ZIMBABWE NATIONAL HIV AND AIDS STRATEGIC PLAN

2021 – 2025

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2021 – 2025

AIDS & TB PROGRAMME
MINISTRY OF HEALTH AND CHILD CARE
July 2020

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
OI	Opportunistic Infections
ART	Antiretroviral Therapy
ANC	Antenatal Care
CARGS	Community ART Refill Groups
CATS	Community Adolescents Treatment Support
CeSSHAR	The Centre for Sexual Health and HIV AIDS Research
CSOs	Civil Society Organisations
TLD	Tenofovir Lamivudine Dolutegravir
DSD	Differentiated Service Delivery
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother to Child Transmission of HIV
FARGS	Family ART Refill Groups
FSW	Female Sex Worker
EQA	External Quality Assurance
HIV	Human Immunodeficiency Virus
HIVST	HIV Self Testing
HTS	HIV Testing Services
KP	Key Population
LTFU	Lost to Follow Up
MOHCC	Ministry of Health and Child Care
MSM	Men who have Sex with Men
MOT	Modes of Transmission Study
NAC	National AIDS Council
OVC	Orphans and Vulnerable Children
NASA	National AIDS Spending Assessment
NMRL	National Microbiology Reference Laboratory

Acronyms

NVP	Nevirapine
NACS	Nutrition Assessment and Counselling
PCR	Polymerase Chain Reaction
PLHIV	People Living with HIV
POC	Point of Care
PrEP	Pre Exposure Prophylaxis
PSI	Population Services International
PWD	People With Disabilities
PWIDs	People Who Inject Drugs
PWUDs	People who use drugs
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SOP	Standard Operating Procedure
STIs	Sexually Transmitted Infections
SRH	Sexual Reproductive Health
TAT	Turn Around Time
TB	Tuberculosis
TPT	TB Preventive Therapy
U=U	Undetectable=Untransmittable
UIC	Unique Identifier Codes
UNAIDS	The Joint United Nations Programme on HIV/AIDS
VMMC	Voluntary Medical Male Circumcision
VL	Viral Load
WHO	World Health Organization
ZDHS	Zimbabwe Demographic Health Survey
ZIMPHIA	Zimbabwe Population Based HIV Impact Assessment
ZNASP	Zimbabwe National AIDS Strategic Plan

Acknowledgements

The ZNASP IV (2021-2025) represents the aspirations and commitments of the Government of Zimbabwe, local and international stakeholders in scaling up HIV interventions towards epidemic control and eventual ending of AIDS as a public health threat. The strategic shift towards granular targeting of locations and populations and the transition towards a knowledge management-based monitoring and evaluation approach as well cost-efficient approaches in this ZNASP will enhance its implementation and potential to achieve intended results.

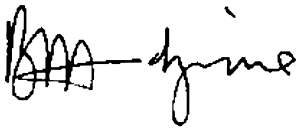
Development of this national strategic plan benefited from tremendous participation and contributions from various stakeholders in the multi-sectoral response to HIV. Individuals and institutions contributed their time, technical support and financial resources that made it possible to produce this document.

The National AIDS Council would like to register its profound gratitude to all individuals, sectors and partners that dedicated their time, intellectual and financial resources towards this national strategic plan. They include but not limited to the Ministry of Health and Child Care and other government departments, National AIDS Council structures, the UN family, networks of people living with HIV, implementing and civil society organizations, faith-based organizations, and many other entities whose contributions are invaluable.

We also thank the expert reviewers who provided critiques and valuable recommendations to improve the ZNASP.

We acknowledge the lead consultant and his team for their tireless work in gathering and synthesising contributions from sectors.

The worthy of strategies in this ZNASP will be achieved through implementation. We therefore look forward to continued and strengthened partnerships in implementing this national strategic plan to transform the landscape of the response to the pandemic.



Dr Bernard Madzima
Chief Executive Officer
National AIDS Council

Foreword

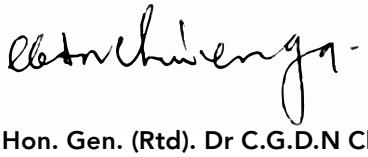
Zimbabwe has made tremendous progress towards attaining the UNAIDS 90-90-90 treatment targets and the 2020 Global Prevention Coalition Road Map under its multi-sectoral response. Out of the country's estimated 1.3 million people living with HIV, the percentage of those knowing their HIV was estimated at 90 % in 2018. The country has achieved and surpassed the second 90 now reported to be more than 95 %. There has been progress in the number of AIDS-related deaths, with a 60% decrease from 2010 to 22,000 in 2018. The number of new HIV infections has also decreased by 39% by 2018 from 63,000 in 2010. Although this is remarkable progress when compared to most countries, there is still the need to sustain the momentum and further scale up HIV prevention to achieve epidemic control.

These results were achieved through implementation of an array of evidence-based combination of behavioural, biomedical and structural combination prevention interventions targeted at different groups based on their needs as defined in the extended national strategic plan [ZNASP III 2015-20]. ZNASPIII aligned the national response to elements of the Zimbabwe Agenda for Sustainable Socio-Economic Transformation - ZIMASSET (2013-2018) priorities, the UNAIDS global 90-90-90 by 2020 fast track targets and the Sustainable Development Goals. A review of ZNASPIII provided the basis for the Zimbabwe National HIV and AIDS Strategic Plan 2021-2025 (ZNASP IV).

Zimbabwe is aspiring for an AIDS free generation. The goal of the Zimbabwe National ZNASPIV is to End AIDS as a public health threat in alignment with the Sustainable Development Goal 3. This will be realised through accelerating the scale up of HIV programmes and transitioning the HIV response into a sustainable phase. ZNASPIV seeks to achieve the following: reduction of new HIV infections among adults, adolescents and young people (15-24 years) and children 0-14 years by 80% by 2025; reduction of AIDS deaths by 80% by 2025; and to eliminate HIV stigma and discrimination.

Within the context of "not leaving anyone behind", ZNASP IV will focus on micro targeting districts and populations guided by evidence on HIV burden and gaps in service coverage. ZNASP IV establishes measures for long term sustainability of the response through prioritising strengthening of the community response and establishing a long term plan for increasing investment to community based interventions; scaling up integrated HIV services with other health services to optimise use of resources and increase access to HIV services and developing cost efficient approaches for HIV service delivery based on evidence from periodic cost efficiency analysis in the country and evidence from other countries

The Government of the Republic of Zimbabwe remains committed to the national response to HIV and AIDS and would like to thank stakeholders, partners and donors for their continued support. Dedicated commitment is needed to meet the SDG 3.1 target to End AIDS as a public health threat by 2030.



Hon. Gen. (Rtd). Dr C.G.D.N Chiwenga "GCZM"
Vice President of Republic of Zimbabwe and
Minister of Health and Child Care

Executive Summary

Overview

The Zimbabwe National HIV and AIDS Strategic Plan 2021-2025 (ZNASP IV) has been developed to guide the HIV programming, resource allocation and implementation of the HIV response for the next five years. The vision of the strategic plan is to End AIDS as a public health threat through accelerating the scale up of HIV programmes and transitioning the HIV response into a sustainable phase.

» The strategic plan will place Zimbabwe on the path to achieving the Fast-Track targets by adopting the following strategic shifts:
» Shifting from a national level planning approach to district responses micro-targeting locations and populations based on evidence.
» Establishing district and population specific targets to drive tracking of progress of the response.
» Refocusing monitoring and evaluation systems and tools to support the localised HIV programming and tracking progress.
» Prioritising investment in decentralised coordination structures at district level.
» Establishing measures for long-term sustainability of the response such as strengthening community response; scaling up integrated HIV services with other health services; and developing cost efficient approaches for HIV service delivery.

ZNASP IV impact targets

To accelerate progress towards Ending AIDS as a public health threat by 2030, ZNASP IV seeks to reduce new HIV infections among adults, adolescents and young people (15-24 years) and children 0-14 years by 80% by 2025; reduction of AIDS deaths by 80% by 2025; and to attain zero HIV stigma and discrimination.

To this end, the strategic orientation for the HIV programmes under ZNASP IV is as follows:

I. Programmes and strategies for combination HIV prevention

- **Condom programming:** Two key issues driving condom programming in the next five years are sustainability and equity. Condom promotion interventions will be scaled up to position condoms as a life-saving devise; differentiated condom distribution channels tailored to specific populations will be expanded; condom demand creation will be intensified; and M&E systems for condom programming will be strengthened to provide quality data. In addition, advocacy for domestic funding for condom procurement will be scaled up to sustain the programme in the long term.

- **Voluntary Medical Male Circumcision (VMMC)** will be scaled up in districts with low coverage while those with over 80% coverage will transition into the VMMC sustainability phase. Males 20-29 years will be prioritised given the low VMMC coverage among this group and VMMC will be offered as a routine service in health facilities, a transition from the current veriticalised service delivery approach.

- P**re-Exposure Prophylaxis (PrEP)** will be scaled up in all districts targeting all persons at substantial risk of HIV infection. This will be achieved through sustained demand creation, reframing messages to address stigma associated with PrEP, increasing availability

of PrEP services, strengthening collaboration between PrEP and RMNCAH programme and conducting operational research to inform programming.

- **Post Exposure Prophylaxis** will be offered to all persons exposed to HIV infection through sexual assault, occupational hazards and unprotected sex. PEP will be universally available in all health facilities and demand for PEP will be generated through PEP education delivered through multiple media.

- **Elimination of Mother to Child Transmission** will focus on dual elimination of HIV and syphilis. EMTCT will be tracked at district and facility level to ensure the country attains EMTCT status by 2025. Interventions will include case-based MTCT tracking mechanisms at facility and community level, scale up of male involvement and re-testing of HIV negative pregnant and lactating women as well as viral load monitoring of HIV+ pregnant and lactating women.

- **HIV testing services** will aim at ensuring 95% of PLHIV know their status through intensifying high yield testing models appropriate for different populations, rolling out a package of services for those testing HIV negative, integrating stigma reduction into mobilisation approaches for HTS and strengthening community-facility linkage to improve initiation on ART for those testing HIV positive.

- **Antiretroviral therapy and viral suppression programming** will aim at ensuring 95% of PLHIV who know their status are on ART and 95% of those on ART are virally suppressed through tracking ART scale up and retention at district and facility level, scaling up use of community actors to improve linkage to care, scaling up differentiated service delivery models countrywide, engaging private healthcare providers in the programme, improving quality of patient level data, scaling up psychosocial, mental health and nutrition support as well as viral load monitoring of patients.

II. HIV integration

- **STI prevention and management** has been inadequately funded for several years. Priority will be given to advocating for resource allocation to address programming gaps. Programming strategies prioritised include scaling up mentorship at health facilities to improve the use of STI management guidelines, strengthening laboratory capacity to conduct STI tests, integrating STI screening into HIV prevention sites and strengthening M&E and surveillance for STIs to inform programming.

- **HIV/TB integration** is well established and will be sustained in the next five years. Key areas of improvement will be the scale up of TB preventive therapy and scale up of TB treatment literacy among HIV patients.

- **HIV and non-communicable diseases integration** will prioritise the roll out of guidelines and screening and diagnostic tools for NCDs among PLHIV, integrating literacy on HIV and NCDs among PLHIV in health education and strengthening referral mechanisms for PLHIV to NCD treatment sites. Data systems will also be improved to collect data on NCDs among PLHIV.

- **HIV and RMNCAH and Nutrition integration** will focus on updating and disseminating integration guidelines, SOPs and job aids; building the capacity of healthcare workers and community actors on HIV/RMNCAH/nutrition assessment and support and expanding integration of these services to private healthcare providers.

III. HIV programme for vulnerable and key populations

- **Key populations programme** will strengthen delivery services through the already established models; generate evidence to inform programming especially for key populations lacking population size estimates as well as HIV burden and behavioural data such as transgender people, prisoners and people who use drugs. It will also provide a defined

package of services and strengthen service delivery using KP-led groups. The programme will strengthen M&E systems so as to improve data quality and establish mechanisms for long term sustainability of achieved results.

- **HIV programme for adolescent girls and young women** will focus on scaling up gender transformative and social norm changing interventions, sustaining on-going combination prevention interventions and developing a comprehensive AGYW programme to improve coordination of the on-going activities. Comprehensive Sexuality Education (CSE) and social protection interventions for in-school youth will be scaled up. For out-of-school youth, on-going CSE and SRH initiatives will be scaled up in all districts while HIV services for youth in tertiary institutions will be strengthened.

- **Vulnerable populations** during the ZNASP III period there was an inclusion of small scale mineworkers, mobilisation of cross border populations, farm workers, fishermen, people with disabilities and the informal sector. Currently, there are no specific interventions for these populations. Data on HIV burden and vulnerabilities among these populations will be generated to inform programming and interventions targeting each of these population groups will be developed and implemented.

- **HIV in humanitarian and emergency settings** will be strengthened through establishing mechanisms for coordination of the HIV response including establishing an emergency coordination team and technical surge teams; strengthening the preparedness capacity to provide HIV services during humanitarian emergencies; and integrating the HIV response into the overall country disaster preparedness and response plan and systems.

IV. Strengthening social enablers

- **Policies, laws and practices and enforcement** will focus on two aspects: improving enforcement of existing laws and policies; and advocating for reviews of laws and policies impacting negatively on access to HIV and TB services. Interventions will include monitoring and tracking progress towards legal and policy reform and enforcement of existing laws; reviewing laws that reinforce stigma and discrimination; empowering PLHIV and those at risk and affected by HIV to know their rights and access justice services; and enhancing policy makers understanding and appreciation of legal and policy challenges related to HIV and health.

- **Access to justice for people living with and affected by HIV** will be achieved through enhancing rights based law enforcement; increasing legal and rights literacy and scaling up existing interventions supporting vulnerable and key populations to access services.

- **Reduction of HIV stigma and discrimination programming** will focus on generating comprehensive data in stigma index to establish a baseline and support programming; strengthening monitoring and reporting mechanisms for HIV stigma and discrimination and developing a comprehensive programme to reduce stigma and discrimination implemented through integration with other HIV programmes.

- **Gender and male engagement mainstreaming** is critical for ensuring quality of the HIV response. Focus for ZNASP IV will be on generating evidence on gender and HIV as well as using the evidence for decision making at all levels; promoting positive social norms to advance gender equality and improve health of men and women; scaling up comprehensive SRHR/HIV male engagement programmes targeting high-risk men and boys and improving gender-mainstreaming coordination.

V. Health and community systems strengthening

- **Health systems strengthening** will focus on improving the capacity and motivation of

human resources for health to deliver integrated HIV services; strengthening storage, inventory management, distribution of HIV commodities and logistics management information systems at all health facilities; and improving the HIV laboratory capacity through sustaining EQA, increasing coverage of laboratory services, improving laboratory infrastructure and information management systems.

- **Community systems strengthening** will prioritise the development and roll out of community based monitoring tools; community led advocacy based on evidence; social mobilisation and community linkages tailored to prioritised populations and linked to health facilities to support community level HIV service delivery; and strengthening the capacity of community based organisations to delivery HIV service through a social contract framework.

- **Coordination, strategic information and financing** of the response

- **Coordination of the HIV response** will be reconfigured to respond to the ZNASP IV strategic shifts through establishing joint review and accountability platforms at all levels; reconfiguring technical working groups; strengthening district level coordination; enhancing coordination supportive supervision; establishing clear guidelines for coordination and implementation of ZNASP and strengthening coordination structures for civil society, public and private sectors.

- **Strategic Information Management and Research** will prioritise management of patient level data to support patient tracking; strengthening systems for collecting granular data; adopt electronic data collection and dissemination tools; strengthen community based monitoring systems and improving data dissemination, access and use at all levels. HIV surveillance and research will also be undertaken based on a defined agenda.

- **Financing of the HIV response** will aim at closing the funding gap and sustaining HIV response. Priority strategies include establishing public-private partnerships to increase domestic resources; implementing a social contract framework for civil society to sustain community level interventions; increasing participation in regional procurement pool and implementing interventions that increase cost efficient gains.

Implementing ZNAP IV

ZANSP IV will be implemented through a multi-sectoral and decentralised approach. NAC will play a leading role in coordinating ZNASP IV implementation. Implementation processes will be as follows:

- Development of ZNASP IV operational plan to translate the strategy into implementation modalities
- Development of ZNASP IV district targets to support district specific responses and assist in tracking HIV response at district level
- District work plans to set out activities that will achieve set targets
- Development of ZNAP IV M&E plan to operationalise the ZANSP IV results framework
- Establishment of a joint review platform with representation from all TWGs to review ZNASP progress twice in a year
- District ZNASP progress review to be led by DAACs on a quarterly basis
- Support supervision by national and provincial coordination teams to be conducted across all districts
- Providing real time feedback to districts through a situation room to be established and managed by NAC

01

Introduction

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1.1 Background

Zimbabwe is a landlocked country located in southern Africa region, bordering Zambia to the northwest, Mozambique to the northeast, South Africa to the south and Botswana to the southwest. It has a land area of 390,757 square kilometres. Administratively, Zimbabwe is divided into 10 provinces and 63 districts.

As shown in Table 1, Zimbabwe has a total population of 15,021622 people, with 7,227,683 being males and 7,793,940 females (ZimStat, 2019). The country has a young population with those below the age of 15 years representing 40% of the total population. Sixty seven percent of the population resides in rural areas. In terms of provincial distribution, Harare has the highest proportion of the population (16%) while Matabeleland South and Bulawayo have the least proportion (5%). The population is almost evenly (11% to 13%) distributed among the five provinces. Population distribution to some extent determines the level of investment of some of the HIV programmes such as primary prevention.

Zimbabwe has a weak macroeconomic environment resulting from multiple factors including inadequate external inflows, low international commodity prices that keep liquidity conditions tight, and an appreciating United States dollar. The Gross Domestic Product (GDP) declined from 10% in 2012 to 1.1% in 2015, while inflation rate has been accelerating since 2015. The country has a huge debt burden estimated at US$8.3 billion in 2015 (which has since doubled) which limits the ability to finance social services including health. Given the weak economic situation in the country, most programmes, including the HIV response, are heavily dependent on external support raising sustainability concerns.

The health indicators below depict the disease burden and health systems context within which the HIV response is implemented. Indicators showing slight decline include new HIV infections, maternal mortality ratio, infant mortality rate and under-five mortality rate. Other indicators have either stagnated or have a marginal increase. This illustrates the need to build national health systems for long term sustainable health (including HIV) service delivery. The trends for selected health indicators are shown in Table 2.

Table 1: Population distribution by sex and province, 2019.

