among adults.

The following figure shows ART retention by age after 12 months on ART.

Figure 16: ART Retention by Age



2.2 HIV and TB Collaboration

Fifty three percent (53%) of HIV patients were screened for TB in 2015. There was a decrease in the proportion of HIV positive TB patients started on ART from 48% in 2014 to 46% in 2015. In support of the HIV and TB collaboration activities, NAC procured MDR TB medicines worthy $627,249.58 in 2015.

2.3 Community and Home Based Care (CHBC)

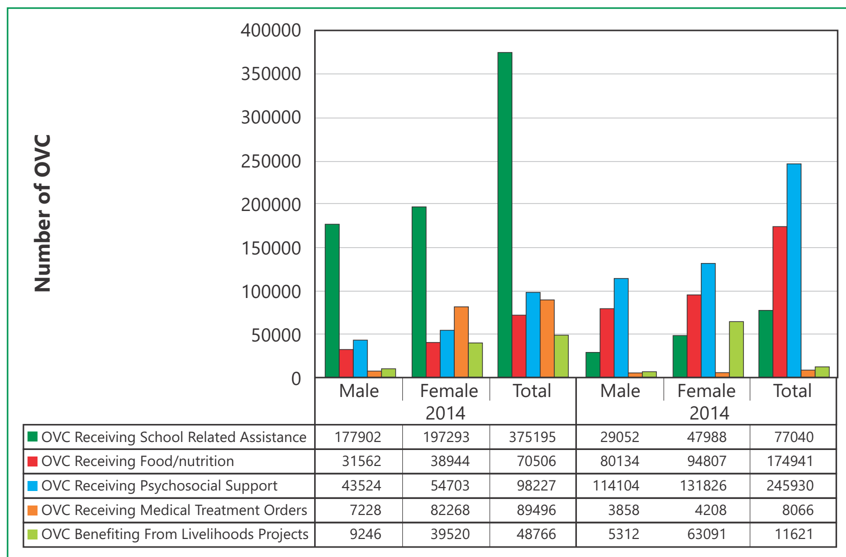
There was a 55% (16,429) decline in the number of clients who accessed CHBC services in 2015 compared to 2014, where 30,097 clients were served. The decline has been related to the results of ART, wherein most people have better treatment outcomes. A slight increase was recorded in the number of bed ridden clients from 5.2% in 2014 to 6.2 % in 2015, while 6.2% of CHBC clients died in 2015. It has been observed that most of the clients who died while on CHBC would not have adhered to prescribed treatment regulations resulting in treatment failure.

2.4 Orphans and Vulnerable Children (OVC)

A general decline was recorded in various indicators for the OVC programme in 2015, mainly due to resource constraints among implementers.

Assistance Module (BEAM) in 2015. The number of OVC that received support declined during the course of the year as shown in the figure below except for support through food and nutrition.

Figure 17: Support to OVC



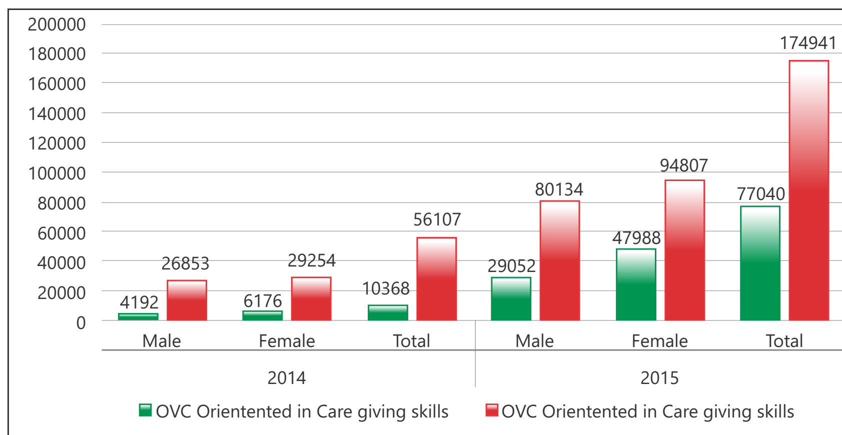
	Male (2014)	Female (2014)	Total (2014)	Male (2014)	Female (2014)	Total (2014)
OVC Receiving School Related Assistance	177902	197293	375195	29052	47988	77040
OVC Receiving Food/nutrition	31562	38944	70506	80134	94807	174941
OVC Receiving Psychosocial Support	43524	54703	98227	114104	131826	245930
OVC Receiving Medical Treatment Orders	7228	82268	89496	3858	4208	8066
OVC Benefiting From Livelihoods Projects	9246	39520	48766	5312	63091	11621

