

Delivering our commitment to: Zero new HIV infections, Zero discrimination, Zero AIDS-related deaths.



Government of Zimbabwe

ZIMBABWE NATIONAL HIV AND AIDS STRATEGIC PLAN (ZNASP) 2015 – 2018

***COMMITMENT TOWARDS FAST TRACKING ENDING AIDS BY 2030
AND 75/90.90.90 AMBITIOUS TARGETS BY 2020***



Ministry of Health and Child Care



NATIONAL AIDS COUNCIL

MARCH 2015

'Ending the AIDS epidemic in Zimbabwe as a public health threat by 2030' is provisionally defined as 'reducing new HIV infections, stigma and discrimination experienced by people living with HIV and key populations, and AIDS-related deaths by 90% from 2010 levels, such that AIDS no longer represents a major threat to any population or the country'

PREFACE

Whilst Zimbabwe is one of the countries with the highest burden of HIV and AIDS in the world, it remains a best practice country in rapid scale-up and decentralization of prevention, treatment and care services to achieve population effect in order to save lives, sustained domestic resource mobilization through the AIDS levy, value for money and timely accountability reporting to both national government and its donor partners

The country is witnessing high declining rates of new HIV infections and is one step closer to eliminating new HIV infections among our children from HIV positive pregnant mothers. In addition more people living with HIV know their status and are receiving most efficacious HIV medicines as lifesaving treatment while relatively fewer people are dying of AIDS-related illnesses in the country. The number of men who opted for medical male circumcision in the country has tripled in the past two years and in the last decade, TB-related deaths among people living with HIV have also declined by triple fold.

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

The third Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III 2015-2018) is a successor of the ZNASP II (2011-2015) is an effort to align the national response to the ZIMASSET (2013-2018) priorities. ZNASP III is aimed at responding to experiences and lessons learned from the implementation of the ZNASP II and emerging evidence about the epidemic. There is every indication that the country can begin ending AIDS epidemic in every district, province, in every location, in every population and community and the country at large.

ZNASP III is designed to respond to sustaining the gains made to date as well as changing the emerging dynamics of the epidemic positively. This is the bedrock of ZNASP III. It is designed to promote smart investment on children, adolescent, young people, girls, key populations and women as well as prioritized geographical locations while building on the successes of the last five years and commitment to filling identified gaps.

The Government of Zimbabwe remains committed to achieving Zero new HIV infections, Zero HIV related deaths and Zero HIV related stigma and discrimination. Among many of our success stories, we are on track to achieving the HIV related MDG goals by 2015 and beyond. Zimbabwe has made formal commitment towards fulfilling international obligations including the United Nations General Assembly Special Session Declaration of Commitment on HIV and AIDS (UNGASS 2001); the Abuja Declaration and Plan of Action (2001); the Maseru Declaration on HIV and AIDS; the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW); the UN Convention of the Rights of the Child; the Universal Human Rights Declaration; and commitment to attain the Millennium Development Goals.

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The plan has also domesticated global instruments and commitments such as 90.90.90 and fast tracking, post 2015 SDG, Africa Union roadmap on domestic sustainable financing, ending AIDS etc.

The National AIDS Council (NAC) is mandated to coordinate and lead a multi-sectoral response established through an Act of Parliament (Chapter 14:15 of 1999). Over the years NAC has established the necessary coordination structures and systems for an effective response. With the response achieving over 50% of reduction of new HIV infections over the last decade, the future efforts are to ensure that the national response is driven by the grass-root and communities with emphasis on the most high risk populations, geographical location and hotspots. The response is designed to use the investment framework, promoting efficiency and effectiveness and sustainability of our collective efforts.

The Government of the Republic of Zimbabwe renews and pledges its continued highest commitment to the course of the epidemic. We all, as partners will need to work together as always, in order to ending AIDS in Zimbabwe.

DR P D PARIRENYATWA,
MINISTER OF HEALTH AND CHILD CARE

FOREWORD

Zimbabwe is one of the 22 priority countries in the Global Plan for the elimination of mother-to-child transmission of HIV. The country has one of the highest HIV prevalence at 15.2% among adults aged 15 to 49 years (17.7% among females and 12.3% among males)[1](#).

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

The National response is now in its most advanced stage and the next five years are critical to end AIDS in Zimbabwe. This third Zimbabwe National HIV and AIDS Strategic plan for 2015-2018 (ZNASP III) is a people centered plan meant to ensure no person is left out in benefiting from the response especially young people, key populations, women and children with strong community empowerment and greater ownership in order to achieve a more effective national response. It is also designed to ensure that pockets of locations with high risk of new HIV infection are prioritized. The plan is well aligned to the ZIMAsset which is aimed to contribute to the national vision of an Empowered Society and a Growing Economy

We have seen over 50% reduction of new HIV infection rate among adults and 75% in children born from HIV positive mothers in the last decade. HIV related deaths have also been reduced by over 60% as a result of our very successful treatment and support programme. Overall, the country has attained universal access in most of our key Prevention (including prevention of mother to child transmission), Treatment, Care and Support, and Mitigation services. However, we are still lagging behind by 55% in providing treatment for HIV positive children in the country. We are making concerted efforts to bridge this gap as a matter of urgency. The implementation of interventions for eMTCT in the country utilises an integrated approach, based on the four strategic pillars of comprehensive eMTCT with adoption of option B+.

There has been in particular, strong political leadership and commitment towards the response to HIV and AIDS in the country right from the highest level with the office of His Excellency the President. This commitment is also illustrated by the funding by Government through subventions in the national budget as well as through the National AIDS Trust Fund (NATF), which was enacted by an Act of Parliament and had remained sustained. The AIDS levy is 3% of income tax, which is collected from all employees in formal sectors and corporate bodies to strengthen the prevention, treatment and mitigate the impact of HIV and AIDS. The national multisectoral response is managed by the National AIDS Council (NAC) established also by an Act of Parliament.

These successes gained over the years are based on national leadership, global solidarity and strong partnership among all key stakeholders including communities, people living with HIV, civil society, implementing partners, government, public and private sectors and development partners.

The HIV response for the next four years and beyond should be firmly underpinned by strong effort to effectively mobilize and engage the community for empowerment and greater

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ownership that are so much needed to drive , expand and sustain interventions that are sensitive to local HIV and AIDS realities and needs.

Given the country's success and experience in reducing HIV to lower levels, the NAC enjoins all partners to focus our efforts in (a) allocating more dedicated HIV resources for priority interventions in line with UNAIDS investment principles and fewer dedicated HIV resources for non-priority interventions; (b) setting quality standards for these priority interventions; (c) getting coverage to levels where it will make population impact and difference; (d) efficient and effective response management and multisectoral coordination, generation of real time data and strategic information and (e) better sectoral performance management of those priority interventions that are being implemented so as to improve efficiency and effectiveness.

The National AIDS Council wishes to encourage all stakeholders to identify with these ambitious targets and aspirations towards saving more Zimbabwean lives in order to end AIDS in the country.

Dr. Everisto Marowa

Board Chairman

National AIDS Council (NAC)

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'Ending the AIDS epidemic in Zimbabwe as a public health threat by 2030' is provisionally defined as 'reducing new HIV infections, stigma and discrimination experienced by people living with HIV and key populations, and AIDS-related deaths by 90% from 2010 levels, such that AIDS no longer represents a major threat to any population or the country'

ACKNOWLEDGEMENTS

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

We wish to express our profound gratitude to all individuals and organizations that have made invaluable contributions to the process of developing ZNASP III (2015-2018). We deeply appreciate the guidance provided from the ZimAsset. Most importantly, we are most grateful for the technical support from CompreHealth Services and Mr Lazarus Muchabaiwa who facilitated compilation of relevant information and drafts that culminated in the finalization of ZNASP III document

The support we got from the Minister of Health and Child Care, the Permanent Secretary, MOHCC, as well as management is most appreciated. The technical inputs from the Steering Committee and relevant thematic groups that were involved and participated in ZNASP III preparation are also gratefully acknowledged. We thank all stakeholders and partners who gave their time to work on different aspects of this process. We also take this opportunity to convey special thanks to UNAIDS Country Office, Mr Bartos and Dr Michael Gboun for their exception support and its Technical Support Facility for providing necessary financial and technical assistance.

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

Dr T. Magure

Chief Executive Officer

National AIDS Council

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Acronyms

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

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

EXECUTIVE SUMMARY

Zimbabwe is undergoing some economic challenges as a result of political, social and economic factors resulting in its GDP growth rate declining from 10.6 % in 2012 and to 4.5% estimated in 2013 (ZIMSTAT Quarterly Digest of Statistics). The country however has strong resilient ability resulting in effective use of meagre resources to show improvement in most social indicators. The national response is well linked to the five year (2013-2018) national economic blue print called the Zimbabwe Agenda for Sustainable Socio-Economic Transformation agenda (ZIM Asset).

Zimbabwe has a generalized feminized HIV epidemic, with high level of HIV prevalence in the past and significantly lower levels at present. In the last decade, adult HIV prevalence has halved from 26.5% to 14.3% and new HIV infection declined by over 50% and 75% in children.. HIV related deaths have also been reduced by over 60%. TB-related deaths among people living with HIV has also declined by triple fold.

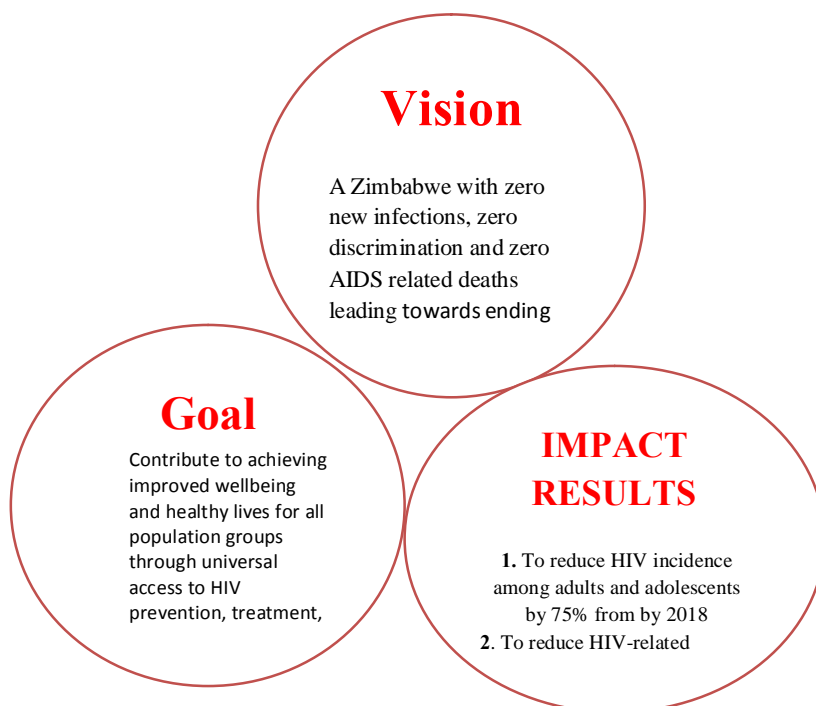
Despite these strides several programmatic gaps exist: Most commitments for ART end in 2016 and as a result, coverage gap will increase from 627 450 in 2014 to 1 235 269 in 2017 and 2018 under the test and treat scenario. Under the CD4<500 scenario, the gap rises from 515 640 in 2014 to 1 093 773 in 2018. The treatment gap for Child on ART falls from 44 242 in 2014 to 39503 in 2018 for the CD4<500 scenario whilst under the test and treat scenario, it falls from 79 849 in 2014 to 62401 in 2018 under test and treat. The HIV testing and Counselling gap rises from 281 006 in 2014 to 3 368 117 in 2018. The VMMC annual coverage gap rises from 249 in 2016 to 201 239 in 2018 whilst the cumulative gap decreases from 2 293 035 in 2014 to 1 693 036 in 2018. HIV/TB gap rises from 6 935 in 2014 to 7245 in 2018 and the coverage gap for PMTCT falls from 10 520 in 2014 to 6 837 in 2018. Behavioural change communication approaches may need to adapt social media networks at all levels where technologies allow. Condom use may need to be focused in persons and locations with greatest risk.

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

The Zimbabwe National AIDS Strategic Plan 2015-2018 is designed to bring hope, ensure no one is left behind, bring the response to the right place for the right people and right location, most affected by the epidemic, and as well as promote stronger partnerships towards ending of the AIDS Epidemic. The plan prioritized based on most recent evidence and promotes the results based approach, efficiency delivery of high quality services and community systems strengthening and linkages to health systems. It promotes focus on three provinces and 14 districts with key hotspots. The thrust of the ZNASP III remains a multisectoral delivery model with the acknowledgement that AIDS is not yet a finished public health problem and still needs predictable and sustainable domestic and international financing. The Government of Zimbabwe remains committed to achieving Zero new HIV infections, Zero HIV related deaths and Zero HIV related stigma and discrimination by 2030. An inclusive and participatory approach of ZNASP III

has been participatory with contributions from various multi-sectoral stakeholders involved in the national AIDS response and strategic areas were decided based on latest evidence and strategic information. The plan promotes prioritization and focus around where most infections are coming from and where the resources can make the greatest impacts.

VISION, GOALS AND RESULTS OF ZNASP III



VISION: The ZNASP III 2015-2018 has adopted and maintained the ZNASP II vision: 'Towards Zero New Infections, Zero stigma and discrimination and Zero AIDS related Deaths' with an aspirational goal of 'Ending AIDS by 2030'.

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

GOAL: ZNASP III seeks to contribute to achieving improved wellbeing and healthy lives for all population groups through universal access to HIV prevention, treatment, care and support services.

IMPACT RESULTS

- To reduce HIV incidence by 50% among children, adolescents and adults reduced by 75% by 2018.
- To reduce HIV-related mortality by 80% for children, adolescents and adults by 2018.
- To increase domestic financing of the HIV response to 30% by 2018

OUTCOME RESULTS

Below is a summary of the outcome results that will contribute to achieving the impact results

- All Adults and children have increased access to effective HIV prevention services and are empowered to participate in inclusive and equitable social mobilization to address drivers of the epidemic
- 90% of all PHLIV know their HIV status, 90% of HIV+ receive sustained antiretroviral therapy, 90% of those on treatment have durable viral load suppression
- Key institutions from government and civil society have improved capacity to effectively and efficiently manage a multi-sectoral AIDS response

KEY STRATEGIES

Priority and focus strategies to achieve the above high impact results include: vigilance to prevent secondary increases in the epidemic curve with lower levels of funding; Sustaining the current treatment and care investment to save more lives; rapid scale up male circumcision using WHO's implementation standards and guidelines to 80% coverage by 2018; ensure implementation of comprehensive HIV prevention programmes for sex workers, adolescent and young people, discordant couples; regulate and rapidly scale-up of innovative community HIV testing initiatives; Integrate social norm and behaviour change interventions into the delivery of social and HIV-related services, community system strengthening and investment case approach to the national response

MULTISECTORAL COORDINATION AND RESPONSE MANAGEMENT

Strong partnerships are key to the success of the national response in fast tracking results. Partners including public sector, International development agencies, the private sector and communities are critical. In order to achieve the coverage targeted in the ZNASP III results framework, \$466 million is required for 2015, \$525 million in 2016, \$567 million in 2017 and \$591 million in 2018. The financial gap rises from 30% in 2014 to 60% in 2018. Treatment, Care and Support services are like to take 43% of the resources in 2015, 47% in 2016, 49% in 2017 and 53% in 2018. The proportion spent on prevention falls from 37% in 2015 to 31% in 2018. Zimbabwe shall build up on the already existing coordination framework at all level and make them more efficient and effective. NAC, will ensure greater flexibility of subnational coordination structures for more efficiencies. The M&E and Strategic information systems will continue to rely on a variety of systems; data sources, routine, periodic collection and collation systems. Strong effort will be made to invest on data harmonization, real time data access and use as well as improved evaluation practice and generation of strategic information for improved response.

01 GEOGRAPHIC, DEMOGRAPHIC AND SOCIO-ECONOMIC PROFILE

“Our mission is to build a better world. To leave no one behind, stand for the poorest and the most vulnerable in the name of global peace and social justice.”

Ban Ki-moon
United Nations Secretary-General

1.1 BACKGROUND

Zimbabwe is landlocked with four border countries: Zambia in the north, South Africa in the south, Mozambique in the East and Botswana in the West. It is divided into 10 administrative provinces, 2 urban which are Harare and Bulawayo and 8 rural. The provinces are sub-divided into 62 districts. The country has a network of roads that enables ease travel of people within and beyond its borders for diverse social and economic activities. Like Zimbabwe, all the neighboring countries are also heavily affected by HIV and AIDS with high HIV prevalence.

According to 2012 Census, Zimbabwe total population stands at 13 061 239 with 48% being male and 52% female. 41% of the population comprises of young people below the age 15 years of age while 4% is aged 65 and above. With two thirds of the population under the age of 25 years, the country has great prospects for economic growth if the full potential of the young people is harnessed by sufficiently engaging them in development and productive activities.

Life expectation which dropped to below 50 years during the 1990s, has increased to 58 years (Census 2012). While Zimbabwe has a high ANC coverage of 90% and institutional deliveries of 65% (ZDHS 2010/11), there is an unacceptably high maternal mortality rate of 518 (MICS 2014) and/or 470 (UN Inter . Agency U-5 Mortality Report). ZDHS of 2010/11 indicates a contraceptive prevalence rate of 57%, family planning unmet need of 13% and 28% teenage pregnancy prevalence.