Province	Male	Female	Total	% of total
Bulawayo	339,739	391,980	731,719	5%
Manicaland	923,976	1,010,787	1,934,763	13%
Mashonaland Central	667,878	681,549	1,349,426	9%
Mashonaland West	860,647	868,668	1,729,314	12%
Mashonaland East	750,262	788,915	1,539,177	10%
Matabeleland North	411,071	440,161	851,232	6%
Matabeleland South	373,685	403,314	776,998	5%
Midlands	891,024	965,185	1,856,209	12%
Masvingo	784,657	898,935	1,683,592	11%
Harare	1,224,745	1,344,447	2,569,192	17%
Total	7,227,683	7,793,940	15,021,623	100%

Source: ZimStat (2019)

Table 2: Trends for selected health indicators in Zimbabwe

Indicator	2015	2016	2017	2018
Life expectancy				
Estimated people living with HIV	1,279,800	1,292,300	1,306,200	1,317,000
Estimated HIV incidence per 1,000 population	3.5	3.28	3.08	2.85
ART coverage, adults, 15+ years) %	65.8	71.4	80.7	75.4
ART coverage, children, 0-14 years	61.3	69.1	72.4	57.5
Maternal mortality ratio (modelled estimates, per 100,000 live births)	480	468	458	
Under five mortality rate (per 1000 live births)	54.3	50.4	49.3	46.2
Infant mortality rate	38.5	36.3	35.4	33.9
Neonatal mortality rate (per 1000 live births)	23.1	22.3	21.5	20.9
Fertility rate (births per woman)	3.9	3.8	3.7	
Adolescent fertility rate (births per 1000 women ages 15-19)	95.2	90.7	86.1	
Contraceptive use, modern methods (% of women age 15-49)	65.8			
Life expectancy at birth m/f	59.5	60.3	60.8	
Mortality from CVD, cancer, diabetes or CRD between exact ages 30 and 70 (%)	19.4	19.3		
Prevalence of undernourishment (% of population)	49.5	50.9	51.3	

Source: World Bank (2019), NAC, MoHCC and UNAIDS (2019)

1.2 Strategic plan development process

This strategic plan was developed through a participatory process involving stakeholders and analysis of available HIV epidemiological and programme coverage data. The process for developing the plan was as follows:

» Review of the health sector HIV and STI programme: This review identified the progress made by the health sector response against set targets since 2015, gaps in programme coverage and challenges in implementation of key interventions and service delivery.

» The gaps and challenges as well as recommendations of this review informed the development of ZNASP IV.

» ZNASP III review: This review covered all aspects of ZNASP including primary HIV prevention, HIV treatment and care, systems strengthening, coordination, strategic information and financing. The review deep dived into three thematic areas – key populations programming; community response and community systems strengthening; and adolescent girls and young women, male engagement and gender. The purpose of this deliberate focus was to have a deeper understanding of progress made, gaps and challenges given the importance of focusing on these thematic areas in the quest to reduce new HIV infections. The ZNASP III recommendations were applied in developing programmatic, systems strengthening, coordination, financing and strategic information strategies.

» Investment analysis modelling: To inform this NSP, strategic investment thinking was applied by modelling the expected costs and impacts of various scenarios (GoZ, 2020). The scenario with the highest return on investment was recommended and adopted in this NSP. Additionally, to estimate (financial) resources needed, costing was undertaken. See Annex 1 for unit costs used.

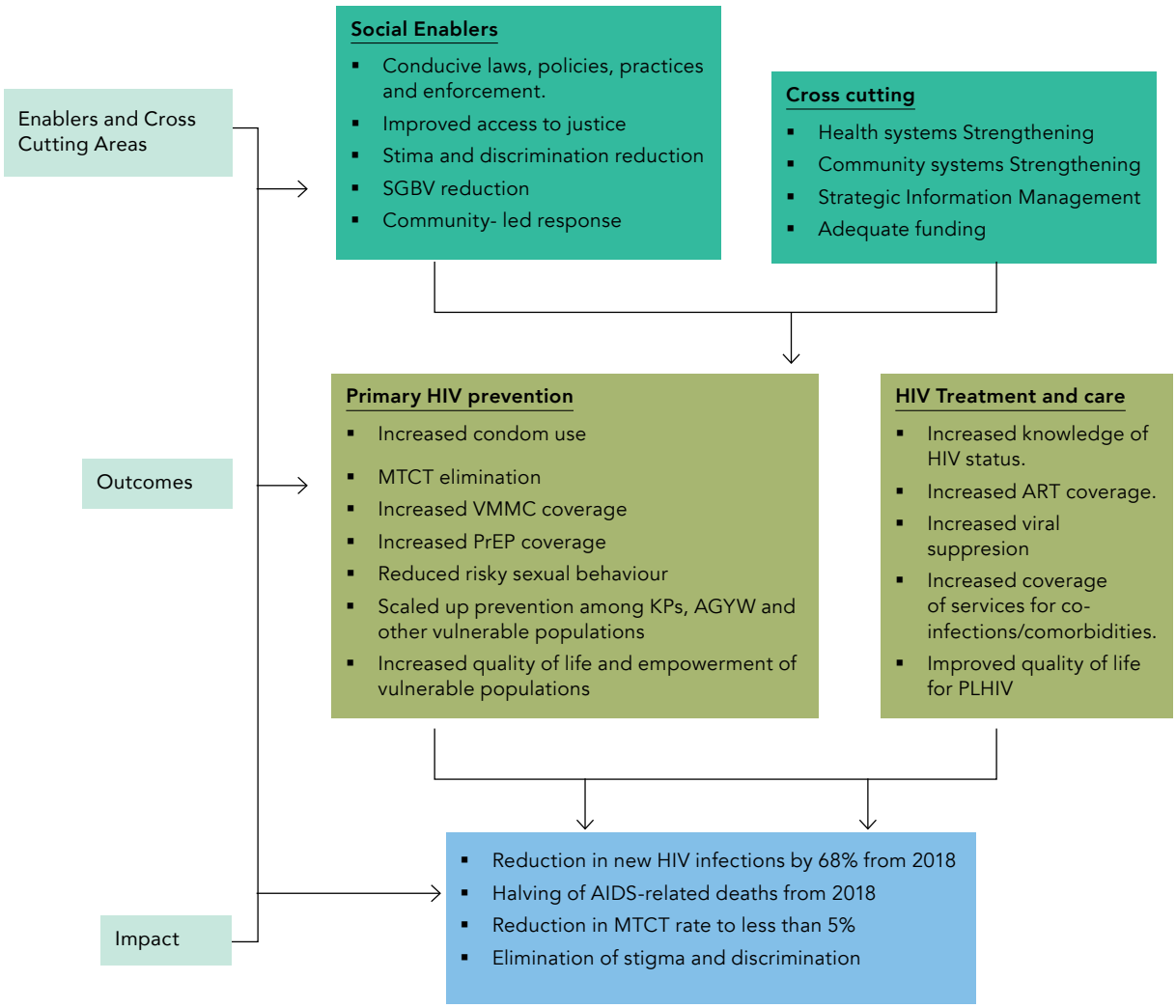
» Epidemiological analysis: HIV Epi-analysis undertaken established the current status of the HIV epidemic in Zimbabwe and identified priority or strategic interventions that would be prioritised in ZNASP IV. This analysis informed the strategic shift and key programmatic strategies outlined in ZNASP IV.

» Stakeholder consultation: Meetings were held involving key stakeholders drawn from all levels (national, provincial and district and all sectors including key populations, adolescents and young people, civil society organisations, faith based organisations, private sector, government ministries and development partners to identify gaps and strategies for ZNASP IV. The gaps and strategies identified were triangulated with available data to inform the design of ZNASP IV.

» Review of draft ZNASP IV: The ZNASP IV document was circulated widely to stakeholders for review. Stakeholder comments, including from external peer reviewers such as UNAIDS, were incorporated into the final strategic plan. In addition, the National M&E Advisory Group, which comprises of M&E experts from all programmes and development partners, also reviewed and finalised the results framework for ZNASP IV.

» Target setting approach: Effective targets were drawn by varying coverage scenarios. As part of the investment case revision process (GoZ, 2020), the Goals model was adapted to the NSP. The model was designed to show the consequences of various prevention care and treatment as well as social enablers programs' targets on reducing HIV incidence and AIDS deaths, among other health outcomes. Coverages/targets that had high impact in terms of new infections averted and AIDS deaths prevented were considered for this NSP. Theory of change: As shown in Figure 1, the NSP development was underpinned by a theory of change. Informed by a comprehensive review of ZNASP III, it helped identify critical design features for success as well as scope for the ZNASP IV.

Figure 1: A theory of change underlying ZNASP IV.



1.3 ZNASP IV guiding principles

» Results-based management: All national HIV programming shall be linked to the ZNASP IV and demonstrate contribution towards results. Relatedly, there is strong desire by the GoZ and its partners to realize value for money in line with the Transition Stabilisation Programme (TSP). To this end, the HIV response will promote results, accountability and good governance at all levels.

» Evidence-based, high impact and scalable interventions: Resources allocation and implementation shall be assigned to high-value, high-impact and scalable initiatives that are informed by evidence and respond to community needs.

» Multi-sectoral accountability: The ZNASP IV provides guidance for interventions and results for which multiple sectors are responsible and accountability mechanisms will be established through the NAC. This will serve to increase

resources and accelerate results. As such, multi-sectoral and mutual involvement, financial and programme reporting will form the basis for ZNASP IV accountability at all levels.

» Country ownership and partnership, shared responsibility and global solidarity: All HIV stakeholders including the government, development partners, private sector, faith-based organisations, civil society and communities shall mutually align their efforts towards the results envisioned in ZNASP IV.

» Rights-based and gender transformative approaches: In line with the Constitution of Zimbabwe, the national HIV response recognizes and upholds human rights and non-discrimination of PLHIV, key populations, people with disabilities, youths, women, children and others who are socially excluded.

» To this end, 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 IV is cognisant of this reality and is rooted in a rights-based approach.

» Efficiency, effectiveness, equity and innovation: In light of the macro-fiscal context in Zimbabwe, the ZNASP IV has taken active steps to explore and operationalise sustainable domestic funding options through improved efficiency in service delivery and innovative approaches aimed at achieving more at reduced cost without compromising on quality. For sustainable financing, the ZNASP IV – informed by the investment case (GoZ, 2020) - will pursue the investment approach to resource mobilization and optimization of available resources for maximum impact. Additionally, the HIV response will ensure adoption and scale-up of evidence-informed equitable interventions.

» Community involvement, ownership and partnership: As communities make the difference, they will be empowered to take control of their resources and programmes for sustainable well-being.

02

HIV epidemic context

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HIV prevalence

HIV prevalence in Zimbabwe has been declining over time but still remains high. According to 2018 HIV estimates (NAC, MoHCC and UNAIDS, 2019), the prevalence among adults 15-49 years declined from 13.79% in 2015 to 12.78% in 2018. HIV prevalence has been on a declining trend among all age groups, although the prevalence among young females is almost twice the HIV prevalence among their male peers. Table 3 below shows the trends in HIV prevalence since 2015.

With HIV prevalence among men who have sex with men (MSM) and transgender women / genderqueer individuals at 17.1% and 28% respectively, key populations have a higher HIV burden than in the general male population (Harris et al., 2020). The same is true for female sex workers (FSW) at a 60% HIV prevalence rate (Cowan et al., 2020).

Additionally, HIV prevalence in Zimbabwe increases by age. Data from the 2015 Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA) (MoHCC, 2019) shows that prevalence peaked at 28.1% among males 50-54 years and at 29.5% among females aged 35-49 years. Similarly, as shown in Table 5, the national HIV estimates for 2015-2018 also show age variations in which adults 15-49 years have a higher prevalence (12.78%) than children aged 0-14 years (1.46%). For the age group 15-24 years, prevalence among females is almost twice that of males. Age is therefore a critical factor that will be considered in designing HIV interventions.

There are considerable geographical variations in HIV prevalence across provinces in Zimbabwe, ranging from 10.46% in Manicaland province to 19.43% in Matabeleland South province. However, provincial HIV prevalence rates tend to mask differences between and within districts, which are critical for effective targeting of interventions.

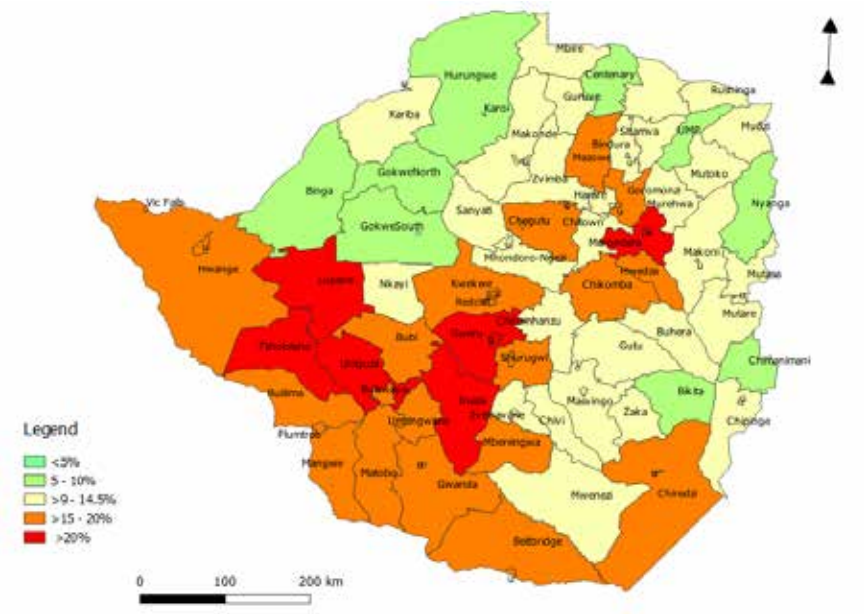
Table 3: Estimated HIV prevalence in adults and children (HIV estimates)

HIV Prevalence	2015	2016	2017	2018
Prevalence adult 15-49 years	13.79	13.46	13.12	12.78
HIV Prevalence 15-24 years	4.91	4.77	4.62	4.45
Prevalence males 15-24 years	3.41	3.36	3.29	3.2
Prevalence females 15-24 years	6.39	6.16	5.93	5.7
Prevalence children 0-14 years	1.74	1.62	1.5	1.46

Table 4: Estimated HIV prevalence in adults, adolescents and young people and children

HIV Prevalence (%)	2015	2016	2017	2018
Prevalence among adults 15-49 years	13.79	13.46	13.12	12.78
HIV Prevalence 15-24 years	4.91	4.77	4.62	4.45
Prevalence among males 15-24 years	3.41	3.36	3.29	3.2
HIV prevalence among females 15-24 years	6.39	6.16	5.93	5.7
Prevalence among children 0-14 years	1.74	1.62	1.55	

Figure 2: HIV prevalence rate among adults by district, 2018



Source: NAC, UNDP and UNAIDS (2019).

Figure 2 above shows uneven distribution of HIV prevalence among adults 15-49 years by district, ranging from highest prevalence of 23.1% in Lupane district to the lowest (5.7%) in Gokwe district. The geographical variation in prevalence is one of the key factors to be considered in targeting HIV interventions.

The number of new HIV infections has been declining over time. New infections among adults 15+ years declined nationally from 61,700 in 2010 to to 34,000 in 2018. During ZNASP III, as shown in Table 5, the number of new infections reduced by 8.9% while in children the decline was by 26.9% from 2015 to 2018 (NAC, MoHCC and UNAIDS, 2019).

Although new HIV infections are on a downward trend, they are not declining fast enough to achieve the globally agreed Fast-Track target of a 75% reduction by 2020 from the 2010 baseline. As shown in Figure 3, forward-looking projections show that at the current level of programming, the new HIV infections trend will likely assume a flat line in the coming years (GoZ, 2020).

Table 5: Estimated number of new HIV infections (2019 Spectrum estimates)

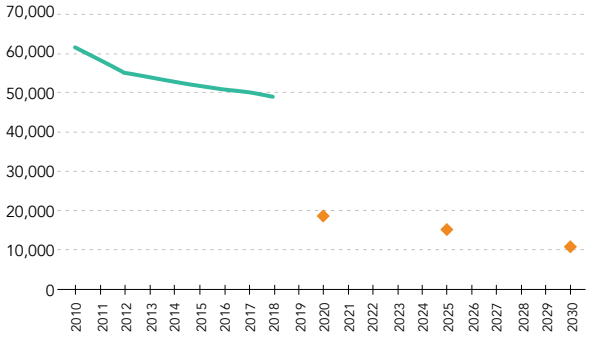
	2015	2016	2017	2018
Total New HIV infections	44,185	42,554	41,081	39,035
New HIV infections Adults 15+	37,395	36,585	35,660	34,070
New HIV infections (0-14)	6,790	5,969	5,421	4,965

Source: NAC, MoHCC and UNAIDS (2019).

The underlying assumption accounting for the slow or even plateauing of new HIV infections is that the combination prevention interventions at the current coverage are insufficient to achieve the more ambitious targets. Going forward, there is need for a combination of further scale up and innovation to modify on-going interventions or develop new interventions that will further reduce new infections to achieve the Fast Track Targets.

A shift to more involvement of the community through social mobilisation and micro-responses targeting locations and populations based on evidence will be critical.

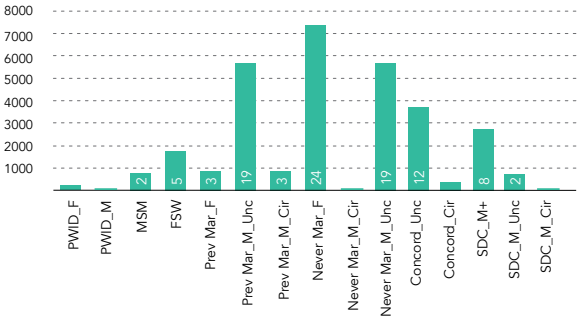
Figure 3: Trend in new HIV infections against fast track targets



The Incidence Patterns Modelling (NAC and UNAIDS, 2017), which estimated the proportion of new infections attributed to each source of infections and its contribution to the total new HIV infection, found that never married females (who are mainly adolescents girls and young women) contributed the highest proportion (24%) of new infections, whereas previously married men who are uncircumcised contributed 19%, and never married men who are uncircumcised also accounting for 19%. These three groups account for 62% of new HIV infections.

The key populations (Female Sex Workers and Men who have sex with Men) also contributed a significant proportion of new HIV infections relative to their population size. The MOT findings – summarised in Figure 4 - underscore the need for interventions tailored to populations accounting for most new infections.