NAC Board Chairman, Dr. Evaristo Marowa handing over a cheque of NAC's BEAM contribution to Permanent Secretary for the Ministry of Health and Child Care, Brig. Gen Dr. Gerald Gwinji for handover to the Ministry of Labour, Public Service and Social Welfare

2.4.1.1 OVC Skills

As illustrated below, there was a marked increase in the number of OVC provided with life skills in 2015 compared to 2014.

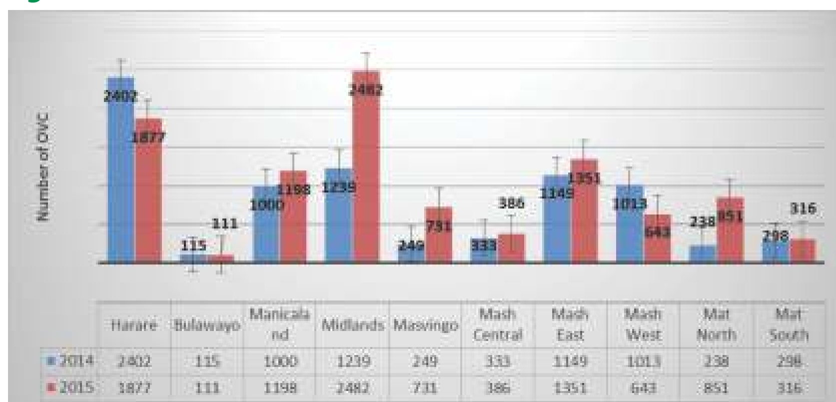
Figure 18: OVC skills



2.4.1.2 Child Abuse

A significant increase was recorded in the number of reported cases of child abuse in seven provinces in 2015 as shown in the figure below, with Midlands, Masvingo and Matabeleland North provinces recording over 50% of cases.

Figure 19: Child abuse



	Harare	Bulawayo	Manicaland	Midlands	Masvingo	Mash Central	Mash East	Mash West	Mat North	Mat South
2014	2402	115	1000	1239	249	333	1149	1013	238	298
2015	1877	111	1198	2482	731	386	1351	643	851	316

CHAPTER 3: ENABLING ENVIRONMENT

This section of the report presents progress and challenges recorded in policies and management as they seek to achieve an enabling environment for the coordination and implementation of the national response. These areas include advocacy and communication, gender, management and monitoring and evaluation among others.

3.1 Advocacy and communication

World AIDS Campaign

An estimated 2000 people attended the World AIDS Day commemoration which was officially launched by the Hon Minister of Health and Social Services for Namibia Dr. Berhard Haufiku. The commemoration, whose theme was "Getting to Zero in Africa – Africa's responsibility, Everyone's responsibility" was held on 01 December 2015, as part of the International Conference on AIDS and STIs in Africa programme.

IYASA Musical Group performing during WAD Commemoration Harare International Conference Centre, 01 December 2015.

Seven provincial WAD commemorations were also held in Mashonaland Central, Mashonaland East, Mashonaland West, Harare, Manicaland, Masvingo and Midlands as part of the World AIDS Campaign (WAC) 2014 post launch activities.