In 2010 and 2011 a real GDP growth rate of 11.4 and 11.9 was achieved respectively (ZIM Asset). However there has been decline to 10.6 % in 2012 and steep fall to 4.5% estimated in 2013 (ZIMSTAT Quarterly Digest of Statistics), underscoring the fragility of the recovery pathway. Health, like other sectors was not spared by the pre -2009 socio-economic and political crisis and as such it witnessed deterioration of most of its indicators. Although some of these indicators are improving, massive work still needs to be done to bring them to the desired level and attain the relevant national targets and MDGs. To stimulate and guide economic development, government came up with a five year (2013-2018) national economic blue print called the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIM Asset) with a vision **“Towards an Empowered Society and Growing Economy”**. ZIM Asset seeks to optimize the abundant natural resources and human capital that exist in Zimbabwe to the betterment of all its people and generations to come as well as to contribute to address the socioeconomic barriers towards universal access to HIV and AIDS and overall health services.

The Zimbabwe National AIDS Strategic Plan 2015-2018 is designed to bring hope, ensure no one is left behind, be at the right place for the right people and right location most affected by the epidemic, and working together to begin the ending of the AIDS Epidemic.

02 RATIONALE, JUSTIFICATION AND APPROACH

2.1 RATIONAL AND JUSTIFICATION

The Third Zimbabwe National HIV and AIDS Strategic Plan (ZNASP III 2015-2018) is a successor of the ZNASP II (2011-2015) as an effort to align the national response to the ZIM Asset (2013-2018) priorities of Government with the aim, to contribute through the HIV sector. There is every indication that the country can begin ending AIDS epidemic in every district, province, in every location, in every population and every community and the country at large.

The country is witnessing high declining rate of new HIV infections, one step closer to eliminating new HIV infections among our children from HIV positive pregnant mothers. In addition, more people living with HIV know their status and are receiving most efficacious HIV treatment as lifesaving drugs, relatively fewer people are dying of AIDS-related illnesses in the country. TB-related deaths among people living with HIV have also declined by triple fold.

More evidence in the country is also showing that service delivery in terms of ART and PMTCT increased by up to five times between 2004 and 2013. It was also noted that majority of the PLHIV live within less than 10 Km from an ART site which shows a generally good service coverage. However, there is strong recommendation to increase the functionality, quality, laboratory capacity supporting existing services. In addition, the epidemic still remains feminized with women and girls bearing most of the burden and risk. Female prevalence is generally higher than that of males. While the epidemic appears homogenous by geographical location, Matabeleland South consistently show the highest HIV prevalence with the lowest people living with HIV. The national incidence was also noted to be highest in this province as well as in Bulawayo. These two areas present the highest likelihood of having new infections and therefore require an enhanced prevention investment portfolio.

Also provinces housing the main borders entry points (Beitbridge, Kariba, Victoria Falls, Plumtree, Forbes and Nyamapanda) generally showed high risk factors with most new infections in the country (sex workers data showed new infection rate of tenfold higher than the national incidence rate). The same pattern of high prevalence was observed in farming areas, growth points and mining areas in the country. More efforts and interventions are required in these populations and locations in order to reduce the spread and impacts of HIV and AIDS affecting communities.

In summary, the main geographic hot spots cover the entire Matabeleland South Province, two districts in Matabeleland North (Nkayi and Bubi) as well as Bulawayo, Mazowe and Marondera. There are 14 districts which have a high potential to become hotspots and need to be prioritized for investment especially on prevention and treatment as well as response management. These include: Bindura, Buhera, Centenary, Chegutu Urban, Chipinge, Epworth, Hurungwe, Makonde, Makoni, Mhondoro- Ngezi, Mount Darwin, Mutasa, Mutare, Nyanga, Shamva and Chipinge.

In 2012 the financial allocation was in tandem with the provinces that have been identified as hotspots i.e. Matabeleland south, parts of Matabeleland North, Mashonaland Central, Marondera from Mashonaland East and Mazowe from Mashonaland Central. The HIV spending

seems to be consistent with where most PLWHIV are located with the exception of Mashonaland West, where there is a need to increase spending. It is interesting to note that Matabeleland South which is the province with all districts identified as hotspots, spent very little on prevention activities. Deliberate efforts should be made to increase prevention activities. Also there is a need to augment the allocation to address the high risk factors in the country. ZNASP III is designed to respond to this changing and emerging dynamics of the epidemic.

This is the bedrock of ZNASP III which is aimed at promoting smart investment focused on children, adolescent, young people, girls, key populations and women and prioritized geographical locations; while building on the successes of the last five years. The plan also domesticated most global instruments and commitments such as 90.90.90 and fast tracking, post 2015 SDG, prioritizing the cities and the Africa Union roadmap on domestic sustainable financing, ending AIDS etc.

The rationale behind ZNASP III are the following :

- “ The multisectoral response will need to match with where most new infections are coming
- “ AIDS is not yet a finished public health problem but still remain a development issue
- “ Predictable and sustainable domestic and international financing will need to be achieved using the invest case approach
- “ The need to align the HIV sector plan to the ZIM ASSET and ensure that we contribute to the overall outcomes that address the urgent and high impact HIV programmes and services directed towards ending AIDS in the country as well as and present an opportunity linkages to Sustainable development goals (SDGs).
- “ Domesticate emerging global strategies such as the UNAIDS Fast-tracking strategies to ending of the AIDS epidemic which fosters innovation, securing sustainable financing, strengthening health systems and communities, ensuring commodity security, promoting human rights, gender equality and ensuring access to HIV prevention and treatment services.

2.2 APPROACH

The development of ZNASP III was through participatory and inclusive process with contributions from various multisectoral stakeholders involved in the national AIDS response. The government constituted a national Steering committee comprising of NAC, MOHCC, UN, donors, INGO, CSO and community representatives to oversee and guide the process. The plan was developed based on empirical evidence generated through document review, analysis and synthesis of data. The strategic priority areas reflected in the plan were identified and agreed upon during these multilayer consultations.

02 KNOW YOUR EPIDEMIC

Zimbabwe has a generalized feminized HIV epidemic, with exceptionally high level of HIV prevalence in the past and significantly lower levels at present - it is estimated that over the last 12 years from 1997 to 2013, adult HIV prevalence has almost halved from 26.5% to 14.3% and new infection declined by over 50%. The country has seen a 50% reduction of new HIV infection rate among adults and 75% in children born from HIV positive mothers in the last decade. HIV related deaths have also been reduced by over 60% as a result of our very successful treatment and support programme

3. CHARACTERIZATION OF THE EPIDEMIC

Zimbabwe has one of the worst HIV burden in Southern Africa with a generalized epidemic in which an estimated 1.4 million adults and children are living with HIV. The major modes of transmission in Zimbabwe are heterosexual (92%), vertical transmission (7%)ⁱⁱ. Antenatal sentinel surveillance has reported a decline from 25.7% in 2002, 21.3% in 2004, 17.7% in 2006 and 16.1 in 2009ⁱⁱⁱ. The ZDHS has also shown a similar decline in HIV prevalence in Zimbabwe from 18.1% (2005/2006) to 15.2% (2010/2011)^{iv}.

Several epidemiological studies in Zimbabwe have supported the conclusion that HIV prevalence has steadily declined since the late 1990s^{v, vi, viii}. Halperin et al (2011)

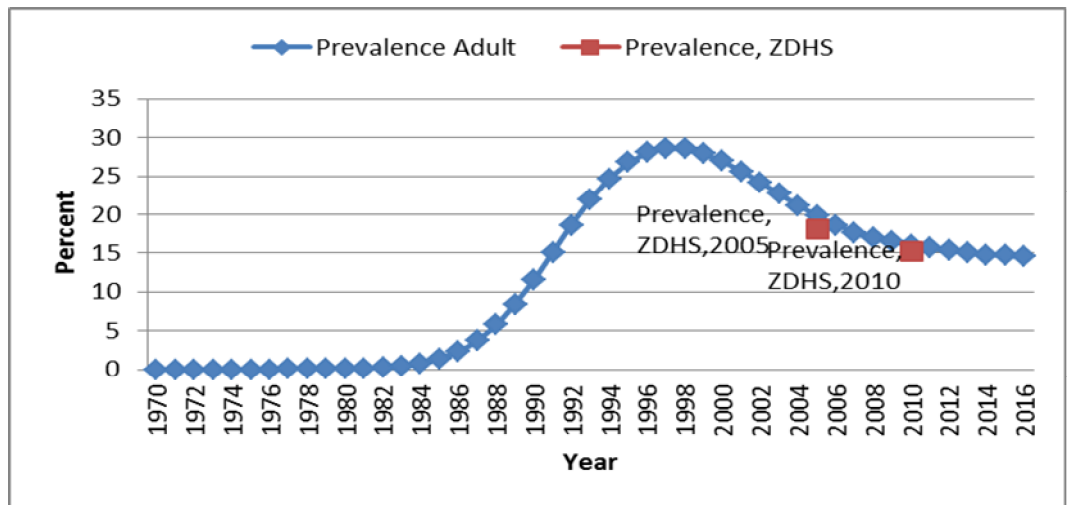
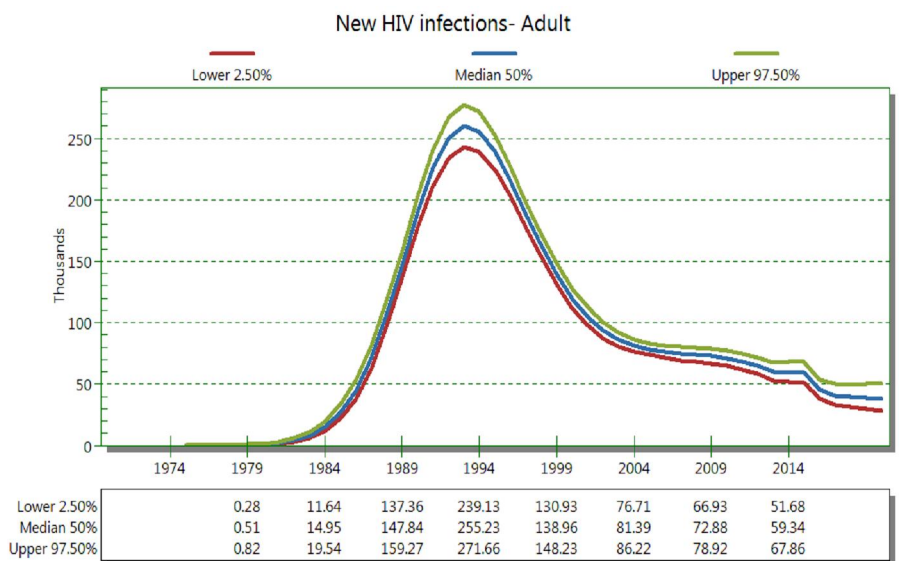


Figure 1: Trends in Adult HIV Prevalence and Projections, 1970-2016. Source: NAC 2013 Estimates

suggested that the decline in the HIV epidemic

was primarily due to the success of prevention efforts and reduction in personal risk taking behavior¹⁴. -changes in casual sexual behavior, partner concurrency, increased condom use and an increased awareness of AIDS deaths.

Figure 2 below shows that adult new infections are decreasing, with an estimated 87 932 new infections in 2010, with a slight increase in 2014 (NAC: HIV estimates 2013). Of note, however, is that an estimated average of 8,600 boys and 14,800 girls between the ages of 15-24 years are newly infected with HIV each year, with Figure 4 showing that in 2013 alone for the 15-24 years age group



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there were 8558 male and 14780 female new infections, but quite a noticeably gender difference between males and females. **Figure 2: New Adult HIV Infections**

The new infections are highest among young girls aged groups 15-24 year and 25-49 years as shown in figure 3 below

Figure 3: New infections by age group and gender

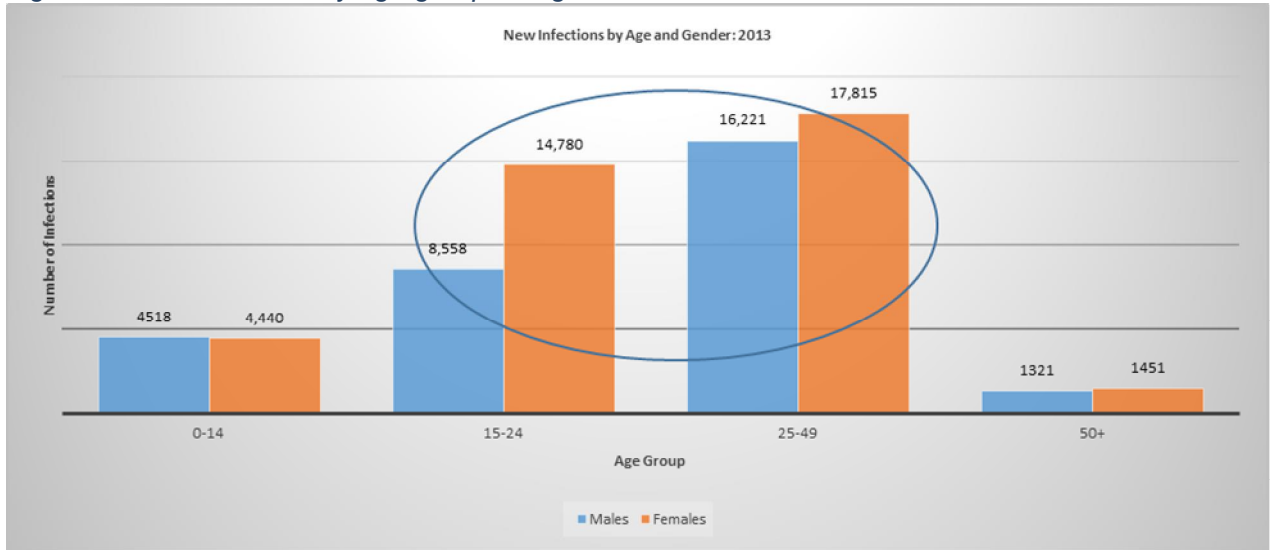
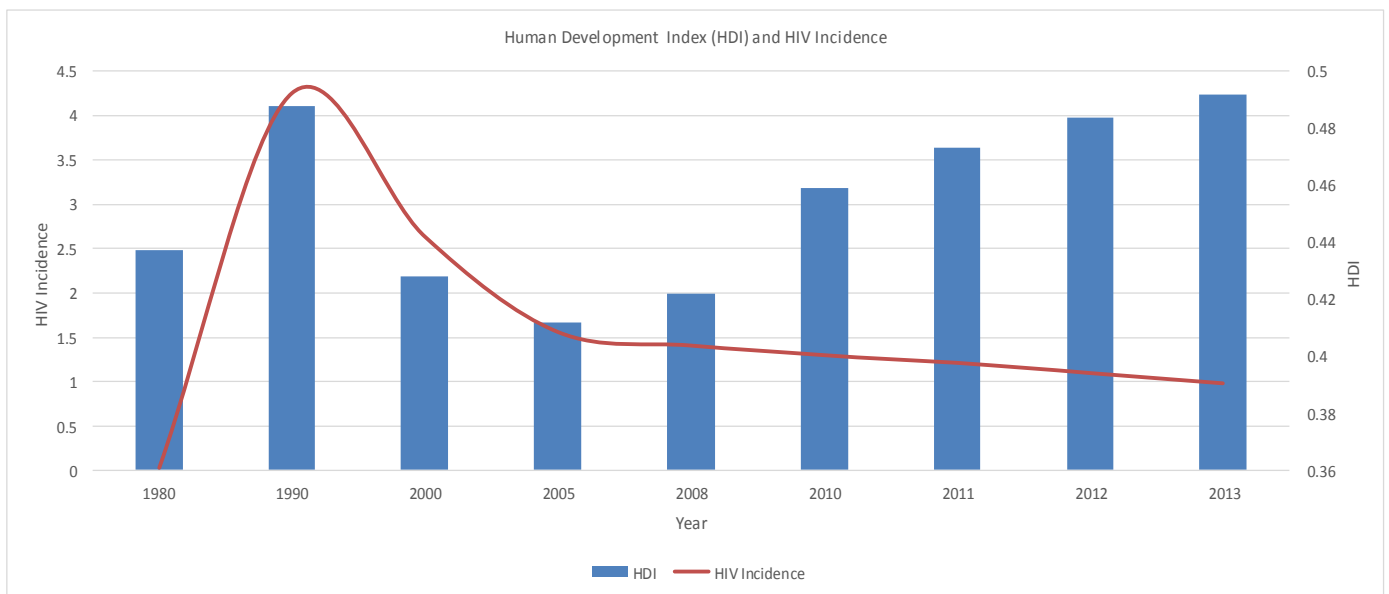


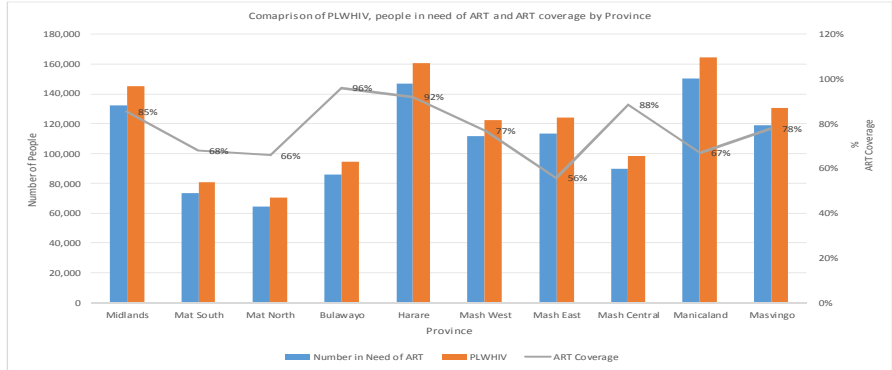
Figure 4 below the decline in HIV Incidences is positively associated with an increase in the Human Development Index.