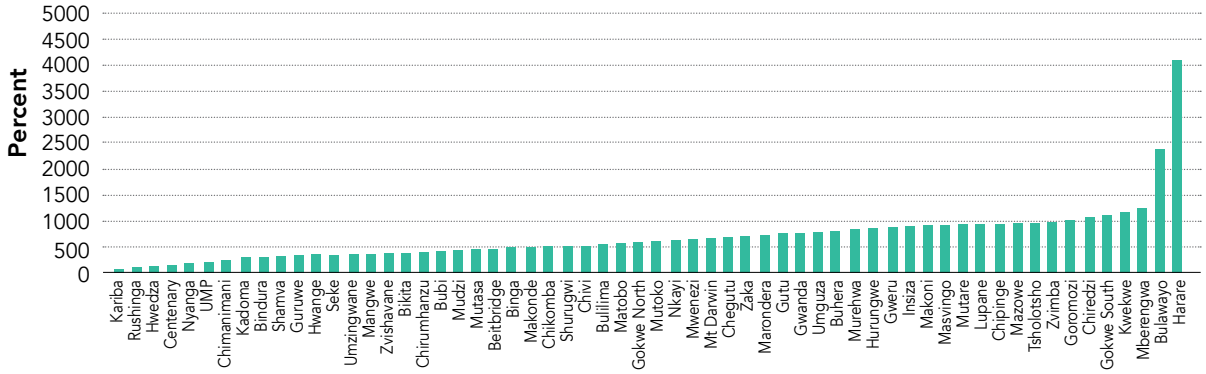
Figure 4: Estimated number of new infections by population group (2017)[1]



It is important to note that absolute numbers of new HIV infections vary across districts with Harare and Bulawayo having the highest number partly due to their relatively large population size while Kariba and Rushinga have the lowest number of new infections. As shown in Figure 5, six districts account for nearly a third of all the new infections, 29 districts contribute half of the infections while 25 districts account for 22% of the new infections. This implies that prevention interventions are required in all districts but with varying intensity and scale. There is a need to identify the populations at risk in each district by undertaking granular vulnerability analyses to identify the populations contributing to new infections for effective targeting.

1 Data source for all baselines is HIV estimates 2018, except for stigma index

Figure 5: Distribution of new HIV infection by district, 2018 HIV estimates



AIDS-related deaths

AIDS-related mortality declined by 59.8% from 54,200 in 2010 to 21,800 in 2018 largely due to success of the HIV treatment programme. Whereas women are the face of the HIV epidemic, men are the face of the AIDS deaths as AIDS-related deaths are higher among males (52%) than females and among adults than children. Table 9 below shows the declining trend of AIDS related deaths among all age groups.

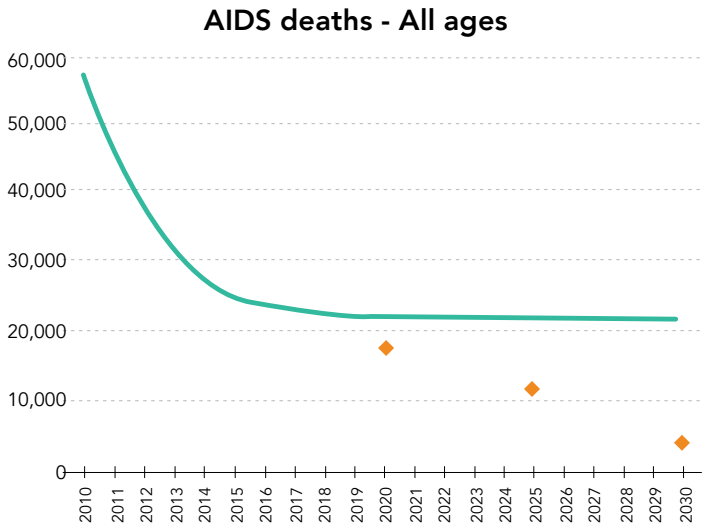
The trend in AIDS deaths shows that the country is not likely to achieve Fast Track Target – a 75% reduction in AIDS deaths by 2020 relative to 2010 baseline - at the current level of programming.

Some of the factors accounting for AIDS deaths are delay in initiation on ART, the "greying of AIDS" - the aging of PLHIV who benefit from ART and the emergence of age-related non-communicable diseases (NCDs) (Mahy et al., 2014; Hontelez et al., 2012; Bendavid et al., 2012), PLHIV not in care and limited psychosocial and nutrition support as well as undiagnosed and untreated TB co-infection among PLHIV. As is the case with new HIV infections, there is a need for a deep dive into the factors accounting for AIDS deaths and to develop approaches to reduce AIDS deaths. The figure below shows the trend in AIDS deaths against the 2020 and 2030 targets.

Table 6: Trend in AIDS related deaths, 2015 - 2018

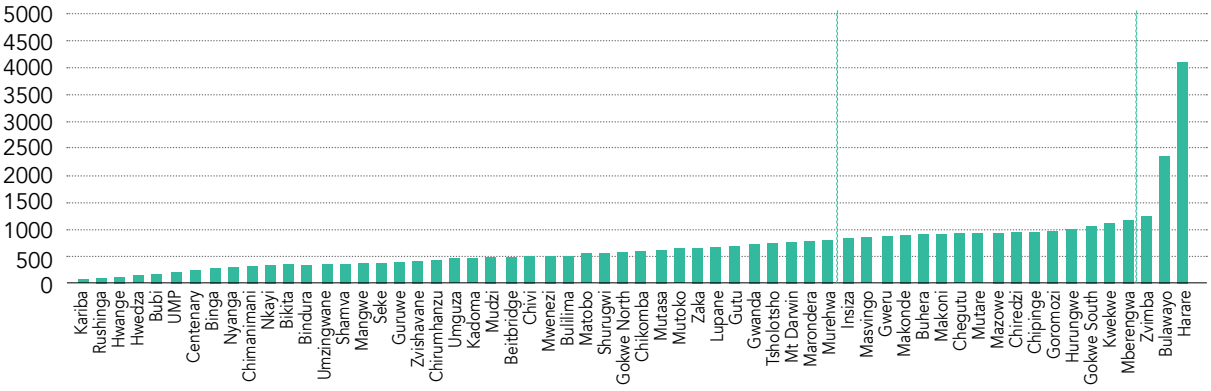
Indicator	2015	206	2017	2018
Annual AIDS deaths (adults and children – Total)	23,852	22,575	22,779	21,801
Annual AIDS deaths - (adults and children – Male)	11,339	11,011	10,998	10,598
Annual AIDS deaths - (adults and children – Female)	12,513	11,563	11,781	11,203
Annual AIDS Deaths (15-24 years) – Total	2,305	2,263	2,299	2,346
Annual AIDS deaths (15-24 years) – Male	2,305	2.263	2,263	1,061
Annual AIDS deaths (15-24 years) – Male	1,302	1,238	1,265	1,286
Annual AIDS Deaths 0-14 years	4,909	3,869	4,130	3,298
Annual AIDS deaths (10-19 years)	2,241	2,032	1,845	1,704

Figure 6: Trend in AIDS deaths against Fast-Track targets, 2010 – 2030



Geographically, three districts (Harare, Bulawayo and Zvimba) account for approximately 26% of AIDS deaths, 11 districts contribute another 26% of AIDS deaths while the rest contribute 48% of the deaths. The figure below shows that AIDS deaths are almost evenly distributed among the districts contributing 48% of the deaths. Overall, there is need to improve the quality of the HIV treatment and care programme in all districts.

Figure 7: Estimated AIDS related deaths among adults by district, 2018



HIV stigma and discrimination

Another aspect of the HIV epidemic is stigma and discrimination. The review of ZNASP III found that whilst progress has been made in reducing stigma and discrimination, but stigma remains a major bottleneck to access to services among various populations particularly men, adolescents and young people and key populations. While still unacceptably high, discriminatory attitudes towards PLHIV have declined. The 2015 Stigma Index Study report showed that 65.5% of PLHIV experienced one or more forms of HIV-related stigma and discrimination. To accelerate progress, ZNASP IV prioritises the development of a comprehensive stigma and discrimination reduction programme.

Overview of the HIV response

The country has made strides in addressing the HIV epidemic in the last five years. Progress made under each programme is analysed in more detail under each strategic direction. The country has made efforts to have condoms available to vulnerable and key populations. Condoms distributed meet about 93% of the estimated national need. By 2019, 85% adult men reported using a condom with a non-regular partner compared to 67% adult women (among those with multiple sexual partners). Condom use among adolescents and young people was relatively low. About 57% females and 84% males 15-24 years reported condom use with a non-regular partner against a target of 90%. On the other hand, condom use among sex workers is high, with 96% of sex workers and 90% of sex worker clients reporting using a condom at last paid sexual encounter (NAC, MoHCC, UNFPA and UNAIDS, 2019). There is a need to scale up condom promotion programmes and increase its use among adolescents, young people and adults to achieve the 90% target. At the same time, there is need to continue sustaining high condom use among key populations.

Remarkable progress has also been made in the provision of voluntary medical male circumcision reaching 63% of the VMMC target in 2019. However, only 30% of the VMMC coverage target for 2020 has been achieved while male circumcision among males 15-24 years is 19%. Pre-exposure prophylaxis is a new initiative introduced in 2018 and by 2019, about 5,000 people had been offered PrEP (NAC, MoHCC, UNFPA and UNAIDS, 2019).

Other programmes that have made significant progress include PMTCT with mother to child transmission of HIV falling from 10.8% in 2015 to 7.8% in 2018; an increase in the proportion of adults on ART from 81% in 2015 to 87% in 2018 and from 60% to 83% among children during the same period. Whilst over 95% of HIV patients are screened for TB and TB patients are tested for HIV, the coverage of TB preventive therapy remains low at 1.9% (MoHCC, 2019). A more detailed review of the programme's reach is outlined in later sections.

03

ZNASP IV strategic shifts

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Zimbabwe seeks to accelerate the HIV response to attain the fast track targets for Ending AIDS as a public health threat by 2025 while sustaining the gains already made. The HIV burden is characterised by district, age and sex variations in prevalence and new infections as well as service coverage. Within the context of "not leaving anyone behind", ZNASP IV will focus on micro targeting districts and populations guided by evidence on HIV burden and gaps in service coverage.

ZNASP IV will make the following strategic shifts:

» Shifting from a national to a local response micro-targeting districts and populations (and sub-populations) based on evidence. An analysis of the HIV burden (Prevalence, new infections and AIDS related deaths) and programmes coverage by district and populations will inform a targeting strategy and level of human, technical and financial resources investment required for each district. Based on this analysis, districts will be disaggregated into high/ medium/low burden (considering the number of new infections and incidence rate) and High/ Medium/Low coverage for primary prevention and treatment services. This process will be undertaken as part of the operationalisation of ZNASP IV.

» Establishing district and population specific targets to track progress for the outlined ZNASP HIV response. As a follow up to the localised responses, the ZNASP IV will have a national results framework guiding the overall response and district level targets to track results of local responses. Whereas national data is critical in providing a picture of the country's response, in the next five years, the tracking of progress will be district and population specific. District targets will allow for such tracking. This implies that capacity of districts to interpret and use data will be enhanced.

» Refocusing monitoring and evaluation systems and tools to support localised HIV programming and tracking progress: Data to support the shifts in (i) and (ii) above will be required. M&E systems and tools will be reconfigured to collect data appropriately disaggregated by district (sub-districts) and populations, together with sex and age, to allow for necessary granular analysis. For instance, M&E tools will need to collect data for smaller age bands and sub-populations for each district.

» Prioritising investment in decentralised coordination structures: Multi-sectoral coordination is currently done by NAC at national level and PAACs and DAACs at lower levels. Programme specific TWGs are also in place providing technical guidance in programming. These structures play a critical role in coordinating the response across a wide range of implementers at all levels. Consideration will be made to re-engineer district level coordination structures if the shifts in (i), (ii) and (iii) above are to succeed. Mechanisms will also be put in place to measure targets and responsibilities across sectors to ensure a strong and accountable engagement of the different sectors including health, education, social service, justice and community among others.

» Increasing investment in social enablers to accelerate primary HIV prevention and access to services: The focus on social enablers was a gap in ZNASP III. ZNASP IV will prioritise investment in improving policies, laws and practices relevant to HIV, reduction of stigma and discrimination in all settings, improving access to justice, and strengthening community led responses.

» Establishing measures for long term sustainability of the response: ZNASP IV prioritises the following actions as steps towards sustainable HIV response: a) strengthening the community response and establishing a long term plan for increasing investment in community based interventions; b) scaling up integrated HIV services with other health services to optimise use of resources and increase access to HIV services and; c) developing cost efficient approaches for HIV service delivery based on evidence from periodic cost efficiency analysis in the country and evidence from other countries

04

ZNASP IV vision, goal and impact

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4.1 Vision, mission and goal

Vision: An AIDS-free generation, with zero new infections, zero AIDS-related discrimination and stigma

Mission: To accelerate the scale up of HIV programmes and transition the HIV response into a sustainable phase through cost efficient and effective strategies

Goal: To end AIDS as a Public Health threat (aligned to SDG3) by 2030

ZNASP IV impact targets

To achieve the vision and goal, Zimbabwe aims at achieving the following impact results:

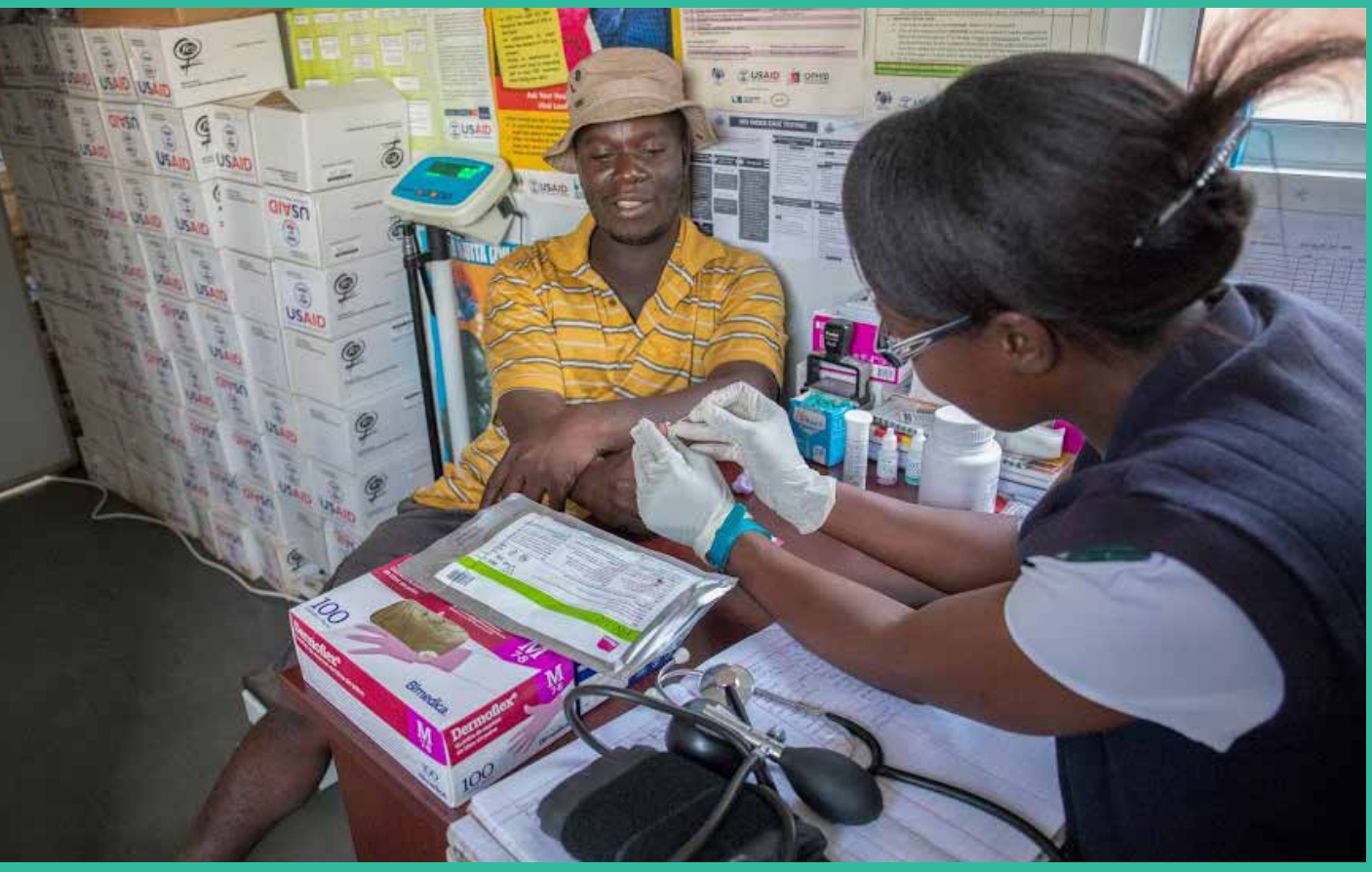
- To reduce new HIV infections by 68% by 2025 from the 2018 baseline;
- To halve AIDS-related deaths by 2025 from 2018 baseline;
- To reduce MTCT rate to less than 5% by 2025; and,
- To eliminate HIV-related stigma and discrimination

Table 7: Impact Results

Impact Results	Disaggregation	Baseline (2018)	2023	2025
Reduced HIV New Infections	Overall	39,000	62.8%	67.7%
Reduced HIV New Infections – Females	Female	22,000	63.2%	68.2%
Reduced HIV New Infections – Males	Male	17,000	62.4%	67.1%
Reduced HIV New Infections among the 0 to 14 years	Children	5,000	30.0%	38.0%
Reduced HIV New Infections among the10 to 19 years	Adolescents	5500	61.8%	67.3%
Reduced HIV New Infections among the 15 to 24 years	Overall	13500	62.2%	66.7%
Reduced HIV New Infections among the 15 to 24 years	Female	9,200	63.0%	67.4%
Reduced HIV New Infections among the 15 to 24 years	Male	4,300	60.5%	65.1%
Reduced HIV New Infections among the 15 to 49 years		32500	68.0%	72.3%
Reduced AIDS deaths per 100,000		141.5	29.3%	38.6%
Annual AIDS deaths reduced	Overall	21,800	42.7%	50.5%
Reduced Annual AIDS deaths – Female	Female	11,200	40.2%	48.2%
Reduced Annual AIDS deaths – Male	Male	10,600	45.3%	52.8%
Reduced Annual AIDS deaths among the 0 to 14 years	Years	3300	57.6%	57.6%
Reduced AIDS deaths for adults (15+ years)	Overall	18500	47.6%	54.6%
Reduced Under 5 AIDS related child mortality		86.1	53.4%	61.4%
Stigma Index	Index			

05

Programmes and strategies for combination HIV prevention



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5.1 Condom programming

Programme objective

To increase condom use among high-risk males and females during risky sexual encounters to at least 90% by 2025

Target populations

All sexually active men and women with particular targeting of adolescents and young people (males and females), adult men and women engaged in risky sexual behaviour, key populations, discordant couples and pregnant women.