Advocacy workshop for Parliamentarians

NAC in collaboration with the Ministry of Health and Child Care, (MoHCC), the United Nations Fund for Population Affairs (UNFPA) and the Zimbabwe Lawyers for Human Rights (ZLHR) conducted an HIV and AIDS meeting for parliamentarians from the Portfolio Committees on Health and Child Care, Women, Gender and Community Development, Justice, Legal and Parliamentary Affairs and the Senate Thematic Committee on HIV and AIDS. The meeting was aimed at updating the parliamentarians on the current and emerging HIV and AIDS issues. A total of 63 parliamentarians attended the meeting and agreed to move motions in Parliament to address issues of key populations, child marriages, access to treatment and funding.

Religious Sector Meeting

NAC conducted a meeting for the religious sector aimed at creating and raising HIV and AIDS awareness among the sector. A total of sixty religious leaders and their spouses attended the meeting which was officially opened by the Mashonaland West Resident Minister Hon Faber Chidarikire. He urged the leaders to remove policies that hinder access and utilisation of HIV and AIDS services within their churches.

HIV and AIDS Musical Campaigns

Four HIV and AIDS musical campaigns where held in Mashonaland East and Harare provinces, aimed at providing HIV and AIDS family health services, such as counselling and testing, family planning services, cancer screening, blood pressure and diabetes checks, as well as information dissemination under one roof. In total 2500 people were tested for HIV and over 3000 females received family planning services during the four musical campaigns.

Scores of people attending an HIV and AIDS musical campaign at the Mbare Netball Complex on 31 November 2015 were approximately 5000 people attended.

Exhibitions

To enhance NAC visibility and put HIV and AIDS on the national agenda through information dissemination, NAC exhibited at the Zimbabwe International Trade Fair, Harare Agricultural Show and various provincial agricultural shows. At least 15,000 people passed through the NAC's exhibitions.

Media Meetings

Two meetings to update the media on the current and emerging HIV and AIDS issues to ensure positive and informed reporting were held for editors and journalists during the year.

Media Coverage

NAC received positive media coverage throughout the year, with at least 180 articles appearing in both electronic and print media. Additional coverage of interventions was achieved through the four volumes of the NAC bulletin published in the year.

3.2 Gender

Gender activities for 2015 benefited a lot from the NAC decentralised funding mechanism, with the bulk of these taking place at community level. The activities targeted community and traditional leaders to

strengthen their capacity to address gender issues, particularly gender based violence. Modes of delivery included dialogues, sensitization meetings and roadshows.

Table 13: Gender

Indicator	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total
	Male	Female	Male	Female	Male	Female	Male	Female	
No. of people reached with HIV programmes	31279	60457	43550	63707	41911	75067	51317	81158	448446
No. of people assisted in economic strengthening programmes	11046	29301	13702	38105	13321	34451	20532	51757	212215
No. of people reporting abuses(sexual, physical, economic)	845	13619	701	338	903	4986	2223	6474	30089
No. of people assisted in legal issues	4333	20757	3666	7443	6123	10221	4148	10190	66881

Cases of domestic violence continue to be high especially among women. In response, NAC in partnership with the Ministry of Women Affairs, Gender and Community Development and other implementing partners conducted activities to create awareness on this matter to the general population.

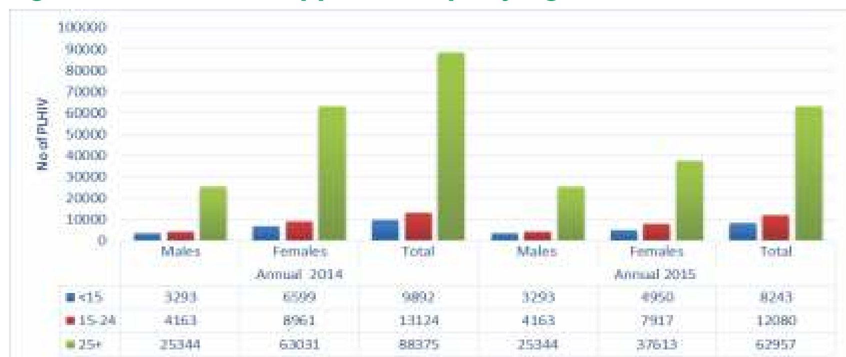
3.3 People Living with HIV (PLHIV)