Figure 4: HIV Incidence and Human Development Index (1980 -2013)



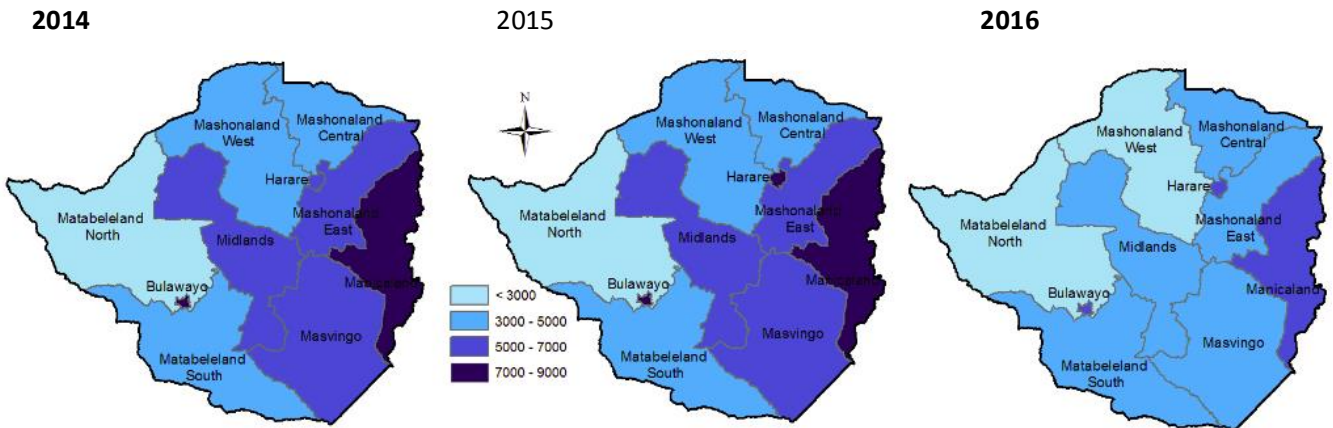
'Ending the AIDS epidemic in Zimbabwe as a public health threat by 2030' is provisionally defined as 'reducing new HIV infections, stigma and discrimination experienced by people living with HIV and key populations, and AIDS-related deaths by 90% from 2010 levels, such that AIDS no longer represents a major threat to any population or the country'

While the current National HIV prevalence stands at 14.8% in 2013, the distribution of HIV burden by province has shown that 3 provinces namely Bulawayo, Matabeleland North and South are above the national average as shown in Figure 2. Yet the Estimated number of



people in need of ART is highest in the provinces of Harare, Manicaland and Midlands as shown in figure 4. The national HIV incidence rates for the country are between 0.5% and 2.5%. The highest rates are observed in Bulawayo (2.5%) and Matabeleland South (1.4%). The rest of the country has an incidence rate below 1%. Manicaland have the highest estimated incidence population. This might be due to the fact that Manicaland is one of the provinces in Zimbabwe with the highest population.

Figure 6: Trend of HIV incidence geo-partial maps from 2004-2016 (15 – 49 years)



Some of the key populations at high risk of HIV infection and/or not adequately reached with HIV services (most-at-risk populations) include the following:

- Heterosexual **people in stable unions** or people considered to engage in low risk heterosexual sex are estimated to account for around 54.8% of all new HIV infections.
- 11.3% of **married/cohabiting couples** are sero-discordant where in 6.7% the man is the HIV positive partner and in 4.5% the woman is the HIV-positive partner
- HIV prevalence in **young women** is significantly higher than in their male peers, (e.g. in 20-29 year age group 20% of women have HIV infection compared to 10% of men). Young women are infected earlier with HIV, although from a lifetime perspective, men and women face a similar level of risk.

- There is no recent estimate of the proportion of new HIV infections in **young people** in Zimbabwe, but global data suggest that around 36% of new infections are in this group
- **Sex workers and their clients** together account for approximately 12% of new HIV infections. HIV prevalence in sex workers is particularly high (60%) due to the high numbers of partners, inadequate access to quality services, and a number of other factors. While incidence is estimated at 10%
- There are currently no local data on the population size estimate or HIV prevalence in men who have sex with men (MSM) in Zimbabwe. Behavioural data from a small convenience sample of MSM surveyed by Gays and Lesbians of Zimbabwe (GALZ, 2009) indicated high HTC practice and suggested irregular condom use. The Blair Research and Training Institute of Zimbabwe (BRTI) has completed a regional size estimation study including MSM, its data is expected to provide more information on the HIV situation and behaviour patterns within this population group.
- Available data indicates that HIV prevalence in prison settings is 26.8% for male inmates and 39% for female inmates and sex worker HIV incidence is 10%;

03 Know your HIV Response

The Government of Zimbabwe remains committed to achieving Zero new HIV infections, Zero HIV related deaths and Zero HIV related stigma and discrimination. Among many of our success stories, we are on track to achieving the HIV related MDG goals by 2015. However, we are still lagging in some core services targeting specific age groups and populations. The country is making concerted efforts to bridge this gap as a matter of urgency.

3.1 SYNTHESIS OF THE NATIONAL RESPONSE

Reduction of new HIV infections in adults and children is being achieved through intensified delivery of combination prevention interventions. In addressing sexual transmission of HIV, GOZ has prioritised interventions around social and behaviour change; increased condom promotion and distribution, coupled with intensified awareness on correct and consistent use of condoms; voluntary medical male circumcision (VMMC); prevention and control of sexually transmitted infections. These strategies have been applied to address key drivers of the epidemic which include multiple and concurrent partnerships, inter-generational sex, discordant couples and low circumcision rates. HIV Testing and Counselling (HTC) has been identified as a strategic entry point for ART. Provider initiated testing and counselling (PITC) services are being scaled up and have been rolled out to 94% of health facilities.

Similarly primary prevention interventions are being scaled up and integrated into other relevant health care services including Maternal, New-born and Child Health (MNCH). Male involvement in the elimination of mother to child transmission of HIV is being strengthened.

Zimbabwe continues to intensify its efforts on blood safety through capacity building and technical support to the National Blood Transfusion Services. Zimbabwe has attained a 100% screening of blood for transfusion transmissible infections (TTIs), including Sexually Transmitted Infections (STIs) and HIV in accordance with national guidelines. GOZ seeks to improve availability and access to Post Exposure Prophylaxis (PEP) services countrywide for occupational exposure and for cases of sexual assault.

Zimbabwe is also committed to addressing the needs of key populations, adolescents and other vulnerable groups like orphans, within the context of prevention, treatment, care and support. In many cases lack of empirical data on the extent of HIV prevalence or key population size estimation prevents effective planning and service delivery, and hence access to services is often compromised. ZNASP III will support efforts that will consolidate mainstreaming of human rights and gender responsive approaches in AIDS planning and service delivery mechanisms, including appropriate integration of reproductive, newborn and maternal health with HIV, responses to gender based violence and adolescent sexual and reproductive health and rights.

Some of the key programmes (including bottlenecks and priority focus areas) implemented in large scale in the national AIDS response are as follows:

3.1.1 Social and Behaviour Change Communication

Building upon the lesson learned, social and behaviour change communication (SBCC) continues to focus on approaches and messages designed for specific audiences but impact of this intervention on behavior change is yet to be substantiated. The model of delivery includes a range of communication channels, including mass media, social media, interactive materials, and interpersonal communication. The key bottlenecks however to be overcome are:

Table 1: key bottlenecks and recommendations.

Key Bottlenecks	Way forward
Programme Areas for special focus	

Limited SBCC programmes tailored for young people	Design SBCC for young people, particularly HIV exposure risks and prevention options Expand SBCC to young people at community level and through social and mass media
Skilled teachers delivering relevant HIV and life skills education	Equip teachers with HIV and life skills education; provide relevant HIV information, education and communication materials to schools; monitor progress through Education Management Information System
Capacity of community volunteers to address social and cultural factors that influence behaviour	Identify, recruit, train and retain community based volunteers with skills and tools to address social and cultural norms
Low male participation in addressing key gender issues and serving as role models and agents for change	Advocacy with key leaders at all levels for men to take a leading role in addressing socio-cultural barriers to adoption of safer sexual practices
Poor linkages between SBCC and service delivery	Social mobilization campaigns to emphasize demand creation and uptake of services
Limited SBCC interventions specifically targeting PLHIV	Involve PLHIV as key actors for promoting combination HIV prevention
SBCC research	
Limited dissemination and use of research findings to inform prevention programmes	Create a platform for sharing behaviour change studies to inform programme interventions

Key SBCC priority areas :

The current plan should include the following recommendations based on implementation research evidence:

- ✓ Minimum packages for social mobilisation may need to be developed for both professionals and community volunteers
- ✓ Advocacy materials will be developed for policy makers at different levels to promote enabling environments and uptake of HIV prevention services
- ✓ All SBCC interventions focussing on partner reduction and faithfulness should incorporate promotion of the uptake of PMTCT, condoms, VMMC and ART and Prevention.
- ✓ SBCC interventions will address socio-cultural factors that limit adoption of safer sexual practices such as gender inequity, inconsistent condom use, and uptake of VMMC
- ✓ Clear and consistent approaches and messages across programme areas to generate demand for services
- ✓ Use of data for evidence-based communication combined with creativity and innovation
- ✓ Establish clear linkages between SBCC and service provision
- ✓ SBCC should utilize technological innovations especially for young people

3.1.2 Elimination of Mother to Child Transmission (e-MTCT)

Zimbabwe has committed itself to elimination of new HIV infections in children and keeping their mothers and families alive, with the aim of eliminating mother to child transmission of HIV and

reducing maternal mortality. This is being achieved through the implementation of all four PMTCT prongs. E-MTCT services are being scaled up, including provision of Antiretrovirals (ARVs) to pregnant women for the woman's own health, accelerating paediatric HIV testing, and provision of ART/Cotrimoxazole prophylaxis to infants. Zimbabwe is currently delivering eMTCT services to HIV negative and HIV positive pregnant women, their partners and their infants in antenatal care and maternal/child health facilities through integrated service models.

Based on the WHO 2013 guidelines and guided by the current National Strategic Plan for Elimination of New HIV Infections in Children and Keeping Mothers and Families Alive, the country has begun implementation of option B+. The programme has achieved almost universal access in HIV testing in ANC with significant number of women testing positive in labor and delivery as well as post-natal. There were notable improvements in paediatric ART though the youngest children (<12 months old) are still not being initiated on time. Laboratory capacity for EID and patient monitoring remains sub-optimal and this is related mainly to limited funding. The key bottlenecks and way forward to achieve virtual elimination of new infections in children are:

Table 2: PMTCT bottle necks

Key Bottlenecks	Way Forward
Programme Areas for Special Attention	
HIV testing and counselling in ANC	
User fees adversely affect ANC ANC services not available throughout the week to all clients who need them Religious barriers to utilising formal health services	Enforce government policy on no user fees for maternal, newborn and child health (MNCH) Strengthen provision of integrated, focused antenatal care Engage religious leaders to jointly plan services for pregnant women
Unmet demand for family planning	
Unmet demand for family planning high among young married women who desire child-spacing, and older married women ready to stop childbearing	Strengthen family planning services in all MNCH (including PMTCT) settings at facility and community level Work with community leaders to encourage delay in child bearing and child spacing Promote adoption of long-term contraceptive methods
Men's participation in PMTCT services	
Low rates of couples HTC Poor disclosure of HIV status to partners	Mobilise demand for HTC among couples Strengthen counselling during ANC and post-natal care (PNC) to support disclosure of HIV status to partners Offer family-centred ART services for father, mother and child in ANC and MNCH settings
Preventing HIV infection in HIV-negative pregnant and lactating women	
Women who test negative may be at risk of HIV infection during pregnancy and the breastfeeding period	Provide retesting and on-going HIV counselling for exposed women and partners Distribute condoms to all pregnant and lactating women
Access to ART for pregnant women living with HIV in need of treatment for their own	

health	
Inadequate capacity for assessment of pregnant women for ART eligibility using CD4 cell count Low provision of antiretroviral treatment to eligible women for their own health due to reliance on OI/ART clinics for service delivery	Expand access to Point of Care (PoC) CD4 testing services at ANC Harmonize and integrate initiation and provision of ART by upgrading ANC and MNCH services
Access to early infant diagnosis	
Weak continuum of care from early infant HIV diagnosis, initiation on treatment and adherence Loss to follow-up of HIV-exposed infants	Strengthen DBS sampling at national level and tracking of children in communities Strengthen linkages with immunization and nutrition programmes
Access to timely initiation of ART for infants living with the virus	
Weak capacity for initiation and provision of antiretroviral treatment for children	Accelerate decentralization of paediatric ART to increase the number of initiating sites Mentor and train health workers in paediatric ART
Community involvement in advocacy, demand creation and service provision	
Inadequate linkages between health facilities and community-based structures e.g. village health workers (VHW), PLHIV networks Inadequate follow up and support of mother-baby pairs within the community	Promote use of the existing community structures and strengthen linkages
Inadequate male participation in PMTCT and paediatric HIV programmes	Mobilise men through SBCC and VMMC to participate in PMTCT

Key areas for future prioritization include:

- ✓ Mothers will leave maternity services having been offered family planning counselling and contraceptives, including condoms
- ✓ Family planning services to offer comprehensive HTC
- ✓ Sex workers have easy access to PMTCT services, such as mobile services
- ✓ All mothers and their partners, regardless of sero-status, will be counselled on assessing their risk and, if appropriate, develop a risk reduction plan
- ✓ HIV+ mothers enrolled into ART treatment
- ✓ Pregnant women in prisons will be given access to PMTCT services
- ✓ Parents be offered early infant male circumcision for their male infants
- ✓ Workplaces and community organizations promote men's participation in PMTCT; men who test positive in PMTCT will be referred for ART
- ✓ Know your family's HIV status to ensure a healthy future for all
- ✓ Practice safer sex during pregnancy and breastfeeding to avoid infecting your child with HIV

- ✓ removing user fees for viral load testing and decentralize viral load test at subnational level
- ✓ procure more POC /CD4 and chemistry machines with service contracts and ensure training of users of these machines in order to prolong their lifespan in service
- ✓ sustainable and harmonized incentives and other support systems for community based health workers to improve effective demand creation for services

3.1.3 Voluntary Medical Male Circumcision (VMMC)

Currently VMMC is being provided through stand-alone (static) sites, co-located sites, and outreach (mobile) clinics, with limited social mobilization through mass media and periodic campaigns. Acceptability of HIV testing prior to VMMC has been universal, while adverse events have remained below 1%, an indication of programme quality. VMMC is being offered more widely throughout the health system. To optimize its benefits, VMMC should be offered with a minimum package of HIV prevention and reproductive health services, comprised of:

- HIV testing and counselling
- active exclusion of symptomatic STIs and syndromic management where required
- promotion and provision of male and female condoms
- counselling on risk reduction and safer sex

Early infant male circumcision (EIMC) will contribute to long-term sustained gains of VMMC. The following table identifies key bottlenecks and the way forward for expanding quality VMMC services:

Table 3: VMMC bottlenecks

Key Bottlenecks	Way Forward
Programme Areas for Special Attention	
Availability of facilities offering VMMC services	
Limited number of facilities offering VMMC	Scale-up static, integrated and outreach facilities equipped to offer VMMC
Social mobilisation to increase knowledge, acceptability and utilization	
Low knowledge on the benefits of VMMC for HIV prevention and reproductive health	Engage mass media, complemented by interpersonal communications, utilising specific messages for different target audiences, including young people

Key future focus should include:

- ✓ All men attending male circumcision services should be tested for HIV and, if positive, referred for ART eligibility assessment
- ✓ All men, regardless of HIV status, should leave male circumcision services with condoms and counselling on MCP
- ✓ All men attending VMMC services should receive information on STIs

- ✓ All men attending VMMC services should receive information about family planning and PMTCT
- ✓ Workplace programmes will promote VMMC
- ✓ Smart men circumcise to improve their hygiene and protect their partners from STIs, cervical cancer and HIV
- ✓ Circumcision works best against HIV when combined with condom use and fewer sexual partners

3.1.4 Condom programming

Zimbabwe has a well-coordinated, comprehensive condom programme with efficient supply chain management of condoms (procurement, supply, distribution) resulting in minimal stock-outs at public sector facilities. Condom programming is well-integrated with other services, including reproductive health, HIV prevention, and care and treatment. The roles played by community level service providers, including peer educators, behavior change facilitators, home-based care facilitators, community based condom distributors and community health workers have greatly benefited the programme.