Situational analysis

Condom use among some groups increased significantly in the last two decades[2]. Among non-marital and non-cohabiting partners, condom use increased from 43% in 1999 to 67% in 2015 among women 15-49 years and from 70% to 85% among men 15-49 years over the same period. Condom use among females with multiple sexual partners aged 15-24 years is lower (44%) than among male counterparts (66%)[3]. Condom use among men and women in low wealth quintiles is much lower than among those in high wealth quintiles indicating equity issues. On the other hand, risky sexual behaviours such as reported multiple sexual partners increased from 11% to 14% between 2010 and 2015 among men highlighting the need for consistent condom promotion to ensure all high-risk sexual encounters are protected[4]. Among female sex workers, reported condom use with the last client is high (96.1%) while only 45% reported consistent condom use in the last one month.

The distribution of male condoms increased from 109 million in 2015 to 133 million in 2018 while the distribution of female condoms has largely remained at the same level, 5.6 million in 2015 and 5.2 million in 2018. Male condom distribution surpassed the target while female condoms did not meet projected target in 2018[5]. The growth in condom distribution was driven primarily by free condom distribution by the public sector. These condom distribution figures are assumed to reflect the level of condom uptake in the country. Notwithstanding the increase in condoms distributed between 2015 and 2018, the UNAIDS Condom Fast Track Tool calculation shows that the total need for condoms in Zimbabwe is 218 million. Thus, the 2018 distribution meets 61% of the total condom need. Figure 9 below shows the annual distribution of condoms between 2016 and 2018.

The condom market has undergone significant changes in the last 10 years. In 2008, social marketing distribution contributed a major portion of the total distribution (70%) followed by the public sector. This situation changed by 2016 with the public sector taking a lead in market share and contributing 77% of the distributed condoms, followed by social marketing at 21%. The commercial sector distribution remained largely stable at 2% over this period. This change is attributed to the continuous rise in hyperinflation which peaked in 2008 and wiping out a significant portion of social marketing distribution with a loss of about one-third (i.e. 2,500 to 3000) retail outlets. Since 2016, further decline in donor funding has also contributed to further shrinking of condoms distributed through social marketing. Hence, the public sector served as the major source of condoms.

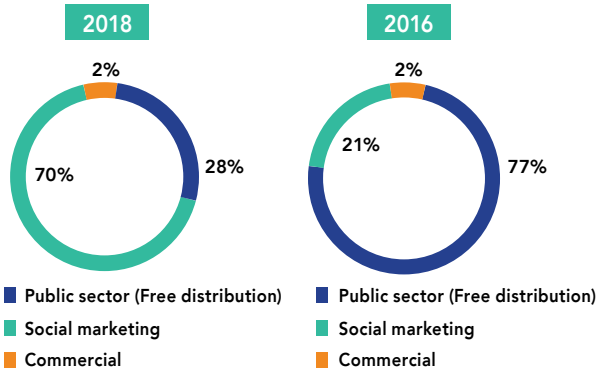
2 Note that recent data on condom use is lacking. The last population based survey on condom use was ZDHS 2015. The planned ZDHS 2020 will provide updated data.

3 Data from Zimbabwe Demographic and Health Survey

4 Strategic donor investment for strengthening condom markers: The case of Zimbabwe, Taruberekera, N. et. al, 2019

5 Condom distribution target are from ZNASP III results framework and distribution figures are sourced from programme data

Figure 9: Zimbabwe condom market by sector 2008 and 2016[6]



Other aspects of condom programming such as demand creation and condom promotion, stewardship, market analytics and strategic information are inadequately funded. Despite these challenges, condom availability and use remain a key prevention intervention that contributes to the reduction in new HIV infection.

Gaps

- Sustained availability of condoms due to inadequate funding for condom procurement and programming
- Unacceptability of public sector condoms by certain target groups; and negative attitudes towards condom use
- Low risk perception hindering condom use among vulnerable and key populations
- Inadequate differentiated or targeted distribution channels for condoms especially for key populations, adolescents and young people
- Low private sector condom distribution partly due to price
- Weak integration of condoms in other HIV combination prevention programmes
- Lack of adequate and quality data to inform condom programming

Strategies

- Two key issues, which will drive the condom programme in the next five years, are sustainability and equity. ZNASP IV aims at increasing sustainability and efficiency in condom distribution and programming and differentiated distribution channels. This will ensure that, within the resource constrained environment, condoms reach those engaged in risky sexual behaviour.
- Rolling out innovative condom promotion interventions including re-branding public sector condoms, expanding condom brands to provide more choices, positioning the condoms as a life saving device and mainstreaming condoms in all RMNCAH sites.
- Expanding differentiated condom distribution systems or channels, beyond the public health systems and tailoring them to specific vulnerable and key populations using community based distribution outlets. This will include introducing condom-dispensing machines in strategic locations or venues.
- Intensifying demand creation to increase uptake and ultimately consistent use of condoms. Demand generation interventions will include enhanced product visibility through mass media platforms and community based promotion combined with interpersonal communication with targeted populations.
- Advocating for domestic funding for condom procurement and programming. Some of the innovative funding options include duty exemption for private sector condom imports, review of regulations for condom importation by private sector and finding alternative donor support for condom procurement.
- Investing in people centred design and market analytics to regularly understand condom market dynamics and improve condom data quality. This will include undertaking more frequent and inexpensive measurement of condom use facilitating factors and barriers to inform condom programming instead of relying on population based surveys occurring after five years.

6 Zimbabwe condom market analysis: a case study. Mann Global Health

5.2 Voluntary Medical Male Circumcision

Programme objective:

To increase male circumcision coverage among those aged 10-29 years to 90% by 2025.

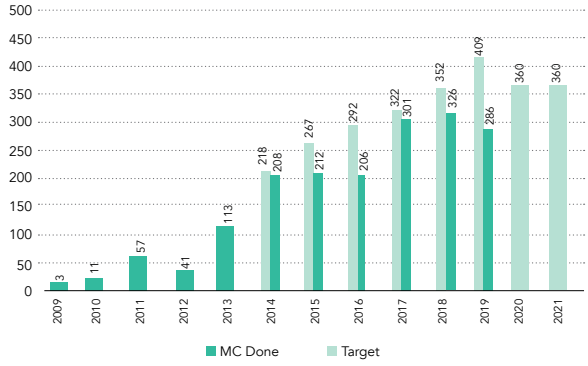
Target populations:

Sexually active males prioritising those aged 10-29 years.

Situational analysis

Since the country adopted Voluntary Medical Male Circumcision in 2009, more than 1.67 million males had been circumcised by September 2019. Figure 10 below shows that the MC programme has not been meeting targets since 2014. At the current level of programming, the country is not likely to meet the target of 80% male circumcision coverage by 2020.

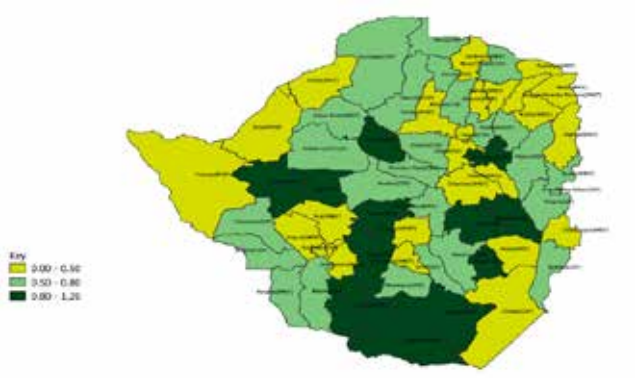
Figure 10: VMMC performed from 2009 to 2018, disaggregated by age



An analysis of the male circumcisions conducted between January to September 2019 shows that males 10-12 years contribute the highest proportion of clients (29%), followed by the 15-19 year olds (27%) while adolescents aged 10-19 years account for 69% of all male circumcisions performed.

VMMC coverage also varies across districts. As at September 2019, 12 districts had surpassed 80% coverage, while 25 districts were below 50% of their annual target.

Figure 11: VMMC coverage by district as at September 2019



VMMC services are offered through three models. The models are: the static model, through which services are offered in health facilities; the outreach model, which involves MC teams traveling to perform circumcisions at other health facilities, especially those in rural areas and the mobile clinics model, where VMMC teams conduct circumcisions in caravans mainly in remote areas with no access to health facilities. Under this model, circumcisions can also be performed at these mobile clinics during MC campaigns. Demand creation for MC is carried out by village health workers, circumcised men, school health coordinators, chiefs, traditional and religious leaders; and through road shows, male sports (e.g soccer) galas and community dialogue meetings. Standard Operating Procedures (SOPs) and protocols for MC have been developed and are available in most health facilities. Mentorship and support supervision is also carried out to ensure quality of the MC services provided. Adverse Events rate is estimated at 0.1% which is below the internationally recommended threshold of 2%. However, age specific adverse events data is lacking. Other HIV services have also been integrated into VMMC and vice versa to increase clients' access to HIV and SRH services.

The VMMC programme is largely externally funded. However, the donor funding for the programme continues to dwindle and casting visibility into the future is uncertain. For instance, geographical reprioritisation of donor funds in 2016 saw funding for VMMC discontinued in 9 districts which had a low HIV prevalence. From the time donor funding stopped, these districts have failed to continue providing VMMC at required levels to meet programme targets. In light of uncertain donor funding, the country has considered several initiatives to reduce cost and sustain the programme. The initiatives include, scaling up task shifting from doctor to nurse led VMMC, decentralising VMMC in-service training, aligning demand creation with service delivery, operational research on the scale up of re-usable kits and reducing the reimbursable unit cost from $25 to $12 per circumcision. These measures, among others, will be scaled up through ZNASP IV to improve efficiency.

It is also noted that a Sustainability Transition Implementation Plan 2019-2021 (STIP) is in place to guide the programme up to 2021. In line with the plan for transition to sustainability, ZNASP IV will guide implementation of approaches that are appropriate to the level of VMMC coverage in each district.

Gaps

- Inadequate coverage in some geographical areas (districts)
- Limited coverage and low demand for VMMC among males aged 20 to 29 years
- Programme sustainability risk owing to heavy reliance on donor funding for the VMMC programme. This has left the programme entirely funded by donors and managed by implementing partners.
- Limited choice of male circumcision methods
- Inadequate severe adverse events surveillance system
- Limited human resource base to provide VMMC services
- Limited domestic funding for VMMC sustainability
- Limited integration of other HIV services with VMMC and weak linkages with other HIV and health programmes. Currently, HTS is the main service integrated with VMMC.
- Limited involvement of key sectors and individuals (such as religious leaders, women and private sector) in the VMMC programme
- Weak waste management infrastructure

Strategies

ZNASP IV will fast track VMMC services availability in districts with low coverage while transitioning district with over 80% coverage to the sustainability phase.

- Update and disseminate VMMC policies and standard operating procedures to protect safety, human rights/ethics and other service needs for boys 10-14 years. The policies should ensure adolescents, parents and health workers have adequate rights-based guidance on consent and confidentiality; and receive independent informed consent for VMMC. Other policy issues to be addressed include provision of other services needed by young adolescents such as tetanus toxoid containing vaccination (between 9 - 15 years) and age appropriate sexual, reproductive and health education. Health care providers will be trained to implement the updated policies and procedures.
- Establish mechanisms to mobilise male sub populations (10-19 and 20-29 years old) through innovative demand generation initiatives such as community based male mobilisers, and strengthening partnerships with the education sector.
- Scale up VMMC among high risk older men 30 years and above, through providing VMMC integrated with condoms and SRH
- Integrate VMMC with existing MOH adverse events surveillance systems especially for boys 10-14 years
- Integrate VMMC as a routine service in health facilities through pre-service training of both doctors and nurses and broadening health service provider base through inclusion

of private health sector providers and insurance companies. In addition, introducing circumcision at birth for long term sustainability.

» Sustain financial resources for VMMC through mobilising additional resources to expand VMMC coverage in underfunded geographical areas or districts and advocating for domestic funding for VMMC services for sustainability.

5.3. Key populations programme

Programme objective:

To ensure at least 90% of the key populations receive a defined package of accessible, acceptable, affordable and high-quality HIV services by 2025.

Target populations:

Sex workers in their diversity, MSM, Transgender, PWUD and prisoners

Situational analysis

Key populations are defined as populations at a higher risk of being infected with HIV. This population group facilitates the spread of HIV and their involvement is vital for an effective response to HIV in Zimbabwe. Other factors defining key populations are stigma and discrimination, criminalisation and lack of access to services. The Modes of Transmission (MOT) study conducted in 2017 found that FSWs contribute about 4,000 new HIV infections while nearly 2,000 new infections occur among MSM annually. These numbers of new infections are significant when considered relative to the sex workers and MSM population. In 2018, HIV prevalence among FSW was 57.1% and 31% among MSM[7] whilst prevalent among prisoners was estimated at 28% (26.8% males, and 39% females) in 2015. However, HIV prevalence data for the wider Lesbian, Gay, Bisexual and Transgender (LGBT) community is, however, lacking. The table below summarises the key populations in Zimbabwe.

7 UNAIDS data, 2018

Table 8: Key populations in Zimbabwe

Sex workers and their clients	Population size estimates of FSWs is 40471 HIV prevalence is 57.1%[8] HIV incidence amongst FSWs estimated at 10%[9] FSWs contribute 4000 new infections annually[10]	Soliciting of sex for the purposes of prostitution, living off the proceeds of prostitution, pimping and a parent or guardian allowing a child to become a prostitute is criminalized	Experienced stigma and discrimination is high. Intimate partner violence is also high Alcohol use and mental health problems
MSM – inclusive of gay and bisexual men	Size estimated for 5 major cities - 20 000[11] HIV Prevalence 31%. MSM contribute 2000 new HIV infections annually[12]	Consensual sexual intercourse involving anal penetration or any act involving physical contact, other than anal penetration, that would be regarded to be an indecent act is regarded as sodomy is criminalized	Reported negative experiences with health care providers and reported avoidance of the health system. Health care providers are largely heteronormative and are not affirming of diverse sexuality

8 Cowan FM, Davey C, Fearon E, et al. The HIV care cascade among female sex workers in Zimbabwe: results of a population-based survey from the Sisters Antiretroviral Therapy Programme for Prevention of HIV, an Integrated Response (SAPPH-IRe) Trial. J Acquir Immune Defic Syndr. 2017; 74:375–382.

9 Hargreaves JR, Mtetwa S, Davey C, et al. Implementation and operational research: cohort analysis of program data to estimate HIV incidence and uptake of HIV-related services among female sex workers in Zimbabwe, 2009–2014. J Acquir Immune De fic Syndr. 2016; 72: e1–e8.

10 2017 MOT study

11 Program data 2019

12 2017 MOT Study

Key Population	Epidemiological evidence of high HIV infection	Criminalization and human rights violations	Faces barriers to accessing health services
Transgender	No data	Same as MSM above transgender women are criminalized under Section 73 of the Criminal Law (Codification and Reform)	Results of 2019 Zimbabwe KP HIV Stigma Index Survey show high levels of experienced stigma, self-stigma, and mental health among HIV positive transgender people
Prisoners	HIV prevalence among prison inmates of 28% (female 39% and males 26.8%)[13]	Due to being incarcerated, there are constraints to availability of health and HIV services within the prison settings.	Exposure to unhygienic and overcrowded conditions that increases exposure to communicable illnesses such as TB
PWID	No data	Criminalization of possession and/or use of drugs	Reported stigma and discrimination and ostracism

13 ZPS (Zimbabwe Prison Service) (2011) Assessment of HIV Prevalence and Risk Behaviours among the Prison Population in Zimbabwe. Harare: National AIDS Council, United Nations Office on Drugs and Crime

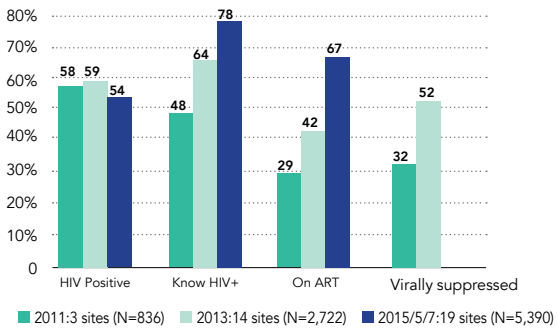
The country has made progress in improving HIV outcomes among key populations. Knowledge of HIV status among HIV positives FSWs is 93.6%[14] and 50% among MSM[15]. The total number of MSM tested for HIV increased from 1,995 in 2018 to 7,717 in 2019, and for FSWs from 13,899 in 2017 to 19,928 in 2019. Index testing, self-testing, provider-initiated testing and counselling, mobile testing and moonlight testing are the key models used to reach SWs and MSM. Prison inmates are offered HTS on admission into prison with immediate linkage to ART for HIV positives. There is no data for transgender people and PWID.

Program data show high uptake of ART for those testing HIV positive. Female Sex Workers testing HIV positive and put on ART increased from 92% in 2018 to 99% in 2019 while there was a slight decrease in MSM tested from 97% to 93% in the same period. Figure 12 below shows a cascade for FSWs that is almost similar to that of the general population.

Reported condom use with last client among female sex workers in a 2014-2016 PrEP trial study was high (96.1%). However, only 45.5% of the women reported consistent condom use in the last one month. One of the factors accounting for unprotected sex is alcohol use in casual sexual encounters. Low condom use was reported during sex with long-term sexual partners and steady partners. While condoms are widely available, lubricants are not always available at non-MSM venues.

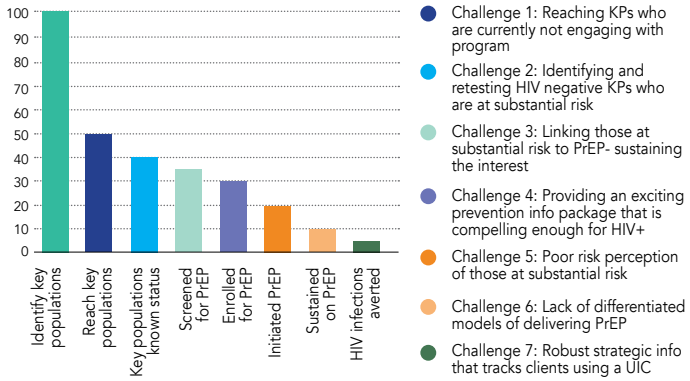
PrEP is also provided to Key population. The highest uptake of PrEP is among FSWs representing 52% of all clients. Figure 13 below shows an analysis of the bottlenecks along the PrEP cascade in Zimbabwe.