The Meaningful Involvement of People Living with HIV, (MIPA) principle calls for their involvement the planning, implementation and evaluation of HIV programmes at all levels. In order to fulfill this principle, the National AIDS Council (NAC) in 2015 collaborated with ZNNP+ as the national network representing PLHIV and affiliated networks and organisations for PLHIV such as ZHAAU, ZHHAU CT, LESO, BHASO, FASO, PLAZ, NAVHO ICW, INERELA, PAPWIC, among others at national and provincial levels to fulfil this mandate. These organisations conducted activities such as support group formation and strengthening, advocacy, community monitoring, and stigma reduction and treatment literacy among others.

3.3.1 Support Groups

As shown in the figure below, membership to support groups declined from 111,391 in 2014 to 83,280 in 2015. Although reasons for this have not been established yet, it could have been due to the fact that some people no longer see the need for support groups since they can access their medication with relative ease.

Figure 20: PLHIV in Support Groups by Age



3.3.2 Support to PLHIV

Support provided to PLHIV declined during the period under review except for psychosocial support. Food support declined by 70% and the number of PLHIV benefiting from support groups also declined from 79233 to 44968.

Table 14: Support to PLHIV

	Annual 2014			Annual 2015		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**
No of PLHIV provided with food /nutrition	38739	59443	98182	11567	17559	29126
No of PLHIV provided with PSS	86917	88375	175292	89588	180341	269929
Number of PLHIV provided with medical support	17145	34260	51405	13366	28031	41397
Number of PLHIV provided with financial support	1699	10303	12002	2168	6859	9027
Number of PLHIV benefiting from livelihoods	15644	63579	79223	8285	36683	44968

The decline in the support for PLHIV mirrors the general dwindling of resources for HIV especially those targeting mitigation activities.

3.3.2.1 Stigma Reduction Initiatives

Stigma was noted as one on the barriers to access to HIV prevention and treatment services. According to the 2014 Zimbabwe Multi Indicator Cluster Survey accepting attitudes by the general population towards PLHIV was 43% for women and 44% for men. This reflects that levels of stigma are still high. Initiatives to reduce stigma implemented in 2015 included the stigma index, which include Positive Health Dignity Prevention and the Inquiry Based Stress Reduction (IBSR).

3.3.2.2 Community Monitoring of ART/OI Services

Community monitoring of opportunistic infections (OI) and ART services was decentralised to provincial levels. Provincial teams were set up, inducted and started work in Mashonaland East, Manicaland, Matabeleland, South and North as well as Bulawayo. The national team visited Matabeleland South and Mashonaland East. ZHAAU-CT also visited Midlands, Masvingo, Mashonaland Central and Mashonaland West to monitor programme implementation.

Picture 3: Community monitoring team interacting

Some of the community monitoring team members interacting with service providers in Masvingo province

The visits showed that there is improvement in the management of ARV stocks as fewer stock outs were reports in 2015. However the issue of side effects of Tenolum E was reported to be a major challenge. Very few centers were offering viral load services and there is need to scale up viral load monitoring in line with 90-90-90 targets.

3.4 Management and Coordination

3.4.1 Coordination

In order to fulfil its mandate, the National AIDS Council facilitated various coordination and stakeholder meetings, integrated district planning meetings, and programme and technical support visits to districts. A total of 1,935 coordination and stakeholder meetings were conducted throughout the year at district, provincial and national levels.

3.4.2 Management and Coordination Meetings

Management meetings were held in all quarters of the year to review progress in the implementation of the national response. Discussed among other issues was the need to strengthen NAC coordination mechanisms with a recommendation to review the current structures so that they are aligned to the new ZNASP.

3.4.3 DAACs/ PAACs/ Stakeholders meetings

District and provincial coordination meetings were held throughout the year. These meetings were meant to provide feedback to implementers on various intervention activities and to strengthen their capacity in the national response.