In 2014, 120 million male condoms and 5million female condoms were distributed to approximately 1600 service delivery points, with stock outs less than 1% (male condoms) and 2% (female condoms). Nevertheless, gaps in consistent condom use persist, particularly amongst sex workers, their clients and their clients' sexual partners, within MCP relationships, with non-regular partners, and by young people, especially unmarried women.¹

Table 4: **Condom bottlenecks**

Key Bottlenecks	Way Forward
Programme Areas for Special Attention	
Use of condoms in multiple including concurrent partnerships and with non-regular partners	
Only 32% of men who had more than one sexual partner at some time in the past 12 months used a condom during last sex ²	Social and behaviour change communication tailored for men in multiple including concurrent partnerships, particularly men aged 20-39, ever married, living in urban areas, and with more than a secondary education
Young people's knowledge of a condom source, and use of condoms	
Never-married young women and men who do not know a condom source are considerably more likely to have had sexual intercourse than their peers who do know a source	Increase discussions among young people on condoms through schools, community organisations and media
Use of condoms by men who have paid for sex	
Use of condoms by men who paid for sex has increased (from 77% in 2005-	Sustain and increase gains in condom use by making male and female condoms widely available

¹ A National Male/Female Condom Operational Plan is currently being developed (2012) by MoHCW and will further guide the national response

² ZDHS 2010-1

6 to 88% in 2010-1)	in sex work settings
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3.1.5 HIV Treatment as Prevention

Zimbabwe's ART programme has grown from a pilot project in 2004 with 500 patients, to currently 80% of eligible adults, well on its way to achieving universal access for adults.³ By reducing the viral load in people living with HIV, which improves their health, ART is also reducing the potential for HIV transmission. HIV Prevention is achieved from increasing access to treatment and emphasizes risk reduction and safer sex will enhance the prevention benefits of treatment.

Table 5: ART as prevention tool

Key Bottlenecks	Way Forward
Programme Areas for Special Attention	
Decentralization of ART	
Inadequate number of initiating and static sites	Continue training and mentoring nurses to initiate ART, and equip facilities to meet criteria to become initiating sites
Early diagnosis, referral to treatment and adherence support for adolescents living with HIV	
Parental/guardian bias towards HTC of their adolescent children Stigma within families, schools and communities affecting adolescents' adherence to ART Health care workers consultation skills for adolescents not supportive	Identify entry points and engage with parents and guardians on HTC and referral to treatment (through schools, faith based organisation, parent clubs) Work with peer counsellors to address stigma and support adolescents' adherence Emphasise adolescent counselling and treatment in integrated training for health care workers
Key populations' access to treatment and adherence support	
Inadequate programmes for sex workers and mobile populations to access ART and follow up support	Point of Care and ART initiation and follow up for sex workers and mobile populations

3.1.6 Integrated service delivery systems

The core programme areas prevention services with potential benefits and linkages are

Table 6: integrated of prevention services

³ MoHCW program data 2012

	Key populations (sex workers, men and women in prison, mobile populations)	Behaviour change	Treatment and prevention	Condoms (and family planning)	Male circumcision
PMTCT	Include PMTCT in programmes for key populations	Include MCP risk message in PMTCT; Include PMTCT message in SBCC	Couples testing & ART assessment, initiation & retention through PMTCT, including for the male partner	Offer condoms in PMTCT Offer post-natal contraception (particularly long-term methods)	Offer early infant MC through MNCH
Male circumcision	(No priority links)	Include MCP message in MC; Include MC message in SBCC	Offer HTC/ART referral during MC; Offer MC referral during HTC	Offer condoms during MC; Include MC message in condom inter-personal communications	
Condoms (family planning)	Provide condoms & contraceptives to programmes for key populations	Include condom messages in SCBC; Include MCP message in condom IPC (ensure that condom message does not undermine MCP message)	Offer condoms & family planning in HTC/ART (make sure ART does not undermine MCP); Refer to HTC/ART during condom inter-personal communications		
Treatment and prevention/ ARV-based strategies	Include ART in programmes for key populations; Explore use of other ARV-based strategies	Include HTC/ART message in SBCC; Include MCP message in ART (make sure ART does not undermine MCP)		Integrate FP into HIV Treatment services; offer condoms during ART	
Behaviour change	Ensure SW programs don't				

	undermine MCP message or make SW a more common choice among young women				
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The public health system with its network of decentralized health facilities will remain the major stream of delivering combination prevention services, which will avoid development of parallel systems and facilitate service integration with other health services. Specific priority will be given to

- Integrating family planning into HIV services: Service providers in all facilities should offer FP counselling to all HTC/ART clients.
- Integrating couples HIV testing into family planning services: Service providers in all facilities should offer couples HIV testing to all family planning clients

3.1.7 Service delivery models

HIV prevention services have been delivered through the public, NGO and private sectors, using static facilities, outreach, and mobile services. The combination prevention interventions will continue to use these mix models, with the aim to provide either free or low-cost HIV prevention services to the widest possible population.

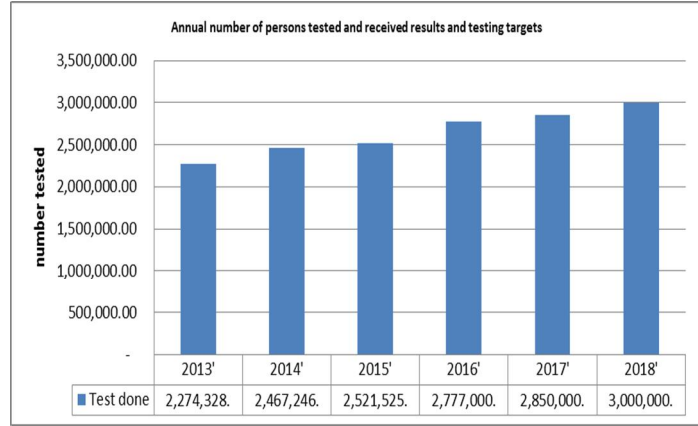
- The public sector provides the largest proportion of services, facilitating the seamless provision of HIV prevention interventions across all public sector settings, irrespective of the type of facility
- Mobile services were particularly important to reach vulnerable, difficult to reach population groups who have limited access to static sites. Mobile services have proven to be particularly effective for campaigns, such as HTC and VMMC.
- NGOs maximized their comparative advantage, including social mobilization for demand creation and uptake of services, as well as follow up of clients in the community. NGOs were particularly important in providing post-test support services for HIV-negative and HIV-positive people that address risk reduction, disclosure, and treatment adherence.
- The private sector, including workplace-based services, also complimented the work of the public sector, and offer referrals and follow-up for those services not available. Workplaces will focus on men's sexual and reproductive health, including their participation in HTC and PMTCT services.
- Integrated services were promoted for clients to have one stop service uptake opportunities.

3.2 TREATMENT, CARE AND SUPPORT

3.2.1 HIV TESTING COUNSELLING (HTC) AS A CROSS-CUTTING ENTRY POINT

HIV Testing and Counselling is the entry point to HIV prevention, care, treatment and support. Knowledge of one's HIV sero-status and successful linkages to other services are critical for access to effective treatment interventions. HTC represents a prerequisite for access to ART, pre-ART care and support, and for most biomedical interventions such as PMTCT and VMMC. Couples-based or individual HTC with partner testing can also assist in identifying sero-discordant couples and supporting prevention of HIV transmission to HIV-negative partners.

According to the ZDHS 2010-1, 36% of men and 57% of women have ever been tested for HIV, showing a significant increase compared to DHS 2005-6 when 16% of men and 22 % women had ever been tested. Nevertheless, that means 64% of men and 43% of women in Zimbabwe have



never been tested for HIV and uptake of couples HIV testing and counselling is still low, especially at public sector health care facilities where most Zimbabweans access HTC. Annually 2 million people accessed HTC through approximately 1,400 health care facilities, either in ANC, TB and STI care settings or through opportunistic infections and treatment centres. In addition, the national programme has a strong network of client-initiated HTC services offered through a social franchise approach, with 17 fixed sites and 22 mobile teams covering all districts in Zimbabwe. The New Start social franchise network is currently testing about 400 000 people per year.⁴ However, 80% population coverage is required for HTC to realize population-level impact.⁵

PLHIV who know their HIV status was at 66% (ZDHS 2010/2011), Testing rates among female 15-19 years is higher at 49% (MICS 2014); Low testing rates among men in general with only 24% of males aged 15-19 knowing their HIV status and having received a result as per MICS 2014; HIV testing for HIV exposed infants (EID) is at 50%; Limited community based testing may be a constraints to access; Young people have extreme difficulty to access testing facility due to health worker attitudes; Operational issues posing challenges- Human Resources constraints- only 900 primary counselors exist, policy and guideline exist, PIT, outreaches, community based approach; and Need to avoid resting of those who are already know positives or living with HIV

Despite the introduction and scale up of PITC in most health facilities there remain many missed opportunities for people to get to know their status and for health workers to intervene early so as to optimize positive treatment outcomes. There are also inadequate, as well as poor, linkages into post HTC services characterized by the lack of standardized systems for tracking linkages into post-test services.+

Table 5: HTC bottlenecks

Key Bottlenecks	Way Forward
Programme Areas for Special Attention	

⁴ PSI Programme Data

⁵ PEPFAR Guidance for the Prevention of Sexually Transmitted HIV Infections 2011

Increase Uptake of HTC	
Low uptake by couples and families of HTC	<p>Community mobilization, interpersonal communication and mass media used to encourage couples/partners and family to utilise HTC services</p> <p>Specific community efforts to include HTC in pre-marriage counselling Increase couples and family uptake through home-based HTC</p> <p>HIV Testing Efforts may need to be focused around special groups and those that are likely to be positive and yield higher yield for enrollment into treatment.</p> <p>Need to invest on what the baseline for 2015 into to easily monitoring progress.</p> <p>Need to review nationally the operations of HTC using time motion studies,</p> <p>Use the opportunities of the several planned reviews to refocus and rebrand testing efforts-HTC guideline implementation review, ISP implementation review. Self-testing safety procedure.</p> <p>Maximize on existing public HTC campaigns as well as adhoc testing-</p> <p>Generate strategic information on calculation of those who need to be tested using historical data, supply chain data. GRZ to sandal the responsibility in the hands of a small taskforce to handle calculation of testing needs.</p> <p>The message for HTC plus should be changed in order for it to be linked to treatment services</p>
Low uptake by men of HTC Limited workplace-based HIV programmes offering HTC services	Intensify innovations such as mobile outreach to workplaces, peer-led activities, couples-only days, after- hours and weekends scheduling of HTC services through public-private partnerships
Integration of HTC with routine health services	
Lost opportunities to offer HTC	Further scale up HTC in the public, private and NGO sectors through integration of HTC services in routine patient care at all levels of the health delivery system

	<p>Further decentralise HTC services through mobile teams providing integrated HIV and health services including HTC at local levels</p> <p>Increase infant and child diagnosis through linkages with immunization and nutrition services Increase young people's update of HTC through integration with ASRH services</p> <p>Commence self-testing as a human right issue</p>
Referral linkages and support	
Poor follow up for clients who test positive to assess ART eligibility, as well as discordant couples	<p>Strengthen referral and follow up of HIV positive clients and discordant couples to appropriate care and treatment services</p> <p>Scale up Point of Care in HTC settings</p>
Supporting HIV-negative clients	
Clients with HIV-negative results not followed further	HIV-negative clients receive post-test services and follow up that includes risk-reduction counselling, promotion and provision of condoms, referral to other interventions such as VMMC, youth activities and community mobilization programmes

3.2.2: TREATMENT, CARE AND SUPPORT SERVICES

Zimbabwe is committed to the provision of antiretroviral therapy for all PLHIV who need it as a life-long treatment measure.

The overall goal of the ART programme is to: reduce HIV-related morbidity and mortality, improve the survival of persons living with HIV and AIDS, improve the quality of life for persons living with HIV and AIDS and reduce transmission of HIV from infected to uninfected individuals through expanded ART coverage and earlier initiation. The ART programme implementation continues to be undertaken in the context of a comprehensive care and support package that addresses medical, social and emotional needs of PLHIV. The comprehensive care and support package is a compliment of an intervention package to prevent HIV infection and to mitigate against the effects of HIV and AIDS. From 530 sites in 2010, the sites providing ART services have increased to 1,459.

Coverage of ART in 2014 is 34.5% for children and 54.9% for adults based on total number of people living with HIV. In 2014 the total number of clients on ART was 747,384 with children aged 0-14 years on ART: 54,010 and number of adolescents 10-19 years of age on ART: 55,632.

There is an upward trend in TB/HIV service coverage; In 2013, 95% of TB/HIV infected patients accessed CTX and 75% were initiated ART; 91% of primary care facilities routinely screen TB patients for HIV; An estimated 73% of TB cases in Zimbabwe were co-infected with HIV. In addition, there is improved health system capacity through training of health personnel,

task sharing/shifting and strengthening of laboratory service as well as strong support from development partners and NAC are some of the main factors that have been highly instrumental for the rapid expansion of ART. Adoption and initiating of HIV clinical mentorship by MOHCC as a key strategy to help improve the quality and outcome of HIV treatment and care has been a crucial development to the health sector response to HIV.

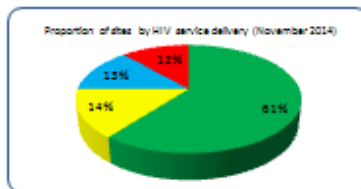
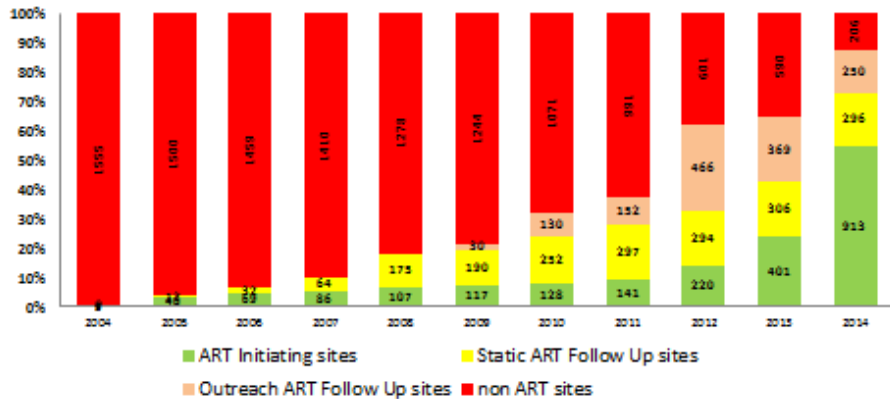
Major scale up of ART in the past five years has taken place in the country which will to be sustained. Scaling of pediatric ART requires concerted efforts as the current coverage is 42%. Focus is intended to reinforce on quality of services, adherence and retention and viral suppression monitoring in care of all those initiated on ART in order to maximize the impact of treatment in keeping people healthy and reducing their infectiousness.

Isoniazid Preventive Therapy (IPT) was recently introduced in pilot sites to help reduce the prevalence of TB among PLHIV and subsequent reduction in TB related mortality is being rolled out nationwide. Integrated capacity building programme for all health care service providers in quality assurance of ART services was institutionalized. Availability of diagnostics for monitoring of patients on ART is ongoing and will be improved. Laboratory capacity has been further strengthened through refurbishment infrastructure, upgrade of equipment, and procurement of equipment for viral load monitoring. Expanded point of care diagnostics and integration of HIV services with other health interventions was a priority to gain on efficiencies.

Procurement and supply chain management systems for medicines and other consumables were being strengthened as part of the broader health systems strengthening and integration of service delivery systems. A roadmap for the strengthening of the National Pharmaceutical Stores has been developed for implementation.

Pharmacovigilance systems of ART, anti-TB and opportunistic medicines in adults and children including those under PMTCT are in place but need continuous review and strengthening in order to ensure early detection of adverse effects. The Medicines Control Authority of Zimbabwe (MCAZ) plays a key role in conducting post-marketing surveillance activities for medicines but requires strengthening.

Geographic Coverage of the ART Programme, 2004 – 2014

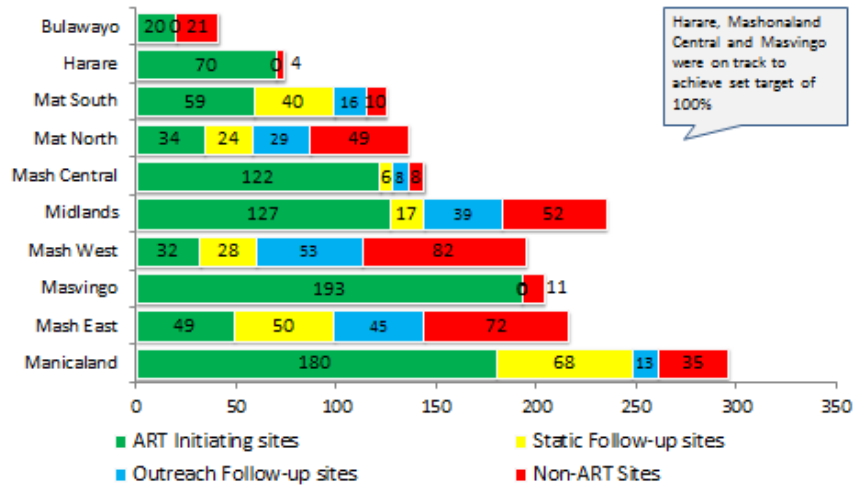


Currently a total of 1,459 sites offering ART services

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

Provincial decentralization of ART services are on track to achieve set target of 100% in Harare, Mashonaland Central and Masvingo. 12 districts decentralized ART services to all their health facilities: Centenary, Mazowe, Mbire, Rushinga, Shamva, Chirumhanzu, Lupane, Bulilima, Insiza, Matobo, Umzingwane and Mhondoro.

Decentralization: Provincial distribution of ART services as at September 2014



The ZNASP II MTR noted that there had been progressive drop in the total number of clients on C & HBC and those bed-ridden due to HIV related illnesses.