Figure 12: 90-90-90 Treatment cascade for FSWs in Zimbabwe



14 Zimbabwe GAM report 2018
15 Zimbabwe GAM report 2018

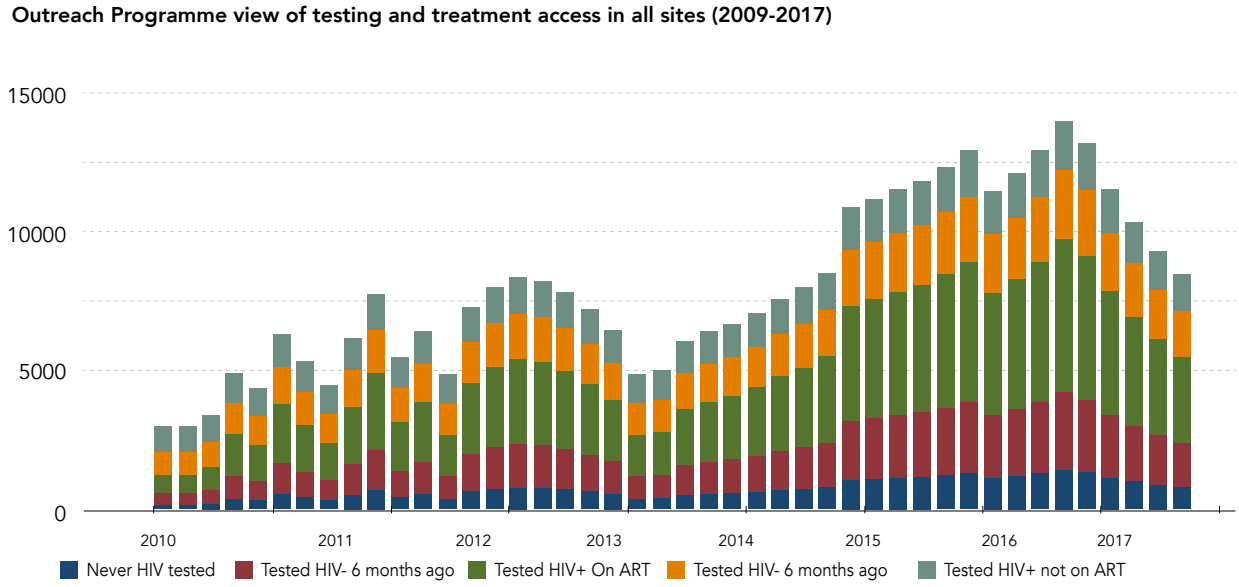
Figure 13: Bottleneck analysis along the HIV prevention cascade among KPs in Zimbabwe - PrEP uptake and adherence



The improved coverage of HIV services among key populations can be attributed to the progress made in programme implementation. Programmes are in place for some of the KPs.

A sex worker programme was established in 2009 with the aim of fostering an empowered and resilient sex worker community fully engaged in HIV prevention and care cascades. The programme runs in 10 static and 26 outreach sites in peri-urban and rural areas with emphasis on hotspots such as border posts and major transport routes. Despite the progress made in the KP programme, the sex worker programme is yet to achieve 90% coverage of the estimated 40,471 sex worker population.

Figure 14: National Sex Worker Programme indicators 2009-2017



The MSM programme started in 2016/17 and has increased its coverage since then, primarily in major urban districts of Harare, Bulawayo, Gweru, Masvingo and Mutare. The programme uses enhanced peer mobilisers and navigators to conduct community mobilisation and demand creation activities through which comprehensive HIV clinical services are provided to the MSM community. Support and mentorship are also being provided to public sector hospitals to provide MSM affirming services. The goal is to eventually transition the programmes from stand-alone models to an integrated KP programme within the public health system.

Transgender people are currently provided with HIV services within the MSM and sex workers programmes. However, there is limited disaggregation of data hence the uptake of services by larger transgender population cannot be ascertained. There is no programme for people who use drugs.

The map below shows the spread of sex worker programme sites (16 static sites and 31 outreach sites) and MSM programme sites (five major cities) across the country.

Figure 15: Sex Workers and MSM Programme Sites

Prison inmates are offered HTS on admission and those testing HIV positive are put on ART. Inmates are also re-tested for HIV every six months. ART is provided to inmates using a directly observed treatment approach to ensure adherence. Various partners including UNODC and VSO also run projects to improve access and quality of health and HIV and AIDS services in prions and support the Zimbabwe Prison and Correctional Services to adopt and implement policies and health reforms in line with international standards.

Gaps

- Lack of data on size estimation and HIV burden among some KPs – WSW, MSM, PWID, Trans-gender people, and prison inmates
- Stigma and discrimination including social exclusion exacerbating vulnerability to HIV especially among young key populations
- Mental health and psychosocial issues poorly addressed in current interventions
- KP programme is largely verticalized presenting sustainability challenges. There is lack of integration into the main programme
- STI management for KPs is limited in public sector facilities and within sex worker clinics use syndromic management which does not address asymptomatic cases
- Limited focus on clients who are SWs
- Low consistency in condom use with regular partners
- Poor risk perception among KPs
- Weak KP led organisations, with most being in formative stage
- Low coverage of some services e.g. PrEP and PEP
- Lack of clear interventions for Transgender people, and PWID
- Poor health infrastructure in the prisons
- M&E system for the KP programme is project based and there is no national system for monitoring the entire initiative

Strategies for SWs, MSM, PWUD and Transgender people

- Strengthening the KP programme through identifying, strengthening and supporting

civil society and community based and key population-led organisations and networks to provide large-scale programming.
» Generating evidence: conducting population size estimation/HIV burden survey and operational research (for sex workers, trans-gender people, PWUDs) to generate gender and age disaggregated data to inform KP programming.
» Reviewing and ensuring that the provision of a defined gender responsive service package is tailored to needs of different key populations
» Strengthening client centred services and community outreach platforms through training, use of KP peers, adoption of differentiated service delivery models, and ensuring, meaningful involvement of KPs in programming and service delivery.
» Developing guidelines and tools for screening and provision of mental health and psychosocial support.
» Establishing a phased approach to integrating KP services in health facilities for long term sustainability (Transitioning from DIC and One Stop Centres to health facilities)– training, mentorship and quality assurance.
» Building the capacity of KP-led organisations to provide peer mobilisation, HTS and linkage to care as well as tracking loss to follow up and provision of prevention services (PrEP, VMMC etc).
» Developing and integrating innovative approaches for delivering services to clients of SWs – HTS, ART, PrEP, STI management, availability of condoms, risk perception, and behaviour change communication. This will include use of KP led organisations and peers to deliver services.
» Strengthen M&E for KP programme to provide granular data – to enable the programme to target sub-groups left behind within the KP (e.g. young female sex workers)

Strategies for prison inmates

» Providing a minimum package of HIV services among inmates aligned to the minimum package recommended by UNODC, WHO and UNAIDS based on the "principle of equivalence of healthcare"
» Capacity building for prison health staff.
» Strengthening referral systems to improve HIV services offered in prisons (e.g. sample transportation and access to services not available in prison clinics)
» Generating evidence on HIV burden among prisoners to influence programming e.g. analysis of ongoing HIV incidence study
» Strengthening HIV M&E in prison settings to be linked to the national Health Information system

5.4 Pre-Exposure Prophylaxis

Programme objective:

At least 50% of people assessed to be at substantial risk of HIV infection provided with pre-exposure prophylaxis annually

Target population:

HIV negative Adolescent girls and young women at elevated risk of HIV infection, Female Sex Workers (FSW), men who have sex with men (MSM), HIV negative partners among serodiscordant couples (SDC), transgender persons, pregnant and lactating mothers who perceive themselves to be at high risk of HIV infection.

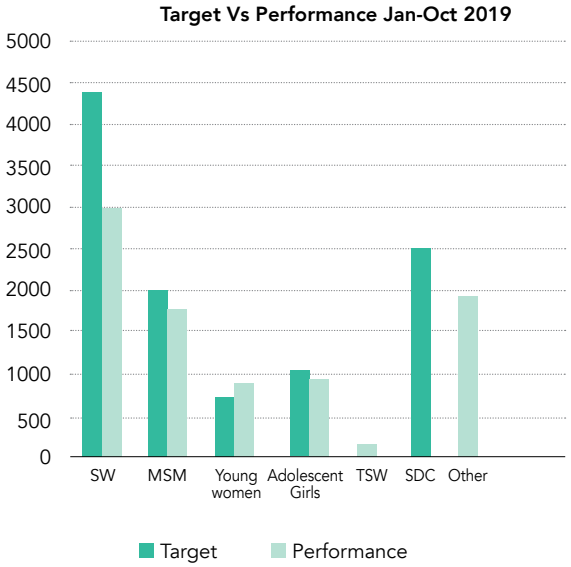
Situational analysis

Zimbabwe included Pre Exposure Prophylaxis (PrEP) in its guidelines for Antiretroviral Therapy (ART) in 2016 as part of the combination HIV prevention. A phased approach for the provision of PrEP services was adopted due to lack of funding and the need to learn lessons. The first phase involving piloting was implemented in four USAID funded DREAMS districts (Chipinge, Mutare, Gweru and Bulawayo) targeting adolescent girls and young women. PrEP was also offered in New Start Centres and at Wilkins Infectious Diseases Hospital targeting mainly Female Sex Workers and MSM.

A PrEP Technical Working Group was established to coordinate implementation. An Implementation Plan for PrEP 2018-2020 was developed and is being implemented. A total of 239 service providers in 38 out of 49 high burden districts have been trained. PrEP registers have been printed and some PrEP indicators are included in monthly reports and efforts are underway to integrate PrEP with other interventions such as HIVST. DREAM champions and ambassadors have been trained; PrEP expert clients identified and PrEP IEC materials developed to create demand.

Between 2017 and October 2019, a total of 17,000 clients were initiated on PrEP, and 90% of the clients who were initiated on PrEP in 2017 were females aged 25-49 years. Also, 52% of all PrEP clients in 2017 were FSWs. Figure 16 below shows progress for January to October 2019.

Figure 16: PrEP uptake by client category - January to October 2019



Gaps

- Limited availability of PrEP services, with services offered in 70 facilities only.
- Limited information and demand generation for PrEP services
- Poor integration of PrEP into RMNACH and Nutrition
- High rates of early PrEP discontinuation especially among young men and women

Strategies

- The strategic focus for ZNASP IV is to scale up PrEP in all districts as part of combination prevention targeting all identified priority groups in the next five years. Persons who perceive themselves to be at high risk of HIV infection and choose PrEP as a prevention method should have access to the service.
- Rolling out demand creation schemes for PrEP targeting those in need

» Increasing availability of PrEP service in all health facilities and service points outside of health facilities such as drop in centres
» Conducting operational research including analyses of preferences among priority populations and PrEP seroconversion studies
» Establishing collaboration between PrEP and RMNCAH, SRH and STI clinics.

5.5 Post Exposure Prophylaxis

Programme objective:

To increase PEP uptake to at least 80% for all HIV exposures

Target populations:

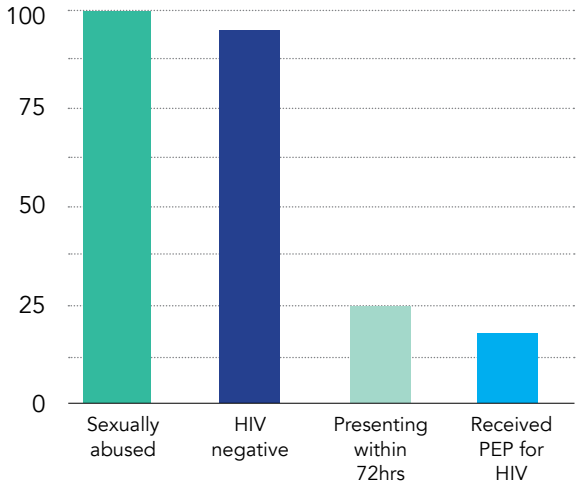
People in healthcare settings and other occupations exposed to accidental HIV infection, survivors of sexual and gender based violence and those exposed to unprotected sex.

Situational analysis

Zimbabwe has guidelines recommending the use of TDF/3CT/ATV/r for adult and adolescents for PEP. Those potentially exposed to HIV through sexual assault (rape, intimate partner violence, or sexual abuse), through a high risk unprotected sexual encounter to accidental exposure at health and other occupational settings should have access to PEP within 72 hours of exposure.

The 2018 data for PEP show that 400 sexual assault cases were reported and tested for HIV. However, only 25% of these were reported within 72 hours and eventually, only 15% received PEP. This data show a huge gap in the timely reporting of PEP and even a higher gap in the provision of prophylaxis.

Figure 17: National; PEP cascade - post sexual assault, 2018



Gaps

» Inadequate availability of PEP services
» Failure to seek PEP services within the prescribed timeframes
» Low adherence to PEP especially among health workers
» Inadequate data on PEP service uptake

Strategies

ZNASP IV will promote PEP as a key prevention method for those accidentally exposed to HIV infection at occupational settings including healthcare facilities and those exposed to unprotected sex including sexual violence. PEP will be included in the HIV primary prevention package promoted to all vulnerable and key populations.

» Making PEP universally available in all health facilities for all accidental and sexual exposures for sexual assault survivors to HIV infection.
» Generating demand through multimedia PEP education to empower communities and individuals to seek PEP services.
» Improving the management of side effects arising from the use of PEP through aligning with updated WHO guidelines on PEP regimen.

5.6 HIV prevention programme for adolescent girls and young women

Programme/thematic area objective:

To ensure at least 90% of AGYW receive a defined package of HIV and SRH services by 2025.

Target populations:

Adolescent Girls and Young Women aged 15-24 years

Situational analysis

HIV incidence is higher among females. Incidence increases rapidly among females from age 15 to 24 compared to their male counterparts. The difference in incidence is most pronounced among young adolescents 15-19 years in which the incidence among females is five times higher than males. The NAOMI model output in Figure 18 shows that the focus on adolescents and young women should cover ages 15 to 24 years, where there is a high HIV incidence.

Figure 18: HIV incidence by age and sex, 2019

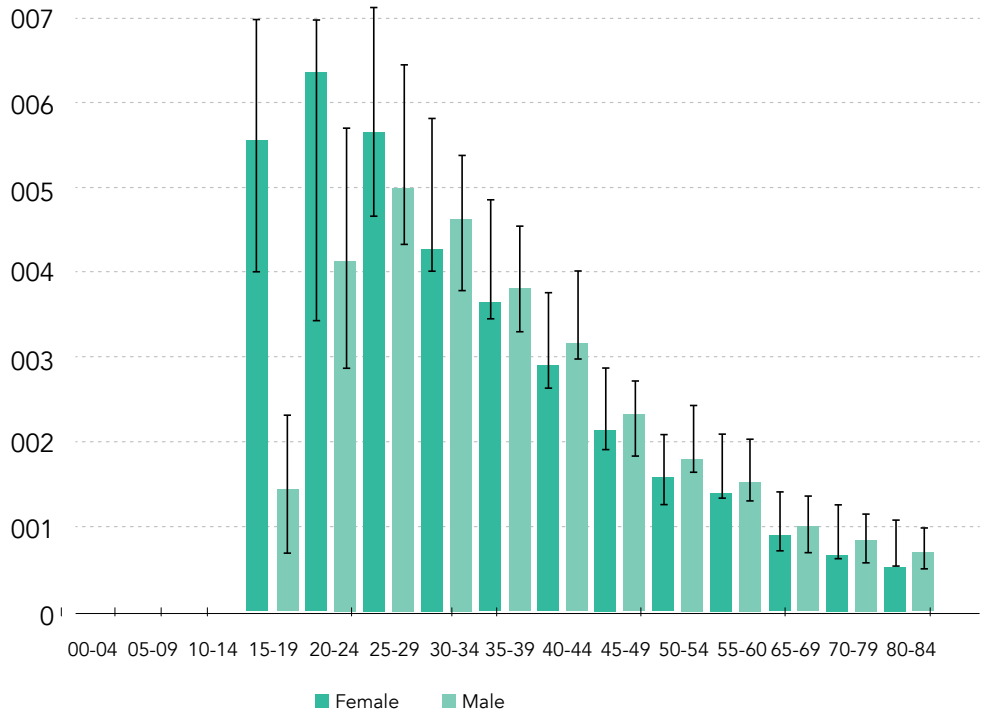
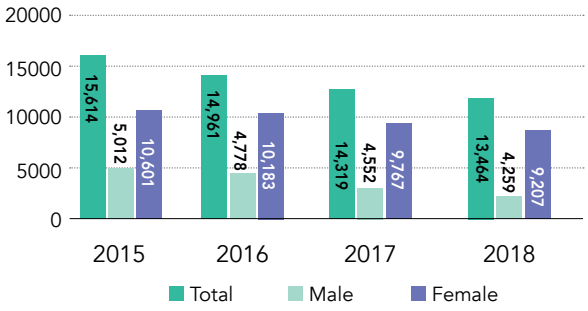


Figure 19: Number of new HIV infections among 15-24 year olds 2015-2018.



As of 2018, a total of 83,471 AGYW (15-24 years) were living with HIV compared to 46, 698 ABYM. The high number of HIV infected AGYW is a reflection of gender inequality challenges that this group faces including GBV, child marriages, early sexual debut, adolescent pregnancies, inter-generational sexual relationships, poverty and failure to negotiate for safer sex. Table 9 below classifies districts according to the number of AGYW living with HIV.