3.4.4 International Conference on AIDS and STIs in Africa (ICASA)

After winning the bid to host the 18th edition of the ICASA, Zimbabwe successfully hosted the conference, which brought 4700 delegates from around the world, including scientists, health workers, policy makers, people living with HIV (PLHIV), community leaders and activists working in the fields of HIV and AIDS, sexually transmitted infections, as well as Tuberculosis, Malaria and Ebola.

The conference whose theme was HIV and AIDS in Post 2015 Era: Linking Science, Leadership and Human Rights, was animated by high quality exhibitions by big pharmaceuticals, satellite and plenary sessions, and the community village, which featured people living with HIV, among other activities.

Zimbabwe benefited immensely from hosting the conference. All hotels were fully booked with positive economic knock off effects in retail, transport, communications and cultural sectors.

3.4.5 NAC Donation to UNAIDS

Recognising the assistance Zimbabwe has received from the international community in support of the national response, the National AIDS Council donated USD100,000.00 to the UNAIDS for its global operations. A cheque of this donation was handed over to the UNAIDS Director, Mr Michel Sidibe during his visit to Zimbabwe in 2015.

Minister of Health and Child Care, Dr. P. D. Parirenyatwa, handing over a cheque of NAC's contribution of US$100,000.00 to UNAIDS Executive Director, Mr. Michel Sidibe

3.5 Monitoring and Evaluation

Monitoring and evaluation activities implemented in 2015 included compilation of the Global AIDS Response Progress Report (GARPR), generation of national and sub-national HIV estimates, the private sector ART survey, and establishment of the private sector M & E system among others.

3.5.1 Global AIDS Response Progress Report (GARPR)

NAC with support from UNAIDS and MoHCC took the lead in the compilation of the Global AIDS Response Progress Report for 2014. Several consultation meetings were held to gather and validate data for the report, which gives a picture of the progress made towards achieving the 2011 High Level Meeting (HLM) targets and MDGs.

3.5.2 Generation and training on national and sub-national HIV estimates

HIV estimates for 2014 were generated as part of the Global AIDS Response Progress Report. Provincial officers from NAC and MoHCC were trained in HIV estimates generation at sub national levels to inform planning and reporting.

3.5.3 SADC Epidemic update report

The SADC epidemic update report, which is a follow up on commitments made by Heads of State at Maseru declaration, was compiled for 2014 and shared.

3.5.4 Establishment of Private Sector M & E System

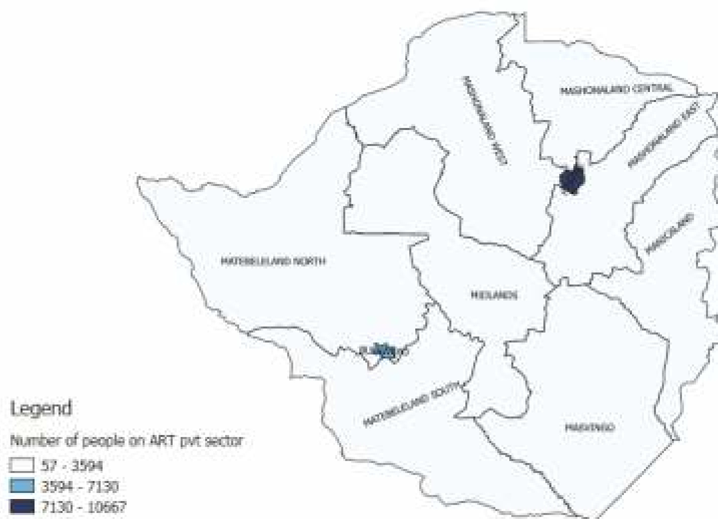
Following consultations, a private sector M & E system on HIV & AIDS, TB and Wellness was developed. Follow up meetings were proposed for NAC and association of retail pharmacies and Collage of Primary Care Physicians to ensure they report through the system.