The key success factors that contributed to the achievements of the ART programme in the country include:

- Leadership and Political Commitment and partnerships
- Effective ART programme management and implementation
- Investment on strengthening of the health system
- Integrated Human resources capacity building and training activities
- Integrated service delivery and Scaling up ART Services
- Community participation, demand creation and Home Based Services
- HIV Drug Resistance monitoring and timely generation of strategic information and use
- Effective Mobilisation of financial resources and efficient use to support for ART scale-up

3.4 RESPONSE MANAGEMENT

The National AIDS Council provided strong coordination and management of the multi-sectoral national response through its decentralized structures. This coordinating structure has ensured inclusion of hard to reach communities, key populations, PLHIV, as well as other government sectors, non-state-actors, the private sector, and for profit companies and partners, faith based organization and the traditional leadership. Zimbabwe continues to mobilise resources from both domestic and international sources to support the national HIV response. The country is currently developing an HIV investment case to ensure sustainable financing of the national response and has completed a hotspot geospatial mapping to support decentralized smart investment and prioritization. The National Monitoring & Evaluation (M&E) system has been decentralized down to district level and is linked to key sectoral systems including the MOHCC HIV M&E systems. This system has provided the evidence necessary to support evidence and results based management of the response.

The relevant international targets agreed to by Zimbabwe include MDG 6 and its HIV-related goal to halt and begin to reverse the HIV epidemic, the UN General Assembly Political Declaration of 2006 committing to universal access to HIV treatment, care and support, and the UN General Assembly Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS of 2011 towards achieving the three zeros, ending AIDS, the All in and other global initiatives.

Regionally, the roadmap on shared responsibility and global solidarity for AIDS, TB and Malaria response in Africa developed by the AU Commission and NEPAD was endorsed at the 19th AU Summit in 2012⁶, the Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African (ESA) was affirmed in December 2013 including by Zimbabwe, and SADC maintains an HIV and AIDS Strategy Framework⁷.

Generally, a supportive policy environment has prevailed and enabled a highly multisectoral participation in the HIV responses from engagement, dialogue, proposal development, program planning, resource mobilization, and monitoring and evaluation. Functional and decentralized broad based NAC- led coordination and management structures have been a strong anchor for the national response to HIV and this has further been reinforced by the National AIDS Levy that is provided for by an Act of Parliament as well as solidarity and resource support from Development Partners (DPs) that have both helped the country to plan and execute HIV interventions over the years.

There has been proactive partnership building to widen the support base for championing the national response. The coming into effect of the new Zimbabwe Constitution in the second quarter of 2013 reaffirmed basic rights and non-discrimination for access to and provision of health and social services. Through their own initiative and with support from NAC, MOHCC,

⁶ ROADMAP ON SHARED RESPONSIBILITY AND GLOBAL SOLIDARITY FOR AIDS, TB AND MALARIA RESPONSE IN AFRICA http://www.au.int/en/sites/default/files/Shared_Res_Roadmap_Rev_F%5b1%5d.pdf

⁷ <http://www.sadc.int/files/4213/5435/8109/SADCHIVandAIDSStrategyFramework2010-2015.pdf>

Civil Society and DPs, PLHIV and their support groups have been involved in diverse ways in the national program of action on HIV.

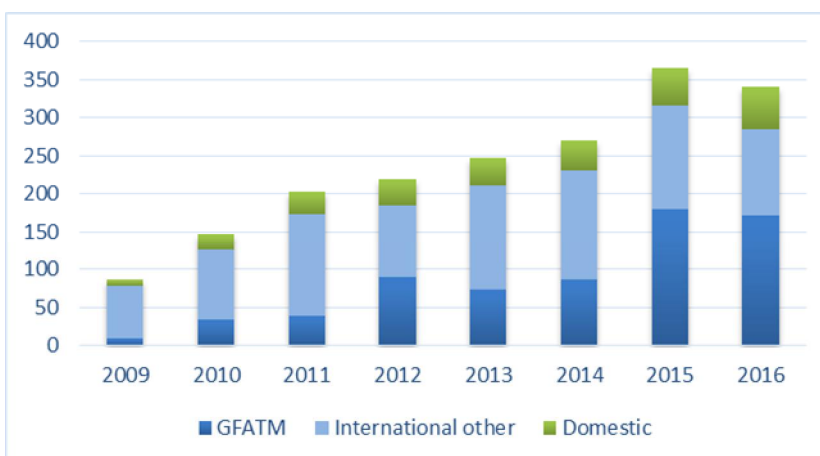
The ZIM ASSET and the National AIDS strategy is well linked to address urgent and high impact programme and services directed towards ending AIDS in the country, and present an opportunity for multisectoral programming and convergence of interventions at service delivery level. Gender responses, the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

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

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

From an historically low base relative to the size of the HIV burden, resources for the Zimbabwe AIDS response have grown strongly over the past 5 years.

On a per-person living with HIV basis, Zimbabwe receives one of the lowest per capita allocations globally from the combined funding of the two largest international funders (the Global Fund and PEPFAR). The World Bank's recent expenditure review found per capita development assistance for health in Zimbabwe in 2011 was well below that of neighboring countries. HIV treatment has taken an increasing share of the resources available, and will continue to dominate resource needs over the coming decade



as more than a million people on life-long antiretroviral therapy.

Public domestic and international resources available for AIDS, US \$ million, Zimbabwe, 2009-2016

are put

Current annual funding of the AIDS response from all sources is around US \$360 million. Annual resource needs are projected to increase to nearly \$600 million by around 2018. However, a more prioritized high-impact response could see resource needs stabilized at around \$550 million annually in the second half of the coming decade if prevention gains and treatment and programme support efficiencies are realized.

Resource availability for AIDS in Zimbabwe has grown markedly since 2009. 85% of the response is externally funded. However, domestic spending increased by 40% from 2011 to 2014. 44% of HIV funding was spent on treatment and care in 2011, rising to approximately 50% in 2015.

Domestic financing, principally through the National AIDS Trust Fund supported by a 3% taxation levy on personal and most corporate income, boosted by strong economic growth experienced in 2010-2012. International funding from bilateral sources, including the doubling of US Government funding under PEPFAR between 2012 and 2013 and its maintenance at these levels since. Multilateral funding, especially through the Global Fund where average annual grant totals increased from \$67 million under Round 8 grants (2010-2013) to \$145 million under the new funding model (2014 onwards) which makes an allocation to the country using a formula based on disease burden, needs and total available financing from all sources.

04 Gaps in the National Response

4.1 Summary Programmatic Gap

Below are summary programmatic gaps in the response:

- The coverage gap for PMTCT falls from 10 520 in 2014 to 6 837 in 2018.
- Most commitments for ART end in 2016 and as a result, coverage gap increases from 627 450 in 2014 to 1 235 269 in 2017 and 2018 under the test and treat scenario. Under the CD4<500 scenario, the gap rises from 515 640 in 2014 to 1 093 773 in 2018.
- The treatment gap for Child ART falls from 44 242 in 2014 to 39503 in 2018 for the CD4<500 scenario whilst under the test and treat scenario, it falls from 79 849 in 2014 to 62401 in 2018 under test and treat.
- Infant prophylaxis gap falls marginally from 16956 in 2014 to 11290 in 2018 under the test and treat scenario.
- The HTC gap rises from 281 006 in 2014 to 3 368 117 in 2018.
- The VMMC annual coverage gap rises from 249 in 2016 to 201 239 in 2018 whilst the cumulative gap rises from 2 293 035 in 2014 to 1 693 036 in 2018.
- HIV/TB gap rises from 6 935 in 2014 to 7245 in 2018.

4.2 Causes of access inequity to services

- **Legal and policy barriers**

Legal barriers to HIV prevention including illegal status of sex work, sex between people of the same sex and prohibition of condom promotion in school settings still exist. Despite the current lack of legal frameworks for prevention activities with sex workers, prisoners and MSM, Zimbabwe has allowed the existence of informal lobby groups for these populations. In the meantime efforts are being made to scale up HIV services to most-at-risk populations using a public health approach.

The primacy of customary law over the Bill of Rights has affected women's and girls' constitutional rights on protection and gender equality. While the Constitution includes a clause that promotes gender equality, it nonetheless maintains a 'law back clause' that undercuts the fundamental values by recognizing the primacy of customary law over the Bill of Rights. A study in Zimbabwe demonstrated that married women who experience physical violence only, or both physical and sexual violence, are significantly more likely to be HIV-positive than those who have not experienced any physical or sexual violence.

- **Gender norms and practices**

Domestic violence is widely acknowledged to be of great concern from the perspective of human rights, economic development, and public health. Despite existing legislation, much more can be done to protect the victims given 27% of Zimbabwean women have experienced sexual violence in their life-time with insignificant variation by wealth and education⁸. Men's

⁸ Zimbabwe National Statistics Agency (ZIMSTAT) and ICF International, 2012, Zimbabwe Demographic and Health Survey 2010-11. Calverton, Maryland: ZIMSTAT and ICF International, Inc.

notions of masculinity, such as fear and denial of HIV, interfere with women's ability to achieve optimum antiretroviral therapy, particularly important for treatment as prevention programmes.

At the same time, social norms on masculinity serve as a barrier to men's uptake of HIV prevention and treatment services. Migration and mobility can increase individual risk behaviour and restrict access to HIV and health services. Higher HIV prevalence in some mining, commercial farming and border areas suggests the need to intensify HIV prevention services in those areas.

- **Geography**

Access to services is geographically homogeneous due to the decentralized scale up of services through health and community structures at all levels. However some hard-to-reach populations remain including resettlement areas, mobile populations such as small-scale and informal miners, and areas distant from health facilities with geographical barriers to access varying on a seasonal basis e.g. restricted access due to rains

- **Stigma and discrimination**

The National HIV Policy promotes zero stigma and discrimination with a supporting legal framework including non-discrimination in relation to employment. Stigma in Zimbabwe has been decreasing, visible in communities with increasing openness and discussion of HIV; the ZDHS showed an increase in the percentage of men and women expressing accepting attitude towards PLHIV, from 17.1% and 10.8% women and men respectively in 2005-6, to 39.8% and 39.2% in 2010-11. The 2015 stigma Index Study report showed 65.5% experienced one or more forms of HIV-related stigma and discrimination; 31.2% verbally insulted, harassed and/or threatened; 21% exclusion from social gatherings; 19% physically harassed and/or threatened; 15% discrimination by partners; 13.1% had to change or denied accommodation; 12.4% psychological pressure; 12.1% denied work opportunity due to status; 11.7% exclusion from family activities and 10.6% exclusion from religious activities

- **Poverty**

Zimbabwe is a low income country and is currently in recovery from an economic crisis under the guidance of the ZIM ASSET blue print. While ARV medicines are provided free of charge, economic access therefore remains a barrier to services including through out-of-pocket expenditures on user fees at health facilities, laboratory and X-ray charges, and transport to attend health facilities. Young girls will need cash transfer to protect their vulnerabilities.

4.3 System-related constraints at the national, sub-national and community levels in reducing the burden of the disease

The economic crisis had severely weakened the health system at all levels (national to primary care level) and within all building blocks of the health system. In responding to HIV, Zimbabwe's communities are organised around community based organisations, support groups and community networks and local level coordinating structures. These structures are intended to support and coordinate communities in community based health interventions including demand creation for services, adherence support and defaulter tracking. Strengthening community participation is an important element in order to ensure high standards of transparency, accountability of health service management and community ownership of health programmes. However, community responses have not been sufficiently defined and prioritised, and have suffered from lack of cohesion and funding. The interface between community and health

Delivering our commitment to: Zero new HIV infections, Zero discrimination, Zero AIDS-related deaths.

service delivery also requires continued strengthening. Capacity within both health and community systems needs to be strengthened in order to better reach key and most-at-risk populations with services.

05 VISION, GOALS AND RESULTS



5.1 VISION

The ZNASP III 2015-2018 has adopted and maintained the ZNASP II vision: 'Towards Zero New Infections, Zero stigma and discrimination and Zero AIDS related Deaths' with an aspirational goal of 'Ending AIDS by 2030'.

5.2 MISSION

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

5.3 GOAL

ZNASP III seeks to contribute to achieving improved wellbeing and healthy lives for all population groups through universal access to HIV prevention, treatment, care and support services.

5.4 IMPACT RESULTS

- i. To reduce HIV incidence by 50% among children, adolescents and adults reduced by 50% from 0.98 in 2013 to 0.49 % by 2018.
- ii. To reduce HIV-related mortality by 80% for both children, adolescents and adults by 2018.
- iii. To increase domestic financing of the HIV response to 30% by 2018

5.5 OUTCOME RESULTS

Below is a summary of the outcome results that will contribute to achieving the impact results

1. All Adults and children have increased access to effective HIV prevention services and are empowered to participate in inclusive and equitable social mobilization to address drivers of the epidemic

- “ % of Female and Male aged 15-49 who had more than one partner in the past 12 months and who used a condom during their last sexual intercourse
- “ % men aged 15-49 who are circumcised
- “ % Women and men aged 15-49 who received an HIV test in the last 12 months and know their results

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- “ % of HIV positive women accessing family planning commodities of their choice
- “ % of schools with teachers who have been trained in life-skills based HIV/AIDS education and who taught it during the last academic year
- “ % key populations, vulnerable and left behind groups reached by prevention programmes (disaggregate by services and gender)

2. 90% of all PHLIV know their HIV status, 90% of HIV+ receive sustained antiretroviral therapy, 90% of those on treatment have durable viral load suppression

- “ Proportion of adult and children living with HIV that are receiving treatment receiving ART disaggregated by sex, age and pregnancy status
- “ Proportion of all people living with HIV who know their HIV status
- “ Survival rate of PLHIV on ART at 12, 24, 36, 48 and 60 months after initiation
- “ Proportion of all people receiving antiretroviral therapy with durable viral load suppression
- “ Proportion of HIV positive adult and children diagnosed of TB patients who are on ART

3. Key institutions from government and civil society have improved capacity to effectively and efficiently manage a multi-sectoral AIDS response

- “ Amount of public and donors funds mobilized and spent efficiently in the past 12 months
- “ Availability of timely, coherent, and relevant data and strategic information disaggregated by gender and appropriate age group for development
- “ Policies, strategies reviewed and implemented regularly to guide the multisectoral response

5.7 GUIDING PRINCIPLES

The key principles for this strategy are based on:

- **Results based management**

There is strong desire by GRZ and its partners to see value for money. The ZIM ASSET is promoting results within the lifespan of the plan in all sectors. The HIV response will be promoting results, accountability and good governance at all levels.

- **Rights based approach:**

The National HIV response recognizes and upholds the human rights, strives to protect and promote the rights, dignity, non-discrimination of the people especially PLHIV, Key populations, people with disabilities, youths, women, children and others who are socially excluded.

- **Equity for fairness and justice:**

The HIV response will uphold equity oriented interventions that promote allocation of resources preferentially to the needy so as to address challenges related to unfair differences.

- **Evidence Informed:**

The interventions for the HIV response will be based on evidence provided and responding to community needs. Resources allocation will be determined by the value, impact and potential for scaling up evidence based initiatives.

- **Accountability:**

Multisectoral involvement, mutual involvement, financial reporting and program reporting will be the basis for ZNASP III accountability.

- **Shared Responsibility and Global solidarity**

For successful implementation of the AIDS response, the Zimbabwean government will ensure commitment of political leadership; allocation of resources in a way that ensures high impact; and have a fair share of the HIV investment gap with assistance from developmental partners in line with.

- **Gender sensitivity and responsiveness:**

A gender responsive national multisectoral AIDS response will be promoted and implemented in the next five years of the national AIDS response.

- **Sustainable financing:**

Due to the poor economic situation in the country- companies closing down, donor fatigue, the resource funding is dwindling negatively affecting the HIV funding situation especially the established domestic funding . AIDS Levy. The ZNASP III will pursue the investment approach to resource mobilization and optimize on available resources using all available avenues..

- **Good Practices for learning:**

The HIV response will take into account lessons learnt and best practices documentation at critical stages of programmes implementation ed at all levels in the country, region and internationally for an improved and effective response.

- **Community involvement ownership and partnership:**

The communities will be empowered to take control of their resources, programmes for sustainable well-being. The concerted efforts in responding the HIV and AIDS epidemic of the multisectoral stakeholders including government sectors, DPs, FBOs, CSOs Private sector-including the informal sector (SMEs), PLHIV will be aligned towards achieving the country's goals and results.

- **Positive Health, Dignity, and Prevention (PHDP):**

The ZNASP III recognizes the important role played by PLHIV in the national HIV response and strives to ensure their involvement in all interventions. The strategy provides for meaningful involvement of PLHIVs in all the implementation and monitoring of the response. The multisectoral actors at all levels are expected to adhere to this guiding principle.

- **Country ownership and partnership:**

All HIV stakeholders including the government, development partners, private sector, faith-based organisations and communities of people living with HIV and Zimbabwean communities shall align their efforts towards the results envisioned.

- **Rights-based and gender transformative approaches:**

The success of the HIV response is dependent on protecting and promoting the rights of those who are socially excluded, marginalised and vulnerable. This ZNASP III is cognizant of this reality and is rooted in a rights-based approach.

- **Efficiency, effectiveness and innovation:**

Zimbabwe is experiencing economic crisis and flattening of donor resources with potential decline, further exacerbating the HIV funding situation. The ZNASP III has taken active steps to sustainable domestic funding options through improved efficiency in service delivery and innovative approaches aimed at achieving more at reduced cost without compromising on quality.