Table 9: Classification of districts by number of PLWHIV and major AGYW interventions in the country

No. of AGYW living with HIV	Number of Districts	Districts covered by DREAMS	Districts covered by Sister 2 Sister	Districts not targeted
200-500	3		Rushinga, Kariba	Hwedza,
501-999	24	Chimanimani, Umzingwane	Mutasa, Chivi, Guruve,Bindura, Chirimhanzi, Zvishavane, Bikita, Nyanga,	UMP, Hwange, Centinary, Kadoma, Seke, Bubi, Shamva, Mangwe, Mudzi, Binga, Mwenezi,Shurugwi, Gokwe North, Beitbridge
1000-2000	24	Umguza, Gweru, Makoni,Mutare, Chipinge,	Nkayi, Matobo, Zaka, Gutu, Gwanda, Murehwa, Masvingo, Buhera, Insiza, Lupane	Chikomba, Mutoko, Bulilima, Marondera, Makonde, Mt Darwin, Chegutu, Tsholothso, Hurungwe,
2001-3000	7	Mazowe, Kwekwe	Goromonzi, Gokwe South, Mberengwa, Zvimba	Chiredzi
3001-5000	1	Bulawayo		
50001 +	1		Harare	

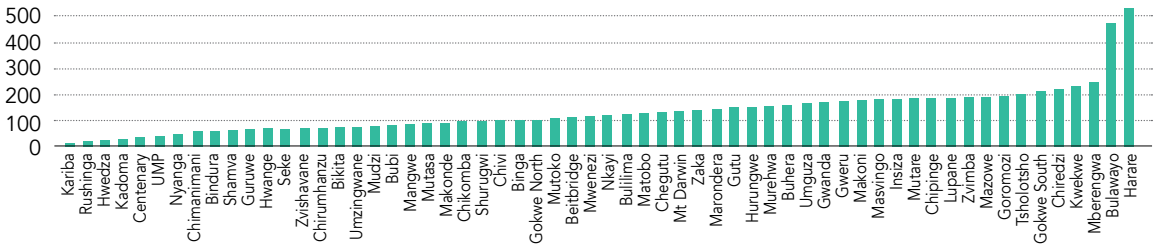
Three districts have less than 500 AGYW living with HIV. Two of the districts in this category, Rushinga and Kariba, were targeted under the Sister to Sister programme while Hwedza District has not been targeted. Twenty-four districts have between 501 and 1,000 AGYW living with HIV and out of these, 2 have been targeted under the DREAMS project while 8 have been targeted under the Sister to Sister programme and 14 have not been targeted. Another 24 districts have between 1,000 and 2,000 AGYW living with HIV, and 5 are in the DREAMS project while 10 are in the Sister to Sister project and 9 have not been targeted. Despite having a high number of over 2,000 AGYW living with HIV, Chiredzi District has not been targeted. Two districts in this category are in the DREAMS project while 5 are in the Sister to Sister project. Harare and Bulawayo, with the highest and second highest numbers respectively, have been targeted.

There has been a gradual decline in the number of new annual HIV infections amongst AGYW. The total number of new infections for both AGYW and ABYM declined from 15,614 in 2015 to 14,319 in 2017 and 13,464 in 2018. Among AGYW, the

number of new infections declined from 10,601 in 2015 to 9, 207 in 2018[16]. The same trend was recorded among ABYM as new HIV infections declined from 5,012 in 2015 to 4,248 in 2018. Although there has been a general decline of new infections among AYP, the number of new infections for AGYW is more than twice that of ABYM, indicating significant challenges that AGYW are facing in the fight against HIV. Figure 20 below shows the number of new infections by district for 2018.

16 National HIV Estimates, 2018

Figure 19: Number of New HIV Infections by district



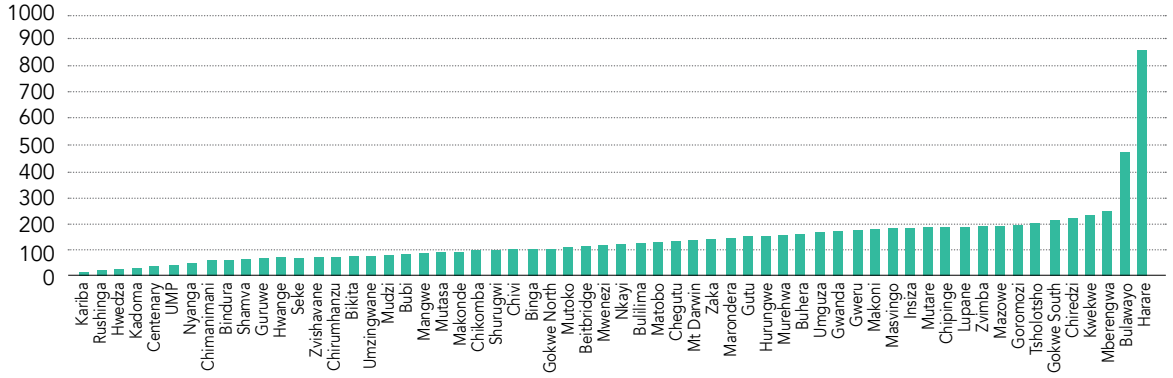
In 2018, Harare had the highest number of new HIV infections (889), followed by Bulawayo with 466. Kariba and Rushinga had the least number of infections at 25 and 44 respectively. The following table shows classification of districts by the number of HIV infections for 2018.

Table 10: Distribution of New HIV Infections by district for 2018 and coverage of major HIV interventions for AGYW

No. of New Infections among AGYW living with HIV	Number of Districts	Districts covered by DREAMS initiative	Districts covered Sister 2 Sister initiative	Districts not targeted
Below 100	18	Chimanimani, Umzingwane	Rushinga, Kariba, Nyanga, Guruve,Bindura, Zvishavane, Chirimhanzi, Bikita,	Hwedza, Kadoma, Shamva, Centinary, UMP, Seke, Hwange, Mudzi,
101-200	29	Umguza, Gweru, Makoni, Mutare,	Mutasa, Chivi, Nkayi, Matobo, Zaka, Murehwa, Gutu, Buhera, Gwanda, , Masvingo, , Insiza,	Bubi, Mangwe, Binga, Mwenezi,Shurugwi, Gokwe North, Beitbridge, Chikomba, Makonde, Mutoko, Bulilima, Mt Darwin, Chegutu, Marondera,
201-300	12	Chipinge, Mazowe, Kwekwe	Lupane, Zvimba, Goromonzi, Gokwe South, Mberengwa,	Tsholothso, Hurungwe, Chiredzi,
301+	2	Bulawayo	Harare	

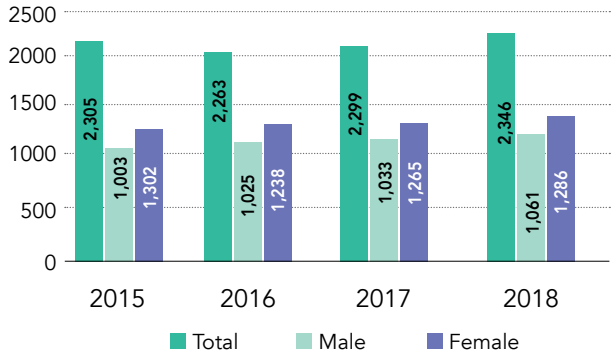
New HIV infections are high in 14 of the targeted districts while 29 have relatively high new infections of between 101 and 200. More work still needs to be done in these districts, particularly if they also have high numbers of AGYW living with HIV. Table 10 demonstrates the need to increase coverage and align AGYW HIV programmes to the HIV burden among this group in each district.

Figure 21 shows number of annual HIV related deaths among AYP.



There was a gradual decline of AIDS deaths from 2,305 in 2015 to 2,263 in 2016 before the number of deaths increased to 2,299 in 2017 and further to 2,346 in 2018[17]. Across the four years, HIV related deaths were relatively higher among AGYW compared to those of ABYM. The increase in deaths over the last two years is cause for concern given the target of ending all AIDS deaths by 2030. Shortage of ART drugs, defaulting due to high mobility, stigma and service providers who are not youth friendly were identified as some of the key factors negatively impacting access to services by AYP enrolled on ART.

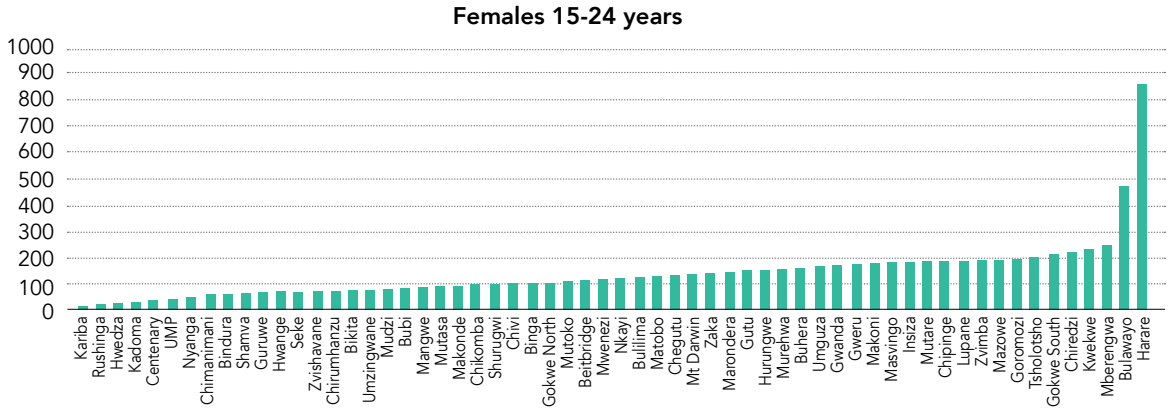
Figure 21: HIV related deaths among AGYW 2015-2018



17 Ibid

The estimated of number AIDS annual deaths of AYP enrolled on ART gradually increased from 1,729 deaths in 2015 to 2008 deaths in 2017 and 2,176 in 2018 . Across the four years , the number of deaths are significantly higher among AGYW compared to ABYM . Increased support for AYP is therefore key in averting HIV related deaths among this age group. Figure 20 shows AGYW HIV related deaths by district.

Figure 20: HIV Deaths by District 2018



Harare had the highest number of deaths (177) followed by Bulawayo (62). Kariba and Hwange had the least number of deaths (6) followed by Rushinga (7).

Drivers of the epidemic among AGYW

Low knowledge and awareness of HIV: Both ZIMPHIA (2015-16) and the ZDHS (2015) confirmed that there are significant knowledge gaps on HIV among AGYW with less than 50% lacking comprehensive knowledge on HIV. ZDHS (2015) results show that only 44.7% of AGYW had comprehensive knowledge on HIV. The results show low knowledge of HIV among both AGYW and this needs to be addressed urgently.

HIV Testing Services (HTS) and STI: Although progress has been made in HTS, more still needs to be done to reach the 90% target. Among AGYW, 65.4% had been tested and received their results[18]. However, the percentage among older adolescents (45.3%) was roughly half of that among young adults (75.1%). Among HIV-positive AGYW, 52% were unaware of their status, according to self-report. Of those HIV positive who knew their status, 5.5% were not on ART, particularly among the 20-24 age group, while 42.2% were on ART. Viral load Suppression (VLS) was observed in 50.2% of AGYW who were HIV positive. STI prevalence among AGYW is 1.9%[19].

Condom use: ZDHS (2015) results showed that the percentage of never married AGYW who used condoms in their last sexual encounter was 49.9%. The results indicate that more than half of the AGYW had not used a condom in their last sexual encounter, thereby exposing them to greater risk of HIV infection. This reflects power imbalances between men and women as the later have less negotiating power for safer sex. This exposes young women to a high risk of HIV infection.

18 ZIMPHIA

19 IBID

Gender Based Violence (GBV) and Harmful Practices: Gender Based Violence (GBV) is a manifestation of gender inequality, gender norms and harmful practices within society. GBV increases women's vulnerability to HIV infection. In 2015, a total of 31.5% of AGYW reported having experienced physical violence in their lives[20] while 11.6% reported ever experiencing sexual violence.

The YAS results show a slight decline in sexual violence prevalence to 9.1% among AGYW aged 18-24 years who ever experienced sexual violence and 4.1% among those aged 13-17 years who experienced sexual violence in the last 12 months. Though showing signs of a decline in DREAMS districts, GBV is still a major obstacle towards eradicating HIV by 2030.

GBV is fuelled by social norms, negative masculinities and patriarchal attitudes that justify wife beating. In 2015, the percentage of AGYW who justified wife beating for at least one specified reason was 47.8%[21]. It is notable that more females compared to males justified wife beating, reflecting widespread entrenched gender norms that justify GBV against women.

In 2015, 3.2% of AGYW were married before the age of 15 while 32.4% were married by the time they turned 18 years indicating a high prevalence of child marriages. Early sexual debut before the age of 15 years was reported by 4.8% of girls[22]. These harmful practices expose the AGYW to a high risk of HIV infection.

Education and Employment Status: Low levels of education expose AGYW to sexual and economic exploitation due to lack of opportunities.

Among the AGYW, 0.4% had no education at all while 9.7% had primary education only. Only 2.8% had completed secondary education, a level which exposes those who have not found better job and economic opportunities. Lack of education is thus one of the key vulnerability factors that affects AGYW. In the 12 months preceding the survey, 66% of the AGYW had not had any form of employment. Income to support livelihoods is therefore generally lacking among AGYW and this predisposes them to risky behaviours such as transactional sex or sex work.

Exposure to media: Women's rights and GBV campaigns by development partners are usually conveyed through various media sources including radio, newspapers and television. ZDHS (2015) revealed that close to half of the AGYW (45.4%) had no access to any of the three media at least once a week. Limited access to media by a large proportion of the AGYW limits their access to information on their rights and developments that affect their SRHR.

On-going interventions: A number of interventions targeting AGYW under ZNASP are currently on going in different targeted districts of the country. Main interventions include Sister to Sister, CATS, SASA and DREAMS programmes which are targeting 15,000 AGYW aged 10-24 years in 30 districts on an annual basis for 3 years (2018-2020). The aim of the programmes is to enhance the self-efficacy of young women to access and utilise integrated HIV prevention, SRH and GBV services. The programme targets in-school girls, older or married, young and unmarried and out of school or working women and girls.

Gaps

- Lack of harmonised policies and enforcement of key laws e.g. age of consent and access to HIV and SRH services by AGYW
- Harmful social cultural practices that increase the vulnerability of AGYW to HIV
- Low comprehensive knowledge of HIV Prevention and Sexual and Reproductive Health
- Inadequate adolescents and youth friendly services
- Poverty/lack of sustainable livelihoods

20 ZDHS, 2015
21 ZDHS, 2015
22 IBID

» Inadequate quality data leading to data gaps including disaggregation and granular data for AGYW groups (e.g. AGYW with disability, AYYW in the street, KP AGYW)
» Weak coordination of AGYW interventions

Strategies

Cross cutting

» Strengthening coordination and M&E for AGYW programmes to provide granular data – through electronic data management systems, institutional capacity building, revisiting TORs for AGYW TWGs at all levels. In addition, a comprehensive AGYW programme will be developed to form the basis for coordination of all interventions.
» Scaling up of gender transformative and social norm changing interventions through sensitising communities, leaders and AGYW
» Scaling up the provision of youth friendly HIV treatment, care and support and SRH services
» Empowering AGYW through livelihood activities for AGYW, knowing their rights and establishing AGYW paralegals to support AGYW access services
» Scaling up the engagement of families on SRH services for AGYW (Family Matters, Lets Chat Models).

In-school youth:

» Scaling up age appropriate SRH and CSE delivery through teacher and learner material development, HR capacity development and continuous support and supervision
» Scaling up social social protection targeting the most vulnerable AGYW to keep girls in school (education support, menstrual health management etc.)

Tertiary institutions

» Strengthening/scaling up peer led HIV awareness, risk reduction and demand creation for HIV services and referrals including reaching out to out of residence students
» Advocating for provision of HIV, STI and SRH services in tertiary institutions through MOHCC
» Strengthening institutionalization of SRH for sustainability through policy development, resourcing health facilities and capacity building of staff and curriculum integration

Out of School Youth

» Scaling up on-going comprehensive CSE and SRH initiatives targeting risk reduction, economic empowerment, education and demand generation for service uptake using peer led and interpersonal communication approaches
» Strengthening monitoring and quality improvement of Youth Friendly Services in health facilities.

5.7 Elimination of Mother to Child Transmission of HIV and syphilis

Programme objective:

To achieve and sustain elimination of mother to child transmission of HIV and syphilis by 2025.

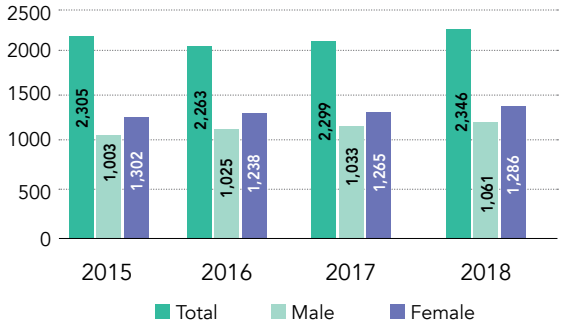
Target populations:

Pregnant women, lactating women and HIV exposed infants.

Situational analysis

The rate of mother to child transmission of HIV including breastfeeding period declined from 10% in 2015 to 7.78% in 2018. The country is on track to achieving the global elimination target of <5% MTCT rate of HIV and <1% of congenital syphilis by 2022. Figure 22 shows the trend in estimated proportion of children newly infected with HIV from mother to child transmission among pregnant women and during the breast-feeding period.

Figure 21: MTCT rate 2011 to 2018[23]



The progress made in delivering PMTCT services varies across key indicators (Table 12). For instance, the proportion of pregnant women put on ART to prevent the risk of MTCT increased from 82% in 2015 to 93.5% in 2018, while low coverage was registered in testing and counselling of male partners of HIV+ pregnant women. The proportion of HIV exposed infants (HEI) receiving ART to reduce the risk of MTCT seems to have declined from 76% observed in 2015, to 61% noted in 2018. In 2017, 0.7% of all pregnant women attending ANC tested positive for syphilis. PMTCT results achieved since 2015 illustrate the need to increase Early Infant diagnosis, ART prophylaxis among HEI, ANC attendance as well as male participation.