3.5.5 ART Private Sector Survey

NAC in collaboration with the Ministry of Health and Child Care conducted a survey to determine the number of people accessing ARVs from the private sector. Findings from the survey show that there are 43521 clients served by the private sector and of these 22,014 were not being reported through the national monitoring system. The following map shows distribution of people on ART who were not being reported.

Figure 21: Number of people on ART not reported in private sector

Number of people on ART through private sector



Harare has the highest number of people followed by Bulawayo.

3.5.6 Research and Hot spot mapping training

The study on the uptake of post exposure prophylaxis whose data collection was done in the 4th quarter of 2014, was completed in 2015. NAC also provided funds for data analysis and report writing of uptake of Option B+ study by Ministry of Health and Child Care. In addition, NAC also completed a study on private sector contribution to ART, in which all clients collecting their ARVs through the private sector were enumerated.

NAC also co-funded the prize giving day event for the 2015 Annual Medical Research Day.

Senior staff members at NAC were trained in conducting research and evaluations, data analysis as well as conducting mapping of HIV hotspots. This training was implemented to consolidate generation and application of evidence for planning and problem solving, which

have become very critical as NAC rolls out the de-centralized funding approach forcommunity HIV prevention interventions.

3.5.7 2016 Planning Process

All districts were supported in developing their evidence informed work-plans for 2016. This included problem identification and analysis as well as developing effective interventions to address the problems.

3.5.8 Global Fund Supported Population Based Surveys

Two population based surveys, the Demographic Health Survey (DHS) and the Zimbabwe population based HIV and AIDS (ZIMPHIA) survey were initiated in 2015, and data collection was ongoing by the end of the year. The Hon. Minister of Health and Child Care, Dr D Parirenyatwa was the guest of honour at the launch of ZIMPHIA in Harare.

Picture 4: Hon. Minister of Health and Child Care,
Dr. D Parirenyatwa addresses guests during ZIMPHIA launch

Hon. Minister of Health and Child Care, Dr. D Parirenyatwa delivering his remarks at the official launch of the ZIMPHIA

3.5.9 Zimbabwe Prison and Correctional Services

As a sub-sub recipient (SSR) of the Global Fund under the NAC sub recipiency, the Zimbabwe Prison and Correctional Services (ZPCS) implemented awareness campaigns and training of inmates on formation of support groups. NAC supported ZPCS with fuel, including M&E allowances for the prison officers.

3.5.10 ZNNP+

As a follow up to Moore Stephens Audit Company audit report, UNDP funded a capacity building workshop for ZNNP+. In response to capacity challenges to implement the GF grant especially in finance and procurement at the SSR, NAC will continue with direct funding instead of normal disbursements.

CHAPTER 4: HUMAN RESOURCES AND ADIMINISTRATION

This chapter presents 2015 activities in the area of human resources and administration.

4.1 Human Resources

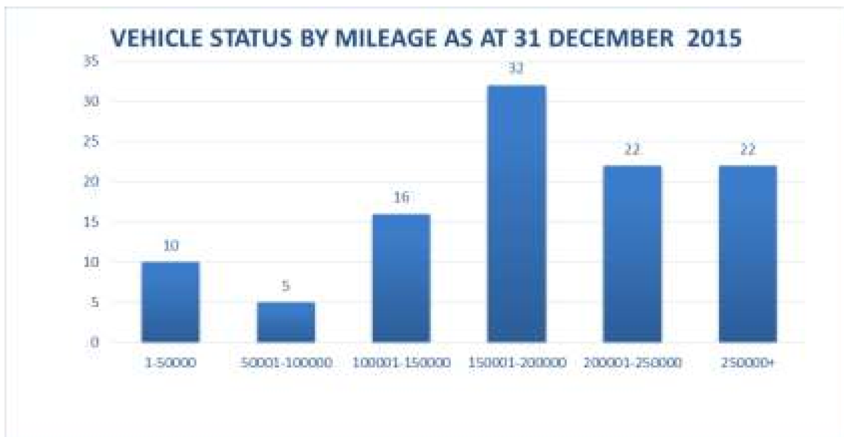
Two hundred and seventy six (276) staff members were on post by the end of the year. Staffing level remained stable due to various factors amongst them competitive remuneration levels.