- **The importance of location and population**

The plan is designed to ensure that NAC and its partners stand shoulder to shoulder with community and city leaders. Cities and urban areas are engines of transformation. They are home to the largest and most dynamic economies and they are energized by young, mobile and diverse populations with talent, creativity and innovation. Urban areas are also home to millions of people who have fallen through the cracks of social, political and economic life. People who lack access to education, health services and prevention measures face significantly higher health risks. Under these social conditions, many diseases, including HIV, spread more quickly. Additionally, poor sanitation and crowding foster the spread of tuberculosis, which is the leading

cause of death among people living with HIV. This plan will give space for cities to address their significant disparities in access to basic services, social justice and economic opportunities.

5.8 PRIORITY AREAS OF FOCUS

The global financial crisis has sent a stark reminder that Zimbabwe - in order to avert an AIDS treatment crisis - need to prevent the maximum of new infections at minimum expense. The cost of treating someone with HIV for life means it makes financial as well as ethical sense to minimise new infections. Zimbabwe commits to adequately resourced high-impact HIV prevention. The following are key areas of attention:

- Reduce acute stage transmission and acquisition by changing the structure of sexual networks and concurrency, condom use during concurrent relationships and high risk sex, and male circumcision with risk reduction counseling;
- Reduce vertical transmission through the 4-pronged PMTCT approach: only planned pregnancies amongst HIV positive women, screening of all pregnant women, scale-up early antiretroviral treatment for all HIV-positive pregnant women, and ARV prophylaxis for the infant;
- Reduce acquisition from or transmission to a long-term sexual partner through couple HTC, targeted HTC, consistent male & female condom use among key populations, male circumcision with risk reduction counseling if the female is the HIV-positive partner and ART ;
- Reduce transmission from PLHIV through ART at CD4 count of 500 combined with risk reduction counselling and condom promotion;
- Reduce transmission from and acquisition during casual heterosexual sex through male circumcision, condom use, and a comprehensive HIV prevention programme for sex workers⁹.
- Reduce HIV transmission among adolescent and young people through early treatment, HTC and comprehensive HIV prevention programme
- Maintenance of 1m+ PLWA on treatment, with nurse care, infrequent care visits (patient initiated) and automatic ART stock control.
- Tailored intervention in the economics of sex for young women.
- All pregnant women, infants and children diagnosed and referred to care through multiple maternal, infant and early childhood health entry points.
- Active social dialogue on inclusion, morality, selling sex and MSM.
- Health accountability led by PLHIV and geographical hotspots

⁹ Such a comprehensive programme for sex workers consist of the following components: HIV and STI testing and treatment, condom promotion programmes, solidarity programmes, violence and abuse support, and protective policing.

Given the country's success in reducing HIV to lower levels already and the fact that there is consensus in Zimbabwe on what to do to arrest HIV, the next wave of focus in HIV prevention in Zimbabwe needs to focus on (a) allocating more dedicated HIV resources for priority interventions in line with UNAIDS investment principles and fewer dedicated HIV resources for non-priority interventions; (b) setting quality standards for these priority interventions; (c) getting coverage to levels where it will make a population impact and difference; (d) efficient and effective response management and multisectoral coordination, generation of real time data and strategic information and (e) better sectoral performance management of those priority interventions that are being implemented so as to improve efficiency and effectiveness.

With an uncertain funding base for the HIV response in the future, and increasing treatment, care, support, prevention funding, as all other aspects of HIV prevention funding, will need to do more with less. Above all, there is a great necessity for **vigilance to prevent secondary increases in the epidemic curve with lower levels of funding**. The recommendations below were developed with this premise and priorities in mind.

- 1. Rapidly scale up male circumcision using WHO's implementation standards and guidelines to 80% coverage by 2018.** If there are funding gaps for MC, other prevention activities that have less/no proof of efficacy (such as STI management as part of HIV prevention) should be downscaled so as to be able to fully execute the male circumcision intervention as planned by the Government of Zimbabwe.
- 2. Scale up comprehensive HIV prevention programmes for sex workers, adolescent and young people, both by creating the specific context for facilitating behaviour change, and by funding targeted and tailored services for these populations.** Such a comprehensive programme for sex workers and other vulnerable and key populations consist of the following components: targeted HIV and STI testing and treatment, targeted condom promotion programmes, solidarity programmes, violence and abuse support, and protective policing.
- 3. Identify opportunities for and scale up a couples HIV prevention programme so that 80% of couples are reached with such a programme by 2018.** Such a programme should focus on concordant negative and discordant couples, and the faith-based community should be widely involved in such an intervention. Components of it should include regular mutual HIV testing and disclosure of status, counselling and support services, earlier ARVs for those discordant couples who choose to have it, family planning services for discordant couples, and relationship and family skills building.
- 4. Regulate and rapidly distribute self test kits for HIV at a subsidised cost** so as to add an additional vehicle through which persons could know their HIV status, and to rapidly reduce the cost of such implementation.
- 5. Integrate social norm and behaviour change interventions into the delivery of social and HIV-related services, as opposed to stand-alone services, whilst continuing with an agreed minimum package of HIV prevention public health messaging at lower cost.** In spite of normative changes, positive behavioural changes and decreased HIV transmission, high-risk behaviours, particularly multiple sexual partnerships, continue to fuel HIV transmission. Partner reduction must remain a primary message, and the advantages of mutual faithfulness need to be communicated (less stress and mistrust, less STIs, less cost,

less jealousy and domestic violence, etc). Condom promotion should emphasize the lack of benefit provided by inconsistent use, especially if additional sexual risks are taken. Social norm and behaviour change interventions must aim at reducing the likelihood of girls to acquire HIV. Communication among couples about HIV testing and disclosure of results must be stimulated. These messages need to be integrated into the delivery of all social services, whilst a minimum standard of public health communication is retained. Expensive mass media campaigns should be discouraged.

It will entail mainstreaming prevention messages into treatment, care, support, and impact mitigation. These thematic intervention areas must all contain HIV prevention components in order to stem the tide of additional people in need of these services in the future. In treatment, individuals in the pre-ART and the ART cohort represent key targets for partner reduction, consistent condom use, IEC on sexual networks and risk perception, and treatment adherence. In care and support, providers including home based carers need to be empowered to practice universal precautions and support the patient in positive living. In impact mitigation, OVCs and widowed people represent major targets for BCC, counselling and protection. The critical enablers, synergies including community system strengthening should remain the bedrock towards demand and enabling environment creation

6. Initiate legal and policy reforms that ensure that:

- a) Legislation and traditional practices are non-discriminatory, gender-sensitive and empowering to women;
- b) All protections afforded to women are strengthened and fully compliant with Zimbabwe's obligations under the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) and are implemented as a matter of urgency

7. Translate the HIV policy into laws and regulations, in order to promote and protect human rights, and deploy the required efforts to enforce the existing policies, laws and regulations.

8. Conduct operational research in order to identify potential efficiency gains. Such research should focus on the *how*+to implement, and not necessarily on the *what*+to implement. In an economic climate of uncertainties and limitations, to make the money go further has become important to National AIDS Responses. This analysis showed two areas where operational research is needed:

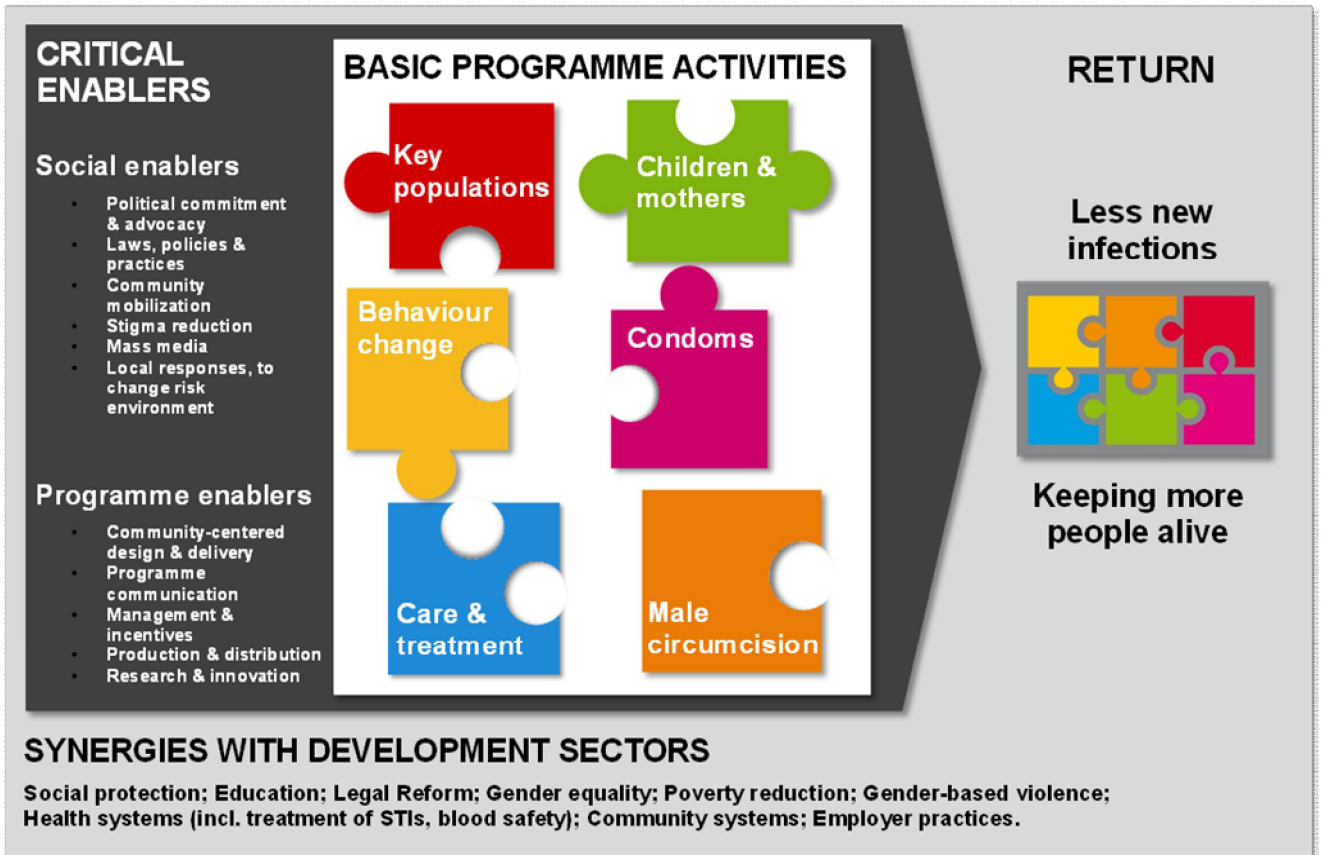
- Although integration and linkage of HIV prevention with other service areas is being promoted, very little is known about whether these service integrations work and achieve the anticipated synergies and impact. The linking and integration includes the strengthening of links with school health services, the integration of sexual and reproductive health, STI and HIV/AIDS services, an expand integration of PMTCT with antenatal, family planning and other MCH related activities, and the integration of couple HCT in family planning and male reproductive health services. This is an area where operational and even process-related research is needed.
- User fees in MCH and TB services contradict policy and have been reported to affect access to services. Operational research needs to assess the exemption system run by social welfare officers, how it works and how such a system can be implemented without impacting equity.
- Unit cost studies are critical to know if we are delivery services at acceptable cost or not.

9. **Make HIV incidence monitoring a focus, use all the measurement tools available, and triangulate data obtained from different sources and through different methodologies.** The policy makers, M&E specialists, and implementers at the front line need to remain alert to any early warning signs that the epidemic trend may reverse. This includes the monitoring of maternal HIV prevalence in young women, in-depth analysis of population level and cohort data, and keeping a close eye on other clues and proxies potentially indicating changes in HIV/STI transmission dynamics (such as, for instance, reported number of partners, statistics on STI episodes).
10. **Conduct impact evaluations.** Impact evaluations estimate the effect of a programme and provide information on the net change that can be attributed to a specific programme. Such evaluations help inform policy as to what works, what does not, and why. Like most countries, Zimbabwe has in the past conducted more often descriptive rather than causal evaluations. But impact evaluations are urgently required in order to make decisions on high-impact priority programmes and interventions. They may need more complex designs, but are more likely to deliver the information policy makers really need. One obvious area where programme effects need to be understood is the **eMCTCT programme following the ongoing cohort**. This intervention is the single largest spending item in Zimbabwe's HIV prevention, and evidence on each of the four prongs of the eMCTCT package is required in order to be able to justify the large expenditure for PMCT while other prevention interventions are seriously under-resourced.
11. **Advocate for resources for HIV prevention, including from domestic sources and the AIDS levy.** The case of Zimbabwe is special: It has one of the most dramatic HIV epidemic declines of any country, and the epidemic has unfolded in a context of multiple other hardships, including recurring droughts, food shortages, and a wide range of political and economic problems. There is evidence that HIV prevention programmes, in conjunction with contextual changes like the economic crisis, have contributed to this success. Sufficient resources must be made available in order to fund proven interventions, and prevent the epidemic from reversing at a time when AIDS mortality and economic hardship may be less present.

5.9 ZNASP III Investment frameworks

Designing the National AIDS Strategic Plan as a new investment approach is proposed for the response to HIV to be simpler and more strategic is intended to support better management of the HIV response. It is aimed to identify specific steps to eliminate inefficiencies in HIV programmes, to enhance equity and inclusiveness for key populations and marginalized groups, and to use available evidence to better understand the health and economic benefits of timely, rights-based, smart HIV investments.

Figure XX: ZNASP III as an investment framework



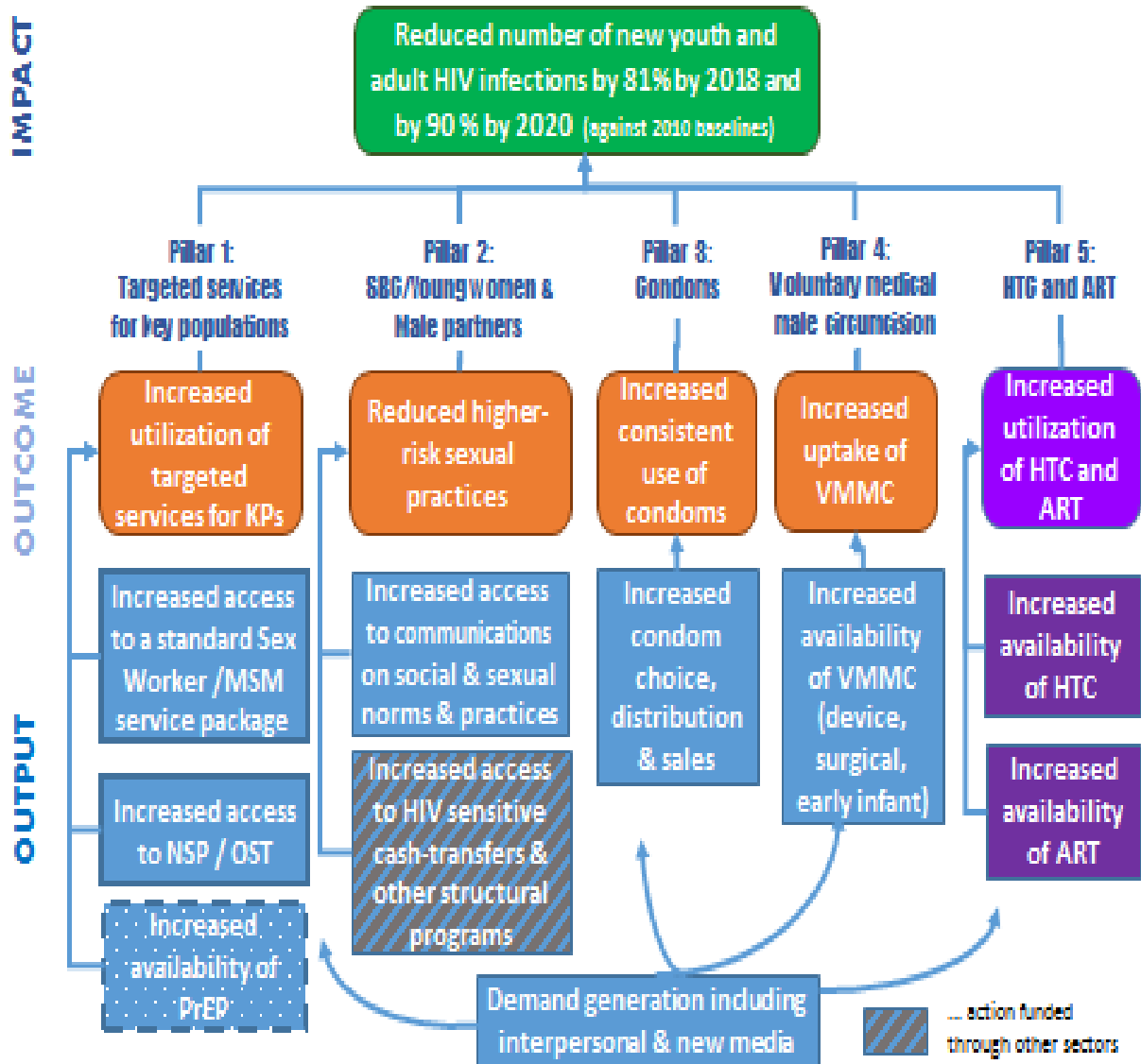
This framework if fully implemented will ensure that that HIV investments are focused on the highest impact interventions to match the epidemic characterization and national context. It will also reduce the cost of delivery, e.g., by capturing efficiencies of scale and scope, improve collaboration, inclusion in broader community / health system activities and reallocate resources for maximum impact; where needed, increase funding in the short term to allow scale-up and long term savings.