23 PMTCT programme data and GAM 2019 report

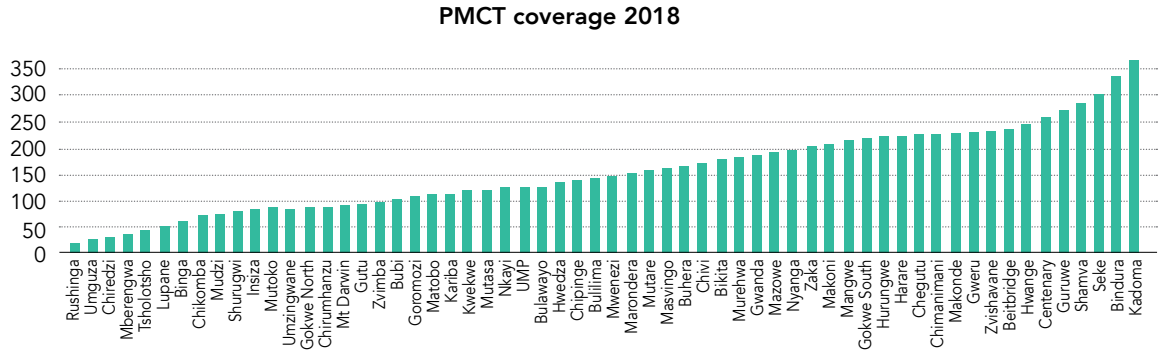
Table 11: Trend in selected PMTCT indicators, 2015 - 2018

PMTCT Indicators[24]				
Indicator	2015	2016	2017	2018
Percentage of infants born to HIV-positive women receiving a Virological test for HIV within 2 months of birth	54%	69.50%	64.9%	63%
Percentage of HIV-exposed infants who received antiretroviral prophylaxis to reduce the risk of early mother-to-child- transmission	76%	76.8%	64.9%	61%
Percentage of HIV positive pregnant women who receive anti-retroviral to reduce the risk of Mother to Child Transmission	82%	96%	95.5%	93.5%
Percentage of HIV positive pregnant and lactating women who receive anti-retro-viral to reduce the risk of Mother to Child Transmission	60%	92%	95.5%	93.5%
Percentage of pregnant women attending ANC	93%	96%	89%	94%
Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months	23%	24%	24%	No data
Number of new child infections due to MTCT	6790	5969	5421	4965

24 PMTCT programme data

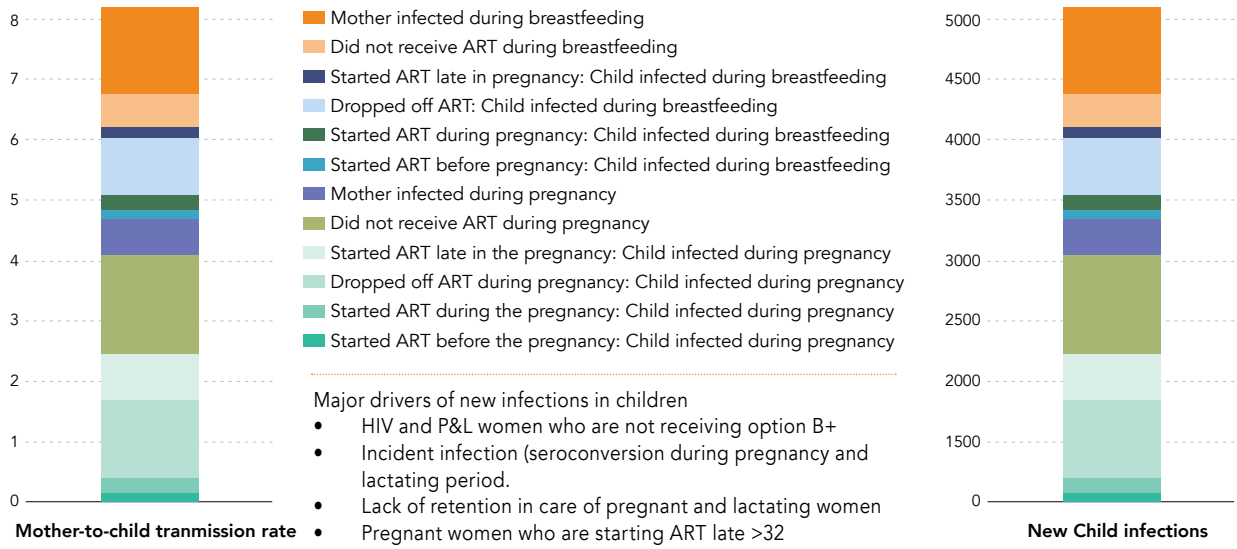
The coverage of PMTCT varies across districts. Twenty (20) districts have reached PMTCT saturation, 8 districts have over 90% PMTCT coverage while PMTCT coverage in 32 districts is below 90%. Among the districts with less than 90% coverage, 11 (35%) have a low coverage of less than 79%. These variations show that national data on EMTCT masks huge variations across districts; and, therefore, the level of investment and intensity of PMTCT interventions should be district specific. Districts that have attained PMTCT saturation coverage will prioritise sustainability strategies; those with over 90% coverage will prioritise facility level micro planning, monitoring and mentorship. Districts with 81% to 89% coverage will focus on fast tracking PMTCT interventions through capacity building and supportive supervision, while those with 79% and below coverage will implement catch up strategies which will include regular bottleneck analysis, intensive monitoring and supportive supervision guided by granular data.

Figure 22: PMTCT coverage by district, 2018



Mother to child transmission of HIV is caused by pregnant and lactating women not receiving ART to reduce risk of transmission, HIV infections during pregnancy and lactating period, weak retention of pregnant and lactating women and infants in care and pregnant women receiving ART late at more than 32 weeks gestation age. Figure 23 below provides a detailed analysis of drivers of MTCT in Zimbabwe.

Figure 23: PMTCT bottleneck analysis



Going forward, the analysis of MTCT drivers will be cascaded to facility level and facility specific PMTCT quality improvement will be implemented to address the bottlenecks . A linkage between facility and community systems will be critical in addressing bottlenecks across the PMTCT continuum.

Gaps

» Late booking and non-booking for ANC delaying ART initiation
» Low coverage of male partners of HIV+ pregnant women tested for HIV
» Sub-optimal adherence and retention in care among pregnant and lactating women
» Low re-testing of HIV negative pregnant and lactating women (pre and post-natal period)
» Low capacity of health care workers to offer long term methods of family planning
» Unavailability of family planning commodities in all health facilities
» Sub-optimal coverage of infant cotrimoxazole and ART prophylaxis of HIV exposed infants
» Stock outs or short supply of paediatric ART formulations
» Inadequate coverage of prevention of congenital syphilis including lack of syphilis test kits and medicine
» Limited primary HIV prevention services for the HIV negative pregnant and lactating women.
» Low coverage of PrEP among HIV negative pregnant and lactating women
» Low coverage of viral load testing among pregnant and lactating women
» Limited involvement of the private sector in EMTCT

Strategies

In the next five years, priority will be on eliminating mother to child transmission of HIV and syphilis in all districts and sub-districts in the country. ZNASP IV will track EMTCT at district level. Within each district, the EMTCT validation committee will monitor EMTCT at health facility level and take corrective action.

- Developing and implementing a package of EMTCT interventions prioritised according to the level of PMTCT coverage in each district. This will be further complemented with granulated data analysis on mothers in high incident areas to support a more targeted strategy.
- Establishing case-based MTCT tracking mechanism at facility and community levels through an electronic system and use of community actors to ensure early booking for ANC, tracking HIV negative pregnant women for HIV retesting and adherence to ART at ANC and PNC periods
- Rolling out male friendly services at all PMTCT sites including a comprehensive package for male services to support access to EMTCT services at all stages
- Strengthening integration with RMNCAH services, especially family planning services for HIV positive pregnant and lactating women.
- Establishing a comprehensive syphilis surveillance system.
- Rolling out a quality assured HIV-syphilis dual testing kit in all facilities.
- Scaling up primary HIV prevention, including HIV re-testing for HIV negative pregnant and lactating women through mentorship and training of healthcare workers on re-testing algorithm, distributing IEC materials; and using young mentor mothers and community health workers to track mothers for re-testing through ANC and PNC periods.
- Scaling up support supervision, data analysis, mentorship and training of both healthcare workers and community actors equitably guided by facility level analysis of MTCT drivers and level of PMTCT coverage in each district
- Scaling up VL monitoring for pregnant and lactating women through orienting service providers on utilisation of VL results, creating demand for VL monitoring among pregnant women and integrating EID into child welfare services.

06

HIV treatment, care and support

To improve the health outcomes and wellness of PLHIV, the country seeks to improve timely identification, linkage and retention in care for persons diagnosed with HIV, including improving the quality of care and treatment outcomes.

6.1.1 HIV Testing Services

Programme objective

To ensure 95% of people living with HIV, including all vulnerable and key populations, know their HIV status.

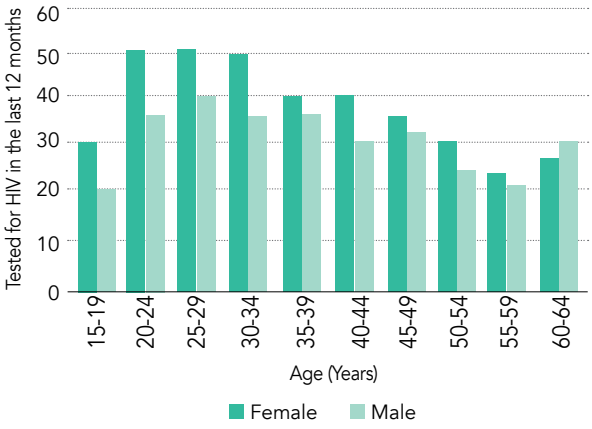
Target population

All people living with HIV and all vulnerable and key populations

Situational analysis

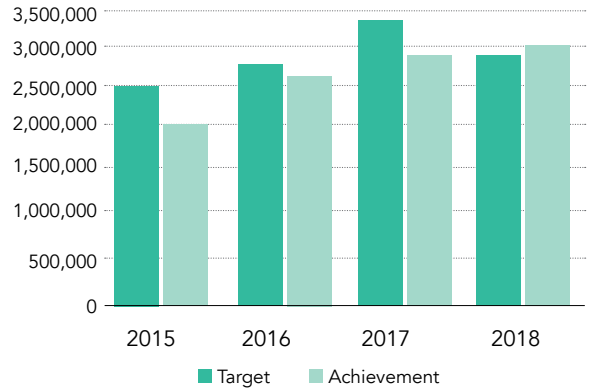
According to UNAIDS, an estimated 90% of the people living with HIV knew their status by end of 2018 up from 82% in 2015. This implies that the country has achieved the first 90% target in the 90-90-90 cascade. According to ZIMPHIA (2016) survey, 73% of adults 15-64 years reported having ever tested for HIV and received their results. Of these, 65.7% were men and 80.9% were women. Also, 35.7% of adults reported having been tested and received their results in the last 12 months before the survey and, of these, 30.6% were men and 40.2% were women. Survey results on adults tested in the last 12 months showed minimal variations across provinces, ranging from 37.9% in Manicaland to 32.8% in Midlands. Adolescents reported low coverage of ever having tested (45.3%). People with no education are likely not to test for HIV. The survey shows the proportion of people with no education ever tested for HIV at 66.8% and those tested in the past 12 months at 27.2%. Based on the ZIMPHIA survey findings, it is critical to increase frequency of testing among men and young people. HIV testing strategies appropriate for men and young people should be scaled up.

Figure 24: Proportion of adults who reported testing for HIV in the last 12 months before the survey by age and sex (ZIMPHIA 2015-16)



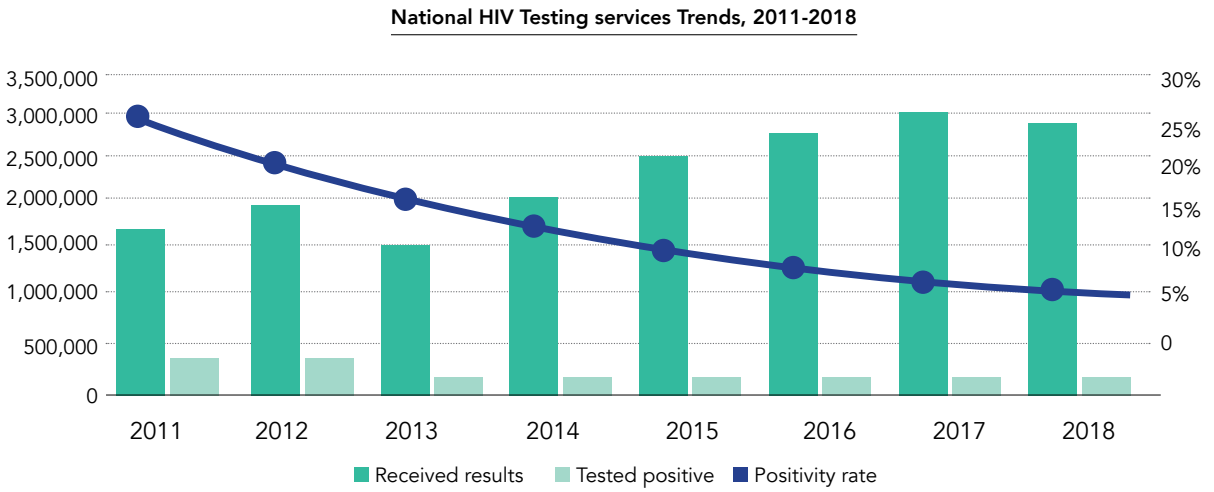
To achieve the first 90% treatment cascade target, the country implemented an integrated HTS model, which deployed different testing approaches for different populations. The approaches included facility based testing (provider initiated and client initiated testing and counselling), facility and community-based index testing, HIV self-testing and targeted mobile outreach testing, HTS is offered in several primary healthcare sites including TB, ANC, STI and MNCH. It is also integrated into other prevention services such as VMMC, PrEP, PEP and is part of the package for the DREAMS initiative for AGYW. As a result of these interventions, the number of HTS tests conducted have been increasing over time as shown in the figure below. For instance, a total of 3 million tests were conducted in 2018 against a target of 2.4 million. It was noted that 67% of these were retests, while 33% were new tests.

Figure 25: HTS clients tested and received results against set targets by year, 2015-2018



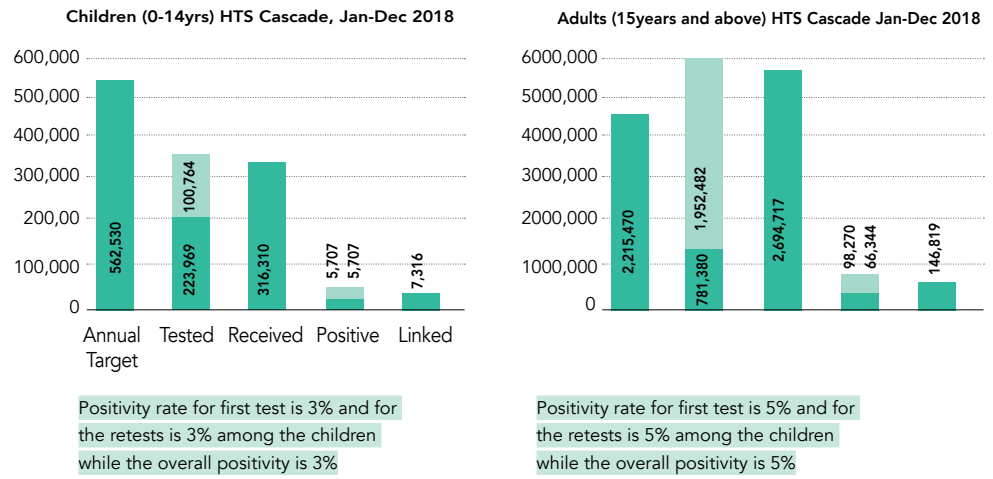
Although HIV tests conducted annually have been increasing, the rate of positivity has been declining. Positivity rate declined from 20% in 2011 to 6% in 2018 and the declining trend is expected to continue as the country reaches the "last mile" in ending AIDS. This makes it more difficulty to identify undiagnosed PLHIV to link them to ART. There is a need for HTS approaches that effectively reach children, adolescents and young people and men. Figure 26 illustrates the declining positivity rate.

Figure 26: HTS coverage and positivity rate among adults, 2011-2018



There are significant gaps in testing and linking those who HIV positive to treatment and care. For instance, 82% of children 0-14 years and 89% of adults 15 years and older testing positive were linked to treatment and care in 2018.

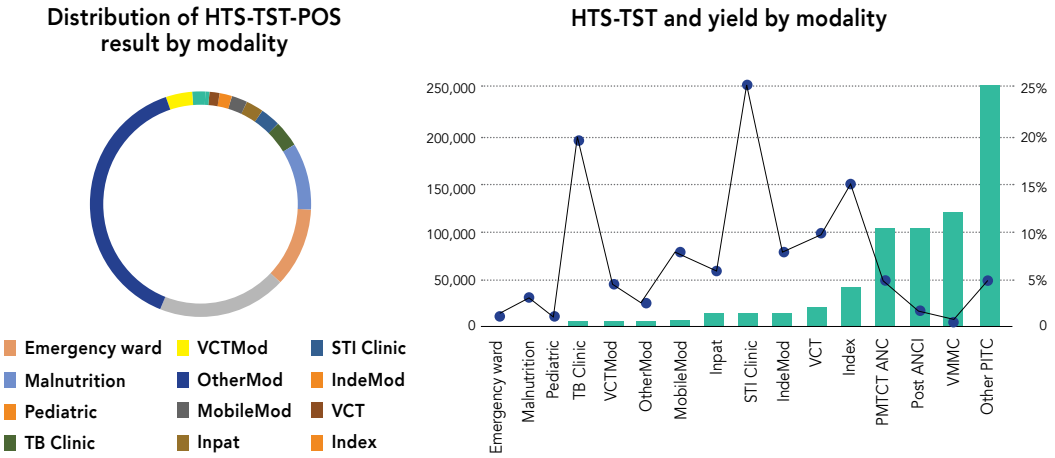
Figure 27: HTS cascade for children and adults, 2018



Going forward, the HIV response can be cost-efficient in the long run if investment in HTS is increased to identify undiagnosed PLHIV (the weakest link in the treatment cascade) as well as providing an opportunity for those testing negative to access prevention services. ZNASP IV will scale up high yield HIV testing models and intensify HTS in districts recording high new HIV infections.

HTS models that have proved to have high yield include facility and community index testing, PITC, HIV partner self-testing and HIV testing for key populations , TB and STI patients among others. Figure 28 shows the high yield HTS modalities appropriate for specific populations.

Figure 28: HTS high yield modalities[25]



25 Data source: PEPFAR 2019

Gaps

- Limited targeted roll-out of HTS to different population groups mainly children, adolescents and young people, men, people with disabilities among others
- Innovative and high yield HTS models are not implemented at the required scale
- Lack of packages for clients who test HIV negative to ensure they remain negative
- Weak linkage between HTS and ART initiation

Strategies

- ZNASP IV will scale up high yield HTS models in an equitable manner across all districts and targeting vulnerable and key populations. District level HTS targets, as is the case with other programmes, will also be set to support performance monitoring.
- Target different populations "remaining behind" in knowing their HIV status (EID, children, adolescents and young people, men, women, KPs, people with disabilities, mobile and cross border populations etc).
- Rolling-out innovative and high yield models at the required scale. These include selftesting; facility (including PITC), community and family index case tracking and use of screening tools to improve efficiency in HTS delivery. Also, scaling up use of community based service providers (including FBOs) to deliver HTS through peer identification and tracking of clients using rights based approaches
- Building the capacity of healthcare workers and community based actors to scale up HTS innovations. Capacity building will focus on documenting, standardising, provision of standard operating procedures and training tools.
- Developing and rolling-out an HIV prevention package of services for those testing HIV negative in all settings
- Integrating stigma reduction messages and advocacy in demand generation for HTS
- Optimizing population specific community and facility linkages to improve initiation of ART for those testing HIV positive

6.2 Antiretroviral therapy and viral suppression

Programme objective:

To ensure at least 95% of people living with HIV who know their status are on ART and 95% of those on ART are virally supressed by 2025.