4.2 Administration

Most of the Council assets have outlived their useful lifespan. There is need to replace some of the obsolete IT Equipment and broken furniture for some Council offices.

4.2.1 Transport Management

Figure 22: Transport Status (Mileage)



The graph above shows that 71% of the vehicles the Council is using is currently over their life span as per the Vehicle Policy. The high repairs and maintenance cost of the aging fleet continues to be of great concern. Fifteen (15) vehicles were grounded due to high repair costs which could not be accommodated in the budget allocations for the year.

4.2.2 Chingwizi Project

The Chingwizi Clinic built by NAC for resettled people from Tokwe Murkosi area was completed and awaiting handover by the end of the year. The picture below shows the completed Chingwizi Clinic, Harare.

Picture 5: Completed Chingwizi Clinic structures

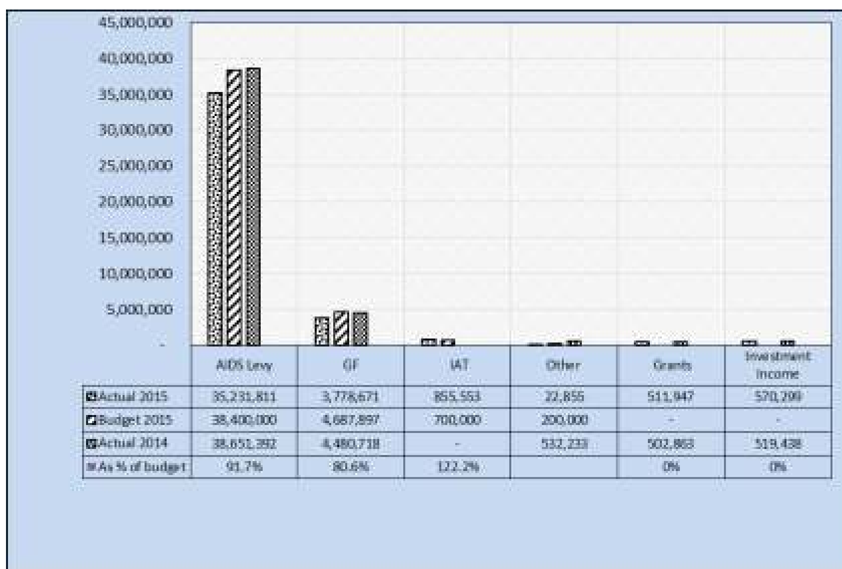
CHAPTER 5: FINANCE

This section presents a summary of financial statements for 2015, which are yet to be audited.

5.1 Income

Total income for the year amounted to $41m against a cumulative target of $44.1m. The Council missed projections by 7%. In 2014, the Council collected a total of $44.7m hence 2015 receipts are 8.5% less than revenue realized in 2014. Of the $41m collected in 2015, AIDS levy contributed $35.2m (86%), Global Fund $3.8m (9%), revenue grant, investment income, other income and revenue from IAT contributed $2m (5.%). The following figure illustrates the sources of income for the organization.

Figure 23: Income



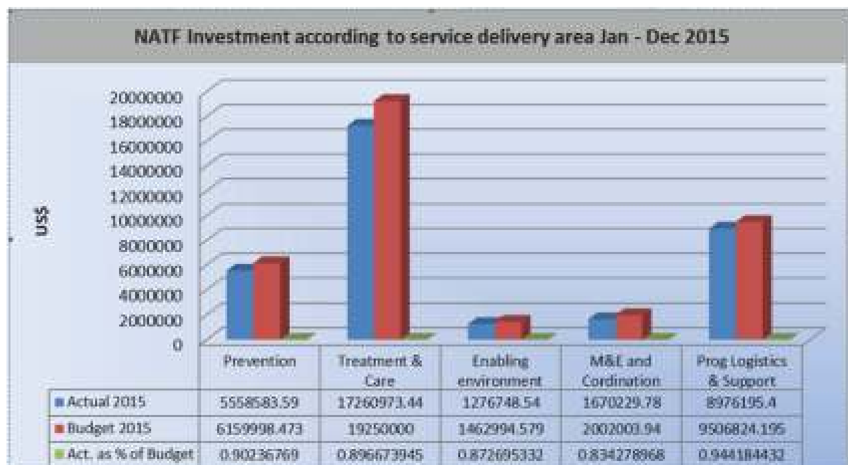
	AIDS Levy	GF	IAT	Other	Grants	Investment Income
Actual 2015	35,231,811	3,776,671	855,553	22,855	511,947	570,299
Budget 2015	38,400,000	4,687,897	700,000	200,000	-	-
Actual 2014	38,651,392	4,480,718	-	532,233	502,863	519,438
As % of budget	91.7%	80.6%	122.2%		0%	0%