5.10 Prevention Framework

Below is a summary description of the results for prevention services:

Fig XXX: Prevention results chain and framework

Overview: Results chain for Prevention

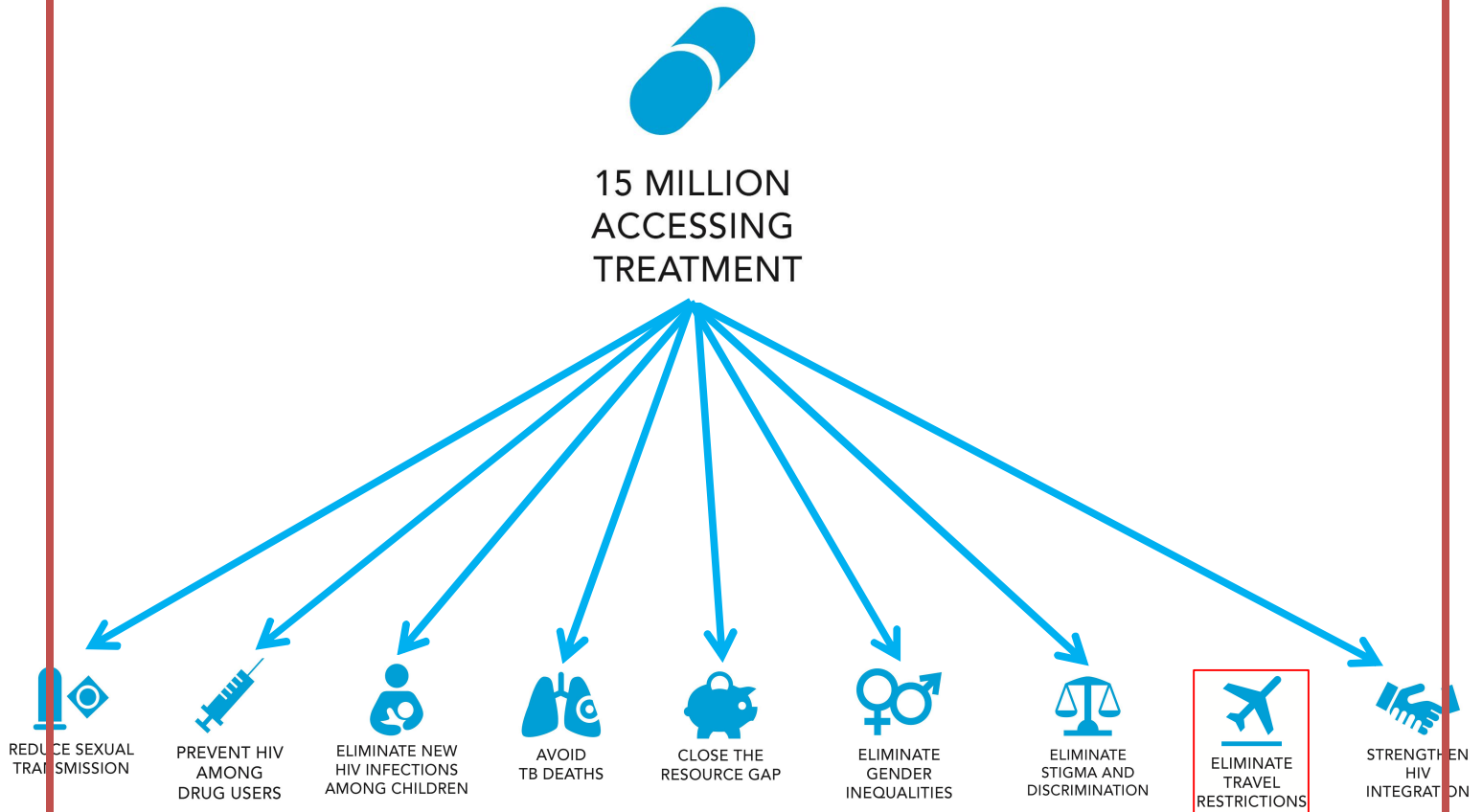


Source: combination prevention strategy

5.11 TREATMENT FRAMEWORK

The treatment framework to contribute to the current global treatment target and beyond is:

Fig xxx: Treatment Framework



Source: 2014 UNAIDS fast track strategy

5.11 AMBITIOUS NATIONAL TARGETS AT A GLANCE

Below are core ambitious national targets for accountability in line the ZIM ASSET and the 2020 global targets.

Table 3: Snapshot of National Targets

	Global Targets			National targets		
	Accelerate towards 2015	Aspire for 2020	To ensure ending AIDS by 2030	2015	2018	2020
Coverage						
People living with HIV who know their serological status	.	90%	>90%	66%	80%	90%
People living with HIV who know their status and are initiated in antiretroviral therapy	80%	90%	>90%	50% Adults 28.2% Chn	80% 79%chn	90% 90%
Viral load suppression among people on ART	.	90%	90%	89% adults[2010]	95%	95%
Pregnant women living with HIV receiving antiretroviral therapy	90%	95%	>95%	66%	80%	90%
Children 0-14 years living with HIV receiving antiretroviral therapy**	90%	90%	>90%	55%	80%	90%
Access to services (including PrEP as appropriate) for female sex workers, transgender, men who have sex with men	80%	85%	90%	??	??	??
Voluntary medical male circumcision for men aged 15-29 years (high prevalence countries with low MMC rates)	80%	80%	80%	11%	??	??
Condoms and lubricants distributed and sold per adult (15. 64 years old),	25	25. 40	40	30	??	??

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Social and behaviour change programmes						
• Access to communication of prevention and demand generation for population (15-49 years)	50%	80%	80%	??	??	??
• Access to cash incentives for young girls (hyper-endemic countries only)	.	30%	50%			

Potential impact to be expected	2015	2020	2030			
Reduction in new HIV infections (baseline 2010)	50%*	75%	90%	69%	81.7%	90%
Reduction in new HIV infections among children (baseline 2009)	90%	95%	>95%	12.75	3%	1%
Reduction in Stigma (baseline 2010)	.	.	90%	35%	60%	90%
Reduction in AIDS-related deaths (baseline 2010) ³	.	.	90%	44%	82%	90%

* 50% reduction will be maintained from 2015-2018

5.12 OUTPUT RESULTS AND CORE STRATEGIES

5.12.1 Prevention

Zimbabwe will maintain combination prevention approach to reduce further the decline of new HIV infections. Combination HIV prevention involves implementing multiple (biomedical, behavioural and structural) prevention interventions with known efficacy in a geographic area at a scale, quality, and intensity to impact the epidemic (MOHCC, 2013). Awareness programs will be realigned to address the social and behaviour change required to adopt safer behaviour and to create demand for appropriate services. During the implementation of the ZNASP III, services for young people (All in) and key populations will be scaled up in target locations. Prevention with positives will also remain a critical component of the prevention package as the approach emphasizes that PLHIV should be empowered to protect their own health and avoid onward transmission of HIV. It is critical to ensure that comprehensive treatment is provided to those who need it as part of indirect prevention benefits. There will be need to address self-stigma among HIV-positive individuals.

Figure xxx: Zimbabwe Combination HIV Prevention delivery Model

Delivering our commitment to: Zero new HIV infections, Zero discrimination, Zero AIDS-related deaths.

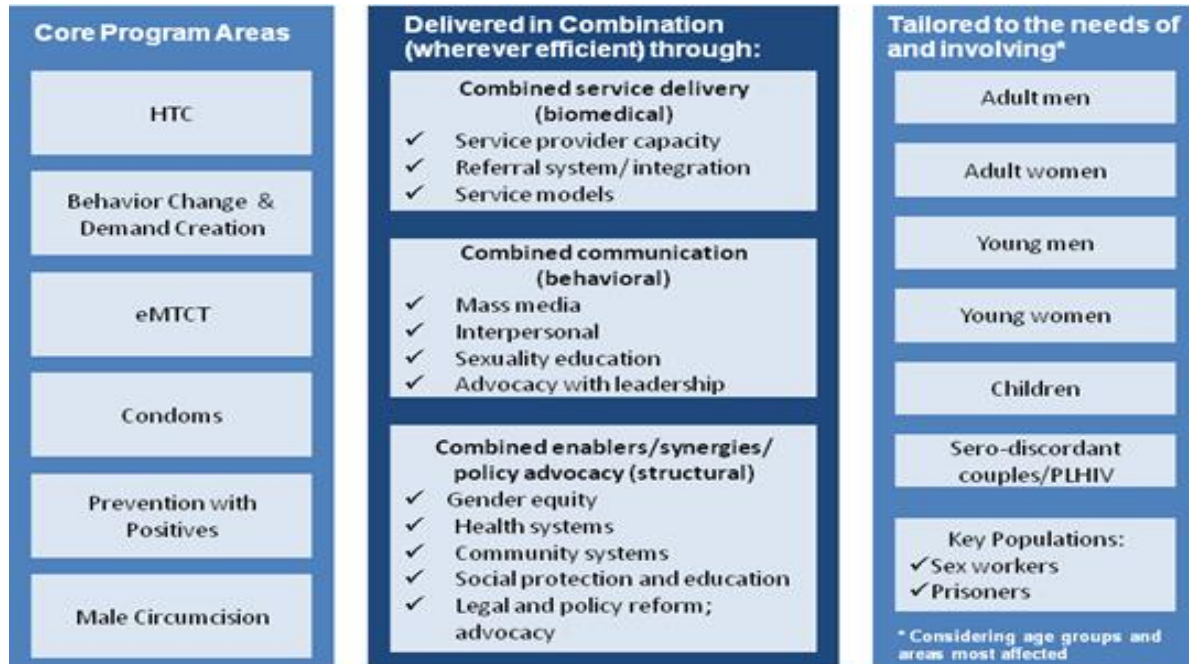


Table XX: Prevention output Results Matrix

Output Results	Core Strategies
Outcome 1: All Adults and children have increased access to effective HIV prevention services and are empowered to participate in inclusive and equitable social mobilization to address drivers of the epidemic	
1.1 Increased coverage of demand generation interventions for SRHR (incl. HIV) services (disaggregated by age, sex, key populations)	<ul style="list-style-type: none"> “ Intensifying advocacy and access to prevention information “ Strengthening integration of condom promotion, demand creation, IPC, workplace programmes, SBCC operational research, “ Promoting evidence based and targeted behaviour change communication interventions, effective parent-child communication, youth and key population friendly HIV and AIDS services. “ Promoting community engagement in SBCC initiatives “ Advocating for an enabling environment to facilitate access to services and promote health seeking behaviour of KPs;
1.2 Increased coverage of youth (10-24 years) in school, out of school and in tertiary institutions reached with comprehensive life skills, Sexuality,	<ul style="list-style-type: none"> “ Strengthening the capacity of stakeholders to manage SRH, HIV&AIDS programmes for young people “ Increasing access and utilization of integrated quality SRH, HIV&AIDS youth friendly services by young people. “ Strengthening young people involvement in the national response to SRH, HIV&AIDS.

HIV and AIDS education	<ul style="list-style-type: none"> “ Strengthening in, out of school and tertiary institutions Life Skills, Sexuality, HIV&AIDS education “ Improving the use of multi-media to increase reaching out to young people. “ Increasing access and utilization of integrated quality SRH, HIV&AIDS youth friendly reproductive health services by adolescents young people. “ Strengthening the capacity of sectors and partners in implementing the %All In+ initiative young people involvement in the national response to SRH, HIV&AIDS. “ Expanding coverage of integrated ASRH friendly services in all public and private health facilities
1.3 Improved availability of male and female and specialized condoms distributed annually	<ul style="list-style-type: none"> “ Strengthening leadership by coordination of partnerships in the condom programme in demand creation, access and utilization of condoms; condom procurement and quality assurance. “ Facilitating the expansion of the distribution networks. “ Promoting integrated (double dividend) condom programming.
1.4 Increased coverage of VMMC	<ul style="list-style-type: none"> “ Strengthening and expanding the integrated VMMC programmes “ Strengthening demand generation initiatives
1.5 Increased coverage of HIV testing	<ul style="list-style-type: none"> “ Scaling up diverse innovative approaches and epidemiologically targeted community-based HIV testing. “ Advocating and promote political leadership and commitment to support HTC the programme. “ Supporting pilot innovative interventions to scale up HTC e.g. such as door-to-door testing and self . testing and scaling them up. “ Promoting integrated testing and treatment for sex workers and other KPs; positive attitudes among health care providers towards KPs; and public- private partnerships with appropriate stakeholders working with KPs.
1.5 Increased coverage of ARV prophylaxis for HIV-exposed children	<ul style="list-style-type: none"> “ Accelerating the roll out and supporting scale-up of Option B+ and initiate operation research in eMTCT. “ Strengthening the capacity of sectors and partners in initiating the integrated %double dividend approach in response to the pediatric HIV. “ Strengthening the coordination and management the of ARV supply and logistics management; health and community systems and involvement; national, provincial, district and community capacity; human resource capacity and systems; syndromic management of STIs; and meaningful involvement of PLHIVs.
1.6 Improved coverage of family planning integrated into OI/ART and PMTCT services	

	<p>“ Scaling up innovative approaches and best practices to enhance male involvement and community leadership and structures involvement in comprehensive PMTCT.- Option B+ and pediatric HIV care, treatment and support;</p> <p>“ Improving the generation, dissemination and use of strategic information for decision making in planning, implementation, monitoring and evaluation of comprehensive PMTCT and pediatric care, treatment and support programmes.</p>
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i. SOCIAL BEHAVIOUR CHANGE COMMUNICATION (SBCC)

SBCC interventions can be of great use if such interventions are delivered to the appropriate population in combination with other evidence-based HIV prevention and care services. SBCC interventions will be intensified in the community, workplace and in schools, targeting most at risk and key populations while taking cognizance of the key findings and recommendation from the ZNASP II MTR of 2013. It is critical to note that SBCC is also a cross cutting intervention that cuts across a wide range of HIV and AIDS interventions. Therefore there will be need for coordination and harmonization of prevention strategies for impact.

ii. YOUNG PEOPLE TARGETED PREVENTION (IN AND OUT OF SCHOOL & TERTIARY)

The youth component in ZNASP II was considered under most at risk and key populations which compromised the response and focus on the Youth as a specific target which needs specific targeted interventions (NAC, 2013). ZNASP III will focus on young people specific and targeted interventions for an effective response and achievement of the national and global vision.

iii. CONDOM PROGRAMMING

Greater efforts will be made to ensure that male and female and specialized condom promotion and distribution is integrated in FP, STI services, VMMC, HTC, eMTCT and ART programmes, and in specific programmes that focus on most at risk and key populations e.g. young people, sex workers, migrant populations, people with disabilities and PLHIV and key populations.

iv. VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC)

The country adopted VMMC as one of the key combination interventions for prevention of heterosexual transmission of HIV. A policy and strategy were adopted in 2009 following studies that indicated that VMMC reduces the acquisition of HIV in heterosexual men by 50-60%. Zimbabwe will up-scale the VMMC programme in the ZNASP III, maximising on the existing political commitment at all levels, including the highest office and parliament as well as

involvement of traditional and religious leadership various partners. VMMC also provides an important opportunity for HTC as an entry point for access to early HIV care and treatment service, SRH information and referrals to other programmes, hence integrated approach will be utilized. In order to improve VMMC coverage the country has now adopted the prepx device as an approach.

v. HIV TESTING AND COUNSELLING (HTC)

HIV counseling and testing remains a key prevention strategy in the national response to HIV. The scaling up of HTC is both public health and human rights imperative and will be linked to achieve universal access to comprehensive HIV prevention, treatment care and support. The programme will continue targeting and working with priority populations including couples (formal and informal unions); partners of PLHIV on the national Pre-ART and ART programme; children (0-14 years), young people (aged 150-294 years) and key populations.

vi. ELIMINATION OF MOTHER TO CHILD TRANSMISSION (EMTCT)

In Zimbabwe, Mother to child transmission of HIV has been noted to account for almost all of the new infections in the infants. In response to this situation, the country initiated interventions for prevention of vertical transmission of HIV as commitment to the vision of a new HIV free generation and families affected by HIV alive and living quality lives. Accordingly, the country's strategic thrust will be to enhance the implementation of the World Health Organisation 2013 Guidelines that include provision of lifelong ART to all pregnant and breastfeeding women living with HIV regardless of CD4 count, or, clinical stage (Option B+), and provision of ART to all HIV-infected infants and children under the age of 5 years regardless of the CD4 cell count, towards the achievement of the elimination targets. Simultaneously, ZNASP III will be responding to and addressing the existing gaps related to coverage, uptake and quality of integrated and comprehensive PMTCT including lifelong ART Option B+ services to pregnant and lactating women as well as and care for the HIV exposed children and infected children as identified in the e-MTCT Strategic Plan MTR Report of August-September 2013.