5.2 Expenditure

A total of $38.8m against a budget of $43.1m was invested in HIV interventions that were in the work plan during the year. The year 2015 investment was $1.9m less than the funds that were used in 2014. Resources were allocated to the five thematic areas as guided by the ZNSAPIII as well as the 2015 approved budget. The thematic areas and

respective weights are Prevention (16%), Treatment, care and support (50%), enabling environment (4%), Program Coordination and Monitoring and Evaluation (6%) and lastly Program logistics and support (25%). Thematic area performance for the year ending 31 December 2015 is shown in the figure below.

Figure 24: NATF Investment



	Prevention	Treatment & Care	Enabling environment	M&E and Cordination	Prog Logistics & Support
Actual 2015	5558583.59	17260973.44	1276748.54	1670229.78	8976195.4
Budget 2015	6159998.473	19250000	1462994.579	2002003.94	9506824.195
Act. as % of Budget	0.90236769	0.896673945	0.872695332	0.834278968	0.944184432

CHAPTER 6: AUDIT

6.1 Audit Summary

Of the sixty-one (61) audits planned for the year, fifty-eight (58) were successfully carried out as shown on the table below. Findings of the audits were communicated to the various respondents.

Table 15: Audit Summary

Audit Area	Planned	Audited	Variances
Routine Audits			
Head Office Departments	5	5	0
Provincial Offices	10	10	0
DAACs	30	30	0
GF - Round - Implementing Partners (IP)	11	11	0
Special Audit: ART Programme	1	1	0
Audit Investigations: Provision	4	1	-3
Totals	**61**	**58**	**-3**

All the audit reports were shared with the auditees and the Board Committee responsible for audit.

Special audit on the ART Programme

A special audit on the ART programme was jointly carried out by MOHCC and NAC Internal Auditors in Harare Metropolitan and Mashonaland West Provinces. The exercise was meant to track ART medicines and other related commodities from the procurement to the health institution and to the ultimate beneficiary/ consumer at grass-root level. The objective was to check on the effectiveness of the programme and whether the beneficiaries/ consumers were receiving value for money.

Enterprise Risk Management (ERM)

NAC adopted the ERM in 2014 in line with modern trends in organizational risk management systems. Risk champions were therefore identified in each department and at every level to help champion the identification, ranking and mitigation of risks at level. Every quarter, the champions submitted identified high risks for national consolidation and submission to the management, ARMC and the NAC Board for higher mitigation measures.

CHAPTER 7: OPERATIONAL CHALLENGES AND RECOMMENDATIONS

The operational challenges that were encountered in 2015 as well as attendant recommendations are outlined below:

7.1 Challenges

- Limited access to cervical cancer screening despite high demand created by the BC programme.
- Diminishing of domestic and international funding for HIV and AIDS.
- Stock outs of ART medicines at some health centres.
- Low coverage for VMMC programme

7.2 Recommendations

- Need to scale up cervical cancer screening facilities and train more health personnel on cervical cancer screening.
- Need for operationalisation resource mobilisation strategy in order to harness resources to finance the national response.
- Natpharm to expedite the ordering and delivery system of medicines
- Need for roll out of demand creation strategies and use of the prepex device

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