5.13 TREATMENT CARE AND SUPPORT

Treatment, care and support remains at the core of provision of services for the infected and affected. While ZNASP II focused on expansion of the ART programme. The strategic thrust of ZNASP III will be to maintain and periodically review the current ongoing programmes. as they are important components of the national response. These include integrated programmes such as HIV/AIDS, MNCH/SRH/TB with a focus on: implementation of Option B+ and CD4<500 cells/ml eligibility for ARV initiation, improving quality of care with emphasis on enrolment, adherence and retention on ART; targeted services for adolescent and youth, discordant couples, key affected populations such as sex workers, OVC and Community Care and Support. Provision of enhanced integrated services will be paramount, as this increases access while reducing limitations to accessing integrated and comprehensive services, including monitoring and follow up of clients in a resource constrained country like Zimbabwe. The overall

focus of treatment, care and support will be to achieving universal access to quality treatment, care and support services for PLHIV and TB; enhance institutional, community and household capacities to provide quality treatment for PLWH/APLHIV; and achieve universal access for OVC and TB/HIV co-infected clients including enhancing institutional, community and household capacities to support and care for OVC, PLHIV and TB.

Table xxx: Treatment Output Results and Strategies

Outcome 2: 90% of all PHLIV knows their HIV status, receive sustained antiretroviral therapy and have durable viral load suppression	
2.1 Improved coverage of ARV treatment	<ul style="list-style-type: none"> “ Increasing ART service delivery points; number of children, adolescents, and adults; and HIV/TB co-infected patients accessing facilitating the scaling up of ART services. “ Strengthening health systems for provision of comprehensive and integrated HIV&AIDS treatment and care services. “ Strengthening community systems for supporting and sustaining integrated care and support services for PLHIV “ Improving timely identification, linkage and retention in care for persons diagnosed with HIV; “ Increasing the number and capacity of health facilities providing quality HIV and AIDS care and treatment services and distribute them equitably so as to increase access; “ Promoting creative and innovative approaches to increase retention of ART clients. , improve yield of tracing lost to follow up clients and reduce double counting of already registered clients during enrolment while preserving human rights and dignity (e.g. use of electronic systems/technology, mobile technology, treatment support groups); “ Strengthening clinical management of HIV-related diseases; “ Increasing adherence to treatment and mechanisms for early identification of PLHIVs experiencing ART treatment failure and switching them to appropriate second line regime. “ Promote provision of enhanced integrated services “ Strengthening coordination mechanisms and a comprehensive community/family-centred plan of action for the protection, care and support of OVC and their caregivers. “ Strengthening the linkages and synergies with developmental partners for strengthened care and support for OVC. “ Facilitating increased access to services by OVC and their caregivers.
2.2 Increased proportion of people on ART who are virally suppressed	
2.3 Adults and Children enrolled in HIV care and eligible for CTX prophylaxis according to national guidelines maintained at 100%	
2.4 Increased coverage of ART among HIV positive TB patients	

	<ul style="list-style-type: none">“ Strengthening community systems; civil society capacity; and services for adolescents and young people for improved care and support.“ Strengthening community response, integration and linkages to health services to support HTC uptake, client follow-up and reporting, taking into account special needs of adolescents and youth living with HIV/AIDS.
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i. ANTIRETROVIRAL THERAPY

The ART programme will continue to initiate strategies that link clients into enrolment for early treatment, and enhance adherence and retention while ensuring improved quality of life and targeting wider population of Zimbabwe. Pre-ART service and care that include:

- “ Screening and treatment of opportunistic infections,
- “ Provision of prophylaxis,
- “ Monitoring of viral loads,
- “ Nutritional support,
- “ Treatment literacy in preparation for art and the avoidance of re-infection,
- “ Counselling and psychosocial support, will be provided to the newly HIV diagnosed clients to facilitate their enrolment,
- “ Adherence and retention on lifelong art.
- “ Community system support

Targeted interventions will be required within the national response for key populations such as for children, the young people, adolescents,, discordant couples and most at risk populations PLHIV. It will also strengthen appropriate and comprehensive harm reduction and risk perception measures for non-infected adolescents as well as specific programmes to address the particular needs of adolescence with acquired or prenatally infected adolescents.

ii. CARE AND SUPPORT

The Plan will also enhance psychosocial support interventions for adolescents and young people living with HIV so that they are implemented to scale. The plan will promote appropriate and comprehensive clinical HIV care that is age appropriate and integrated into sexual and reproductive health and psychological, educational and social services in the country.

The focus and emphasis of the OVC programme interventions will be on increasing OVC access to HIV-related health and care services. The intervention also ensures, as well as child welfare monitoring to facilitate access to and provision of support in health, education, nutrition and psychosocial services. The approach will be enhanced and scaled up to include social welfare and social protection systems within a family-centred social development framework

approach. The response will strengthen synergies and linkages among and with stakeholders for a strengthened response to offer the most appropriate interventions for OVC.

iii. COMMUNITY CARE AND SUPPORT

Community Care and Support will be an integral component of the continuum of care and support under ZNASP III. Services provided in Zimbabwe include palliative care, nursing care, counselling and psychosocial support, spiritual support, and nutrition and referral services. Provision of community care and support these services is premised on the partnership between government, civil society organizations, support groups of PLHIV and the communities themselves. Community Care and Support will be an integral component of the continuum of care and support under ZNASP III. In addition to the continuum of care adherence and retention will be integrated in this ZNASP.

5.14 RESPONSE MANAGEMENT

The National AIDS Council (NAC) that was established through an act of parliament of 2000 and has the overarching responsibility to provide leadership and coordination to a broad based multisectoral response to HIV and AIDS. NAC has successfully streamlined and harmonized of policies, strategies and resources and ensuring that appropriate and robust systems are applied so that the overall national response to the epidemic is delivered effectively and efficiently to achieve the intended goals of arresting new HIV infections and curtailing HIV related deaths. The response is managed with the internationally agreed ~~three~~ ^{three ones+} principles: a) One agreed HIV & AIDS Action Framework; b) One national AIDS authority and c) One agreed country-level Monitoring and Evaluation system.

Table xxx: Response management Output results and Core Strategies

Outcome 3: NAC and its partners including CSO have capacity to effectively and efficient manage a multi-sectoral response	
3.1 Increased amount of public and donors funds mobilized and spent efficiently	<ul style="list-style-type: none"> “ Promote high level engagement to increase Health and HIV funding by GRZ “ Promote donor confidence through efficient use of resources “ Strengthen accountability reporting “ Discourage fragmentation and building horizontal integrated systems “ building National capacity sustainability into discussions from as early as possible “ Improve capacity of donor coordination and realignment to the national priorities “ Sustain the AIDS trust fund to support existing gaps in the national response

<p>3.2 Improved availability of timely, coherent, and relevant data and strategic information disaggregated by gender and appropriate age group for development</p>	<ul style="list-style-type: none"> “ Strengthen system for real time monitoring of incidence and program impact data with partners “ Support generation of relevant strategic information to support improved programming “ Build capacity to improve evaluation practices and use of data at all levels “ Improving strategic information management at Indicators level; Data Source level; Data Collection Tools level; Data Collection Method level; Data Analysis and Data Use level; Information Products level; and Stakeholders level. “ Harmonizing and enhancing M&E capacity among the multi-sect oral stakeholders in: using data for decision-making; building capacity in people for partnerships and planning; and collecting, verifying, and analyzing data. “ Strengthening coordination, collaboration, joint planning and joint action/learning, and linkages. “ Facilitating alignment of Stakeholder M&E IT/IS to the National HIV M&E Strategy. “ Strengthening the Country Response Information System CRIS capacity for a decentralized HIV and AIDS implementation programme and the Systems Strengthening drive. “ Developing Systems and Data for sharing and integrating information and business processes by use of common standards and work practices for program me. “ Improving the generation, dissemination and use of strategic information for decision making in planning, implementation, monitoring and evaluation of comprehensive PMTCT and pediatric care, treatment and support programmes.
<p>3.3 Policies, strategies reviewed and implemented regularly to guide the multisectoral response</p>	<ul style="list-style-type: none"> “ Strengthen leadership forums that involve political, religious and traditional leaders to promote effective response “ Mobilize and support media and journalist for meaningful engagement “ Policy review and analysis for improved enabling environment “ Reviewing and strengthening coordination structures at all levels and their roles to effectively respond to the needs of the response “ Strengthening capacities for enhanced use of resources and HIV programming at the community “ Expanded access to integrated, comprehensive quality HIV and TB services through effective and sustainable public . private partnerships that include increased SMEs involvement.

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ZNASP III puts emphasis on strong, functional health and community systems as key building blocks upon which cohesive and effective responses can be anchored. It regular reviews and ensure an enabling policy and legal environment is available to unblock the barriers to and facilitate access to and demand for services. The national strategic plan underscores the central role of stigma and discrimination in fuelling HIV and AIDS and its impacts and thus highlights the need to deal with it decisively. The AIDS Levy has been recognized regionally and globally as a good practice for improving resource sustainability and ownership of the national response and for this reason a number of countries have come on bench marking visits. This plan is designed to address the verticalization of programmes at all levels, value for money, beneficitation and cost savings using the investment principles.

Partners (Implementing Organizations) from the public, private and civil society sectors will carry out the bulk of implementation in ZNASP III while NAC will provide the overall coordination support as stipulated in the NAC Act. Resource partners include the government, NAC, NGOs, Donors, International development agencies, the private sector and communities. The advantage of developing new partnerships with private sector/ business in a formalized and legal way as Private-public Partnerships is that they have substantial resources available and workplaces provide excellent opportunities to reach the labor in large numbers and with high impact. . ZNASPIII will promote strengthening of partnerships at all levels, with involvement of the public and private sectors as well as civil society organizations

06 Sustainable financing, Coordination, management, and Strategic Information

6.1 STATUS OF FUNDING AND ESTIMATED FUNDING GAPS

From a historically low base relative to the size of the HIV burden, resources for the Zimbabwe AIDS response have grown strongly over the past 5 years. The bulk of funding (85%) is from international sources, with domestic resources linked to economic growth, largely the National AIDS Trust Fund supported by a dedicated taxation levy. On a per-person living with HIV basis, Zimbabwe receives one of the lowest per capita allocations globally from the combined funding of the two largest international funders (the Global Fund and PEPFAR). The World Bank's recent expenditure review found per capita development assistance for health in Zimbabwe in 2011 was well below that of neighbouring countries.

HIV treatment has taken an increasing share of the resources available, and will continue to dominate resource needs over the coming decade as more than a million people are put on life-long antiretroviral therapy. Current annual funding of the AIDS response from all sources is around US \$360 million. Annual resource needs are projected to increase to nearly \$600 million by around 2018, and over \$700 million each year from 2023 onwards, given current cost structures. However, a more prioritized high-impact response could see resource needs stabilized at around \$550 million annually in the second half of the coming decade if prevention gains and treatment and programme support efficiencies are realized.

Resource availability for AIDS in Zimbabwe has grown markedly since 2009. 85% of the response is externally funded; however, domestic spending increased by 40% from 2011 to 2014 and 44% of HIV funding was spent on treatment and care in 2011, rising to approximately 50% in 2015. Three drivers of the current growth in resource availability are:

- § Domestic financing, principally through the National AIDS Trust Fund supported by a 3% taxation levy on personal and most corporate income, boosted by strong economic growth experienced in 2010-2012.
- § International funding from bilateral sources, including the doubling of US Government funding under PEPFAR between 2012 and 2013 and its maintenance at these levels since.
- § Multilateral funding, especially through the Global Fund where average annual grant totals increased from \$67 million under Round 8 grants (2010-2013) to \$145 million under the new funding model (2014 onwards) which makes an allocation to the country using a formula based on disease burden, needs and total available financing from all sources.

Zimbabwe will need to substantially increase the current HIV investment over the next decade just to control the AIDS epidemic in Zimbabwe. The costs of the current coverage levels of treatment and prevention services will rise as the number of people living with HIV increases and with 2% annual population growth.

Pledged resources amount to, \$304 million for 2015, and \$264 million for 2016 respectively. Domestic resources from the Aids levy amount to an average of 16.5% of the total funding as shown in figure 1.

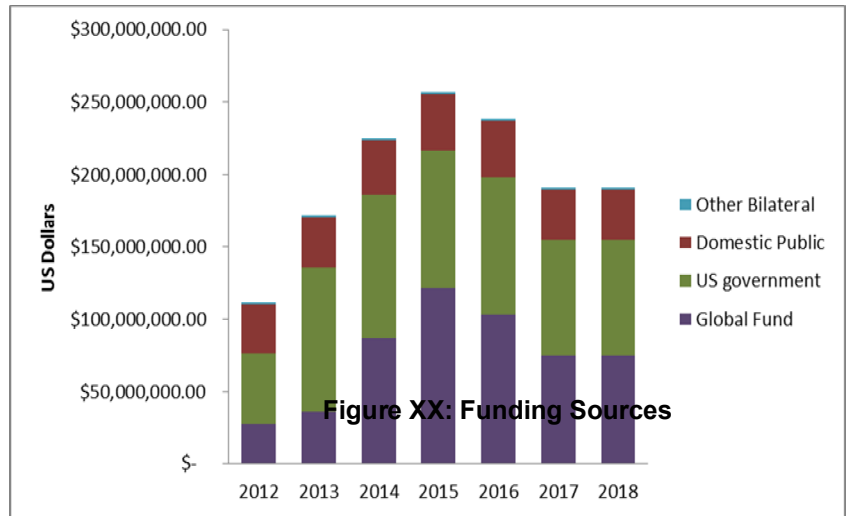


TABLE XX FINANCIAL RESOURCES AVAILABLE, REQUIRED AND GAPS

Year	2013	2014	2015	2016	2017	2018
Total ART Care and Support	\$ 136,652,926	\$ 167,548,683	\$ 200,123,278	\$ 248,003,358	\$ 279,771,197	\$ 311,946,828
Total PMTCT	\$ 18,783,127	\$ 21,112,399	\$ 24,197,319	\$ 25,459,172	\$ 25,704,760	\$ 26,155,678
Total Prevention costs	\$ 108,744,658	\$ 145,329,405	\$ 174,122,010	\$ 182,664,420	\$ 191,482,865	\$ 182,684,898
Policy management and coordination	\$ 58,937,371	\$ 59,821,432	\$ 60,718,753	\$ 61,629,534	\$ 62,553,977	\$ 63,492,287
Strategic Information and System strengthening	\$ 6,649,850	\$ 6,749,598	\$ 6,850,842	\$ 6,953,604	\$ 7,057,908	\$ 7,057,908
Total cost	\$ 329,767,932	\$ 400,561,517	\$ 466,012,201	\$ 524,710,088	\$ 566,570,707	\$ 591,337,599
Resources available	\$ 222,916,705	\$ 279,014,943	\$ 303,797,550	\$ 264,243,234	\$ 237,628,869	\$ 237,628,869
Financial gap	32%	30%	35%	50%	58%	60%

In order to achieve the coverage targeted in the ZNASP III results framework, \$466 million is required for 2015, \$525 million in 2016, \$567 million in 2017 and \$591 million in 2018. The financial gap rises from 30% in 2014 to 60% in 2018. Treatment, Care and Support services are like to take 43% of the resources in 2015, 47% in 2016, 49% in 2017 and 53% in 2018. The proportion spent on prevention falls from 37% in 2015 to 31% in 2018

6.2 COORDINATION AND MANAGEMENT

Zimbabwe shall build up on the already existing coordination framework at all level and make them more efficient and effective. Effective coordination monitoring and resource management are required by all partners in order to focus on the localized epidemics, cities, prioritize, allocate and disburse funding to service providers and communities. While all partners are committed to the 'Three ones' it is imperative that coordination is implemented as a dynamic role and avoiding bureaucratic bottleneck to service scale-up. As such under the guidance of NAC, the coordination structure and mechanisms will be flexible and appropriate to the local context at all levels.

This plan through NAC will build and sustain high level political and technical commitment for strengthened national and district ownership of the HIV response, entrench good governance and strengthen multi-sector and multi-partner accountability for delivery of ZNASP III results and establish and strengthen functional and competent HIV co-ordination mechanism at the national, provincial and district level.

6.3 Monitoring, Evaluation and Strategic Information support

As the routine monitoring and evaluation systems become more accessible, a renewed focus on improving data quality, demand and use of data for decision making at national and districts and health facility levels will be given priority. The national AIDS response to the evolving HIV epidemic is largely influenced by strong commitment to availing quality real data in a timely manner for effective evidence-informed decision making. For the ZNASP III to be effectively and efficiently implemented community, district, provinces will be capacitated to generate and use appropriate evidence for decision making in line with programmatic accountability, transparency and good governance and stewardship.

Zimbabwe has an outstanding track record and leadership for biomedical, behavioural and structural research on HIV. This includes participation in global partnerships for demonstration of efficacy of treatment and pre-exposure prophylaxis as prevention, efficacy of prevention of mother-to-child interventions, epidemiology and analytical studies to determine risk factors of HIV acquisition and modes of transmissions. We will build on strengthen and experiences from ground-breaking socio-behavioural and epidemiologic studies amongst different populations including evaluations of structural interventions and conduct of national surveillance studies.

The M&E and Strategic information systems will continue to rely on a variety of systems; data sources, routine, periodic collection and collation systems, which are supported and maintained by various stakeholders. Strong effort will be made to invest on data harmonization, real time data on incidence and impact of the response. To achieve the ZNASP III goals, greater emphasis should be given to identification and implementation of high-impact research priorities, innovative programming and capacity strengthening to conduct research. We shall build on our existing strength on systems, partnerships, human resources at all levels and sectoral collaborations. A contextual National M&E Plan will be developed to guide the implementation of the plan and its partner systems.

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