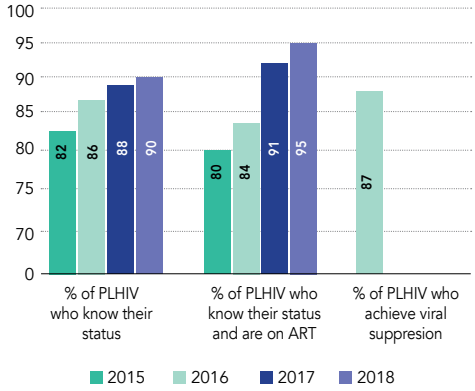
Target population:

People living with HIV

Situational analysis

Since 2015, the proportion of people living with HIV who know their status and are on ART increased from 80% in 2015 to 95% in 2018, while viral suppression among people living with HIV who are on ART was estimated at 87% in 2016.[26]

Figure 29: Progress towards 90-90-90 targets 2015-2018



As of 2018, 1.15 million people (83%) were on ART against a total PLHIV population of 1.3 million. Although national data shows significant progress towards achievement of the second 90% target, performance varied by district and age. A total of 10 districts have achieved 100% ART coverage. Nine (9) districts have 90% to 99% ART coverage. Twelve (12) districts have between 80% to 89%

26 UNAIDS Data, 2018

ART coverage while 8 districts have between 70 to 79% coverage. These districts could be considered to be on track to achieving the 90% target by 2020. Ten (10) districts have 60% to 69% ART coverage; 7 districts are within 50% to 59% ART coverage, while 3 districts have 40% to 49% coverage. These districts are unlikely to achieve the second 90 by 2020. Different approaches and levels of investment will be required based on ART coverage for each district.

Table 12: ART coverage by district, 2018

ART Coverage for all ages, 2018

District	ART Coverage	District	ART Coverage	District	ART Coverage
Gwanda	15	Chirumhanzu	69	Mutasa	89
Insiza	44	Bulilima	70	Masvingo	89
Umguza	44	Hwedza	71	Mutoko	90
Chiredzi	49	Centenary	72	Rushinga	90
Mberengwa	51	Harare	72	Chegutu	92
Binga	55	Matobo	74	UMP	93
Goromonzi	55	Mazowe	75	Chivi	94
Bubi	57	Zvishavane	76	Makonde	94
Gokwe South	57	Kwekwe	76	Makoni	95
Chipinge	58	Chimanimani	76	Hwange	96
Lupane	59	Bikita	80	Beitbridge	99
Shurugwi	60	Shamva	81	Nkayi	100
Gokwe North	61	Gutu	81	Hurungwe	102
Zvimba	62	Nyanga	83	Buhera	106
Chikomba	63	Bindura	86	Mwenezi	107
Mudzi	65	Tsholotsho	86	Kariba	109
Umzingwane	66	Murehwa	87	Gweru	114
Marondera	67	Bulawayo	87	Guruve	117
Mt. Darwin	67	Zaka	88	Kadoma	184
Mutare	69	Mangwe	88	Seke	206

ART coverage among children lags behind that of adults. However, programme data shows that within adults, men have lower coverage than women. Table 13 below shows the variation in ART coverage for adults and children across provinces. Mashonaland West, East and Matabeleland South provinces achieved the second 90 for adults by 2018, while other provinces are below target. No province has achieved the second 90% target for children. Mashonaland Central, Manicaland and Bulawayo have achieved 95% PMTCT coverage.

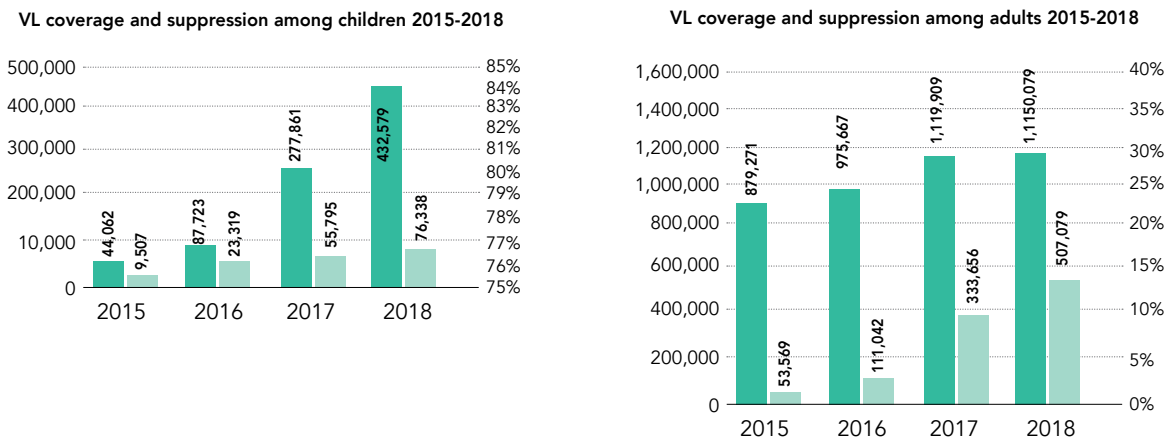
Table 13: ART coverage by age and province

Province	Adults ART Coverage (% of PLHIV)	Children ART coverage(%)	PMTCT coverage (% of pregnant women tested for HIV)
Bulawayo	75.59	67.28	98.58
Harare	69.94	54.40	92.87
Manicaland	71.47	53.17	95.81
Mashonaland Central	76.82	61.83	95.29
Mashonaland East	81.4	64.26	93.7
Mashonaland West	82.04	51.54	93.37
Masvingo	80.68	59.43	92.51
Matabeleland North	69.37	54.72	89.01
Matabeleland South	84.07	73.50	94.62
Midlands	68.21	50.26	93.05

The ability of the ART programme to retain PLHIV initiated on ART is critical for achieving viral load suppression. The ART programme introduced Differentiated Service Delivery (DSD) models designed to increase patient retention on ART. These include Community ART Refill Groups (CARGS), Community Adolescent Treatment Support (CATS) and Family ART Refill Groups (FARGS). Although the effectiveness of these models have not been evaluated, they provide a platform for enhancing retention and adherence to HIV treatment.

The country introduced and implemented viral load monitoring in line with the Viral Load (VL) Scale up plan 2015-2018. Laboratory capacity for VL testing was decentralised to 13 regional laboratories. Viral load coverage among adults increased from 6% in 2015 to 44% in 2018. Among children, the number of VL tests increased from 44,062 in 2015 to more than 400,000 in 2018, with suppression rate increasing from 82% in 2015 to 85% during the same period.

Figure 30: Trend in viral load testing from 2015-2018



Gaps

- Sub-optimal linkage of people testing HIV positive to treatment and care
- Low ART coverage in some districts and some populations such as adolescents, children and men
- HIV-related stigma and discrimination within the community and healthcare settings hindering PLHIV and key populations from uptaking and adhering to ART.
- Low adherence to treatment among mobile populations and key populations (especially female sex workers).
- Long turnaround time for viral load test results and low viral load testing coverage.

Strategies

- ZNASP IV focuses on decentralising HTS and ART services based on district and priority population baselines. District ART targets will be established to allow tracking of progress at district or sub-district level. Districts at saturation point will prioritise sustainability interventions including retaining PLHIV on ART to attain viral suppression. Districts on track to achieving the targets will have to prioritise finding PLHIV and linking them to ART, while districts off-track in ART coverage will intensify interventions with sustained monitoring to identify and address bottlenecks along the treatment cascade.
- Strengthening integration of infants and children health services to enhance testing and linkage in care for infants and children.
- Priority actions to operationalise this strategy will include orienting healthcare workers to implement HTS DSD for children; scaling up of PITC and index testing in all health facility and paediatric service points; integrating HTS and treatment services in community child health outreach programmes; strengthening nutrition assessment; and supporting and scaling up school-focused DSD model for testing, linkage and retention of children in schools.
- Enhancing retention in care for infants and children through scaling up point of care technologies including EID; optimizing formulations and treatment for children; standardising and strengthening adherence and retention package for children; and training caregivers, facility based mentoring of mothers and school nurses and teachers on HIV treatment literacy.
- Strengthening mechanisms for linking and ensuring retention of key population on ART such as peer led case-based tracking system
- Scaling up the use of community actors to improve linkage to treatment and care. This includes expanding the role of expert clients and community linkage facilitators, community – facility referrals and the use of counselling tools at community and facility level.
- Building the capacity of healthcare workers and community actors by standardising training materials and mentoring of community linkage facilitators. Capacity building will be delivered through training and mentorship and will address among other issues the negative health workers' attitudes.
- Scaling-up delivery of Differentiated Service Delivery models – CARGS, FARGS and CATS as well as developing other appropriate models such as palliative care models
- Optimising treatment regimens including scaling up of provision of TLD based regimens and supporting the phase out of NVP based regiments
- Scaling up psychosocial and mental health support through screening and appropriate management
- Sensitising community actors including PLHIV networks to provide treatment and nutrition literacy to PLHIV.
- Establishing a model for engagement of private healthcare providers in the provision of HIV treatment and care services
- Strengthening VL monitoring through decentralising viral load machines as well as a "VL lite" approach, optimising integrated sample transportation system, so as to increase demand in both healthcare workers and patients. In addition, this will institute flexible times for electronic transmission of VL results for children, adolescents and young people.

07

HIV Integration

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7.1 STIs prevention and management

Programme objective:

Effective STI diagnosis, prevention and management for the general population, people living with HIV and key populations

Target population:

All sexually active men and women, key populations and at-risk adolescents and young people

Situational analysis

Sexually transmitted infections (STIs) are monitored through the universal reporting of STI syndromes managed in the public healthcare facilities. An average of 274,000 new STI syndromic cases were recorded annually from 2010 to 2016. New STI cases reported annually are still at a high prevalence and further effort is needed to accelerate the reduction of STIs.

The country made progress in updating plans and guidelines for STI prevention and control. These include STI prevention and control strategy 2017-2021, STI management guidelines, which were revised to incorporate findings from national studies, and monitoring and evaluation tools. Routine syphilis testing for pregnant women is being conducted and reaching more than 90% coverage. Capacity to manage STIs has been improved through the training of 1500 healthcare workers on syndromic STI management. STI surveillance is also being implemented through monthly case-based reporting and ANC surveillance

Gaps

- Lack of domestic funding to support procurement of STI medicines, programming and logistics
- Limited research on STI and other surveillance studies such as Aetiology studies and GASP
- Sub-optimal availability and implementation of guidelines and policies at health facility level
- Stock-outs of STI medicines, especially benzathine penicillin, for 3 to 6 months
- User fees which are a barrier to access to STI services
- Weak laboratory capacity to support STI management including non-availability of syphilis/HIV dual test kits, weak sample referral to NMRL, lack of external quality assurance, sub-optimal testing of stillbirths and limited capacity for STI testing in large hospitals
- Weak monitoring, evaluation and reporting by public sector facilities as well as lack of reporting by private sector healthcare providers

Strategies

- The STI programme gaps listed above have remained unaddressed for several years due to lack of funding. ZNASP IV will prioritise advocacy for funding of the STI programme for the strategies outlined to be implemented.
- Strengthening STI M&E, surveillance and research
- Advocating for prioritisation of resource allocation to the STI programme
- Enhancing norms and standards for patient centred and quality STIs prevention, diagnosis and treatment through updating protocols and SOP Strengthening laboratory capacity to conduct aetiological studies and STI tests (to complement syndromic diagnosis) and train service providers to shift from syndromic management to lab based management of STIs
- Scaling up mentorship programmes at health facilities to improve the use of STI management guidelines
- Integrating STI screening in HIV prevention sites and establishing or defining mechanisms for referral of cases to STI sites for management and treatment.

7.2 HIV/TB integration

Programme objective:

To reduce TB related deaths among people living with HIV by 80% by 2025

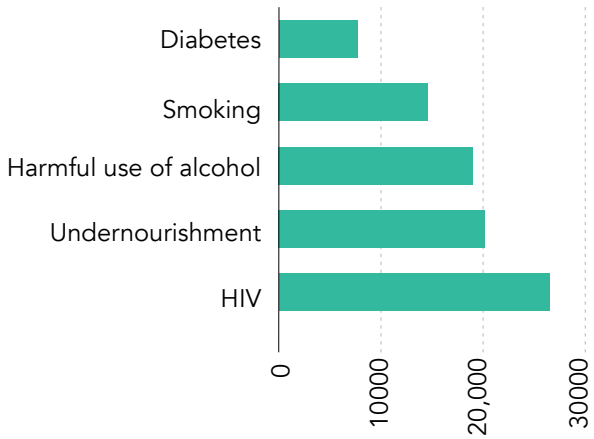
Target population:

People living with HIV and TB patients.

Situational analysis

Zimbabwe is classified as a high TB burden country. TB incidence declined from 242/100,000 in 2015 to 210/100,000 in 2018. HIV-positive TB incidence was estimated at 130/100,000 in 2018. TB/HIV co-infection declined from 70% in 2015 to 62% in 2018. TB mortality among PLHIV declined from 40/100,000 in 2015 to 24/100,000 in 2018. Despite this decline, TB mortality among PLHIV is higher, estimated at 7.7/100,000 in 2018, than among HIV negative persons. This trend shows that the TB burden is declining but still remains significantly high especially among PLHIV. Figure 31 below shows that HIV accounts for the highest proportion of TB cases.

Figure 31: Number of TB cases attributable to five risk factors, 2018



Zimbabwe provides integrated HIV/TB services to ensure PLHIV are screened for TB. Presumptive cases are tested and those with active TB are treated while those testing negative are put on TB preventative Therapy (TPT). However, coverage of IPT was estimated at a low 1.9% in 2019. On the other hand, TB patients are also tested for HIV and those testing positive are put on ART. As of 2018, 95% of PLHIV in care were screened for TB and 91% of TB patients who tested HIV positive were enrolled on ART.

Since 2015, the country has made efforts to scale up TB/HIV co-infection treatment through strengthening health and community systems. In the 32 high burden TB districts, traditional and faith healers were sensitised on TB screening and referrals, whilst communities were sensitised on HIV, TB, MNCH and Nutrition integration. Also, the HIV/ TB treatment literacy manual was revised and disseminated to civil society organisations and community support groups.

Gaps

- Low TPT uptake due to negative service provider and community attitude, stigma and stock out of TPT commodities.
- Loss of presumptive TB cases due to weaknesses in the referral system
- Integrated TB/HIV services are not always offered in central hospitals
- Reluctance to take up TB Preventive Therapy (TPT) or IPT due to previous experiences with TB treatment
- Low reporting of adverse reactions to drugs and utilization of pharmacovigilance reports.

Strategies

- Scaling-up availability of TPT in all HIV sites
- Scaling-up up TB treatment literacy among PLHIV through counselling of TB negative PLHIV and sensitization of service providers on TPT.
- Strengthening monitoring of side effects of TB treatment.

7.3 HIV and non-communicable diseases

Programme objective: To ensure 90% of PLHIV have access to early diagnostic and treatment of defined non-communicable diseases by 2025

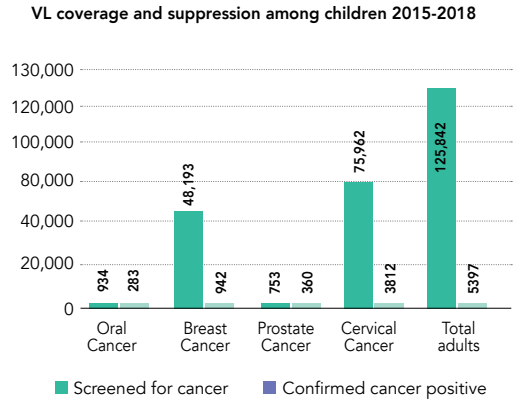
Target population: All people living with HIV

Situational analysis

ZNASP III prioritised the integration of HIV and NCDs to improve the quality of life of PLHIV. This is in response to the recognition that people aging with HIV are vulnerable to NCDs; and PLHIV are faced with NCDs starting at a younger age than those without HIV. However, very limited data is available on NCDs among PLHIV. Data available shows that some progress has been made in screening and treating cancers and hepatitis B and C.

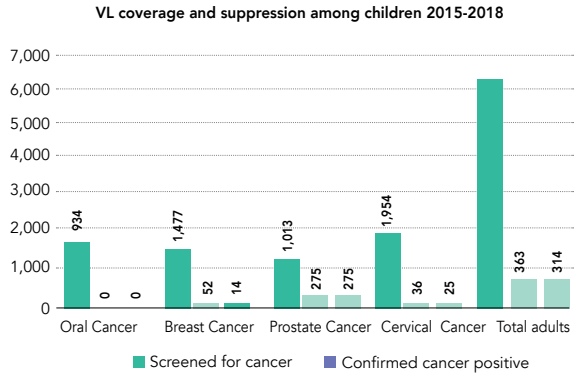
In 2018, more women were screened for cancer due to availability of tests for cancer in women compared to those for men. Figure 32 below shows that cervical cancer is the most occurring AIDS related cancer and it is critical that women living with HIV receive regular screening. As shown in figure 32 below, in 2018, 19,860 women were screened for cervical cancer and 5% were confirmed positive, which is higher than the 3% prevalence in women in the general population.

Figure 32: Cancer screening by type of cancer, 2018



A total of 6,165 adults were screened for hepatitis B in 2018 and 363 cases were confirmed positive. The highest number of those screened were Key Populations (32%) followed by pregnant women (27%). Of the positive cases, 78% (314) were put on treatment indicating a leakage of 13% of the positive cases. The highest leakage of confirmed positive cases put on treatment was among PLHIV (73%) and Key populations (31%).

Figure 33: Hepatitis B screening, 2018



The coverage for screening for Hepatitis C was also undertaken with 402 people screened in 2018. Of these, 12% of the cases screened were STI clients, 26% were PLHIV and 62% were Key Populations. There was 100% linkage to care of the positive confirmed cases.

Whereas the data above shows progress in screening and treating NCDs in PLHIV, the coverage is limited and most PLHIV are not being screened. Secondly, other NCDs prevalent among PLHIV are not systematically screened or data is not available. These include cardiovascular disease, diabetes, chronic lung disease, some types of cancers (Kaposi Sarcoma, Non-Hodgkins Lymphoma) and mental health. ZNASP IV will prioritise scaling up systematic screening and referral of NCDs patients for treatment.

Gaps

» Weak integration between HIV and NCDs such as mental health, diabetes, cancer, BP and aging
» Inadequate data on NCDs among PLHIV
» Weak linkage of confirmed NCD cases to treatment
» Sub-optimal operational research
» Low reporting of adverse drug reaction and utilization and pharmacovigilance reports

Strategies

» Updating and rolling out guidelines and tools for screening and diagnosis of NCDs among PLHIV in all HIV settings and at community level through capacity building; development of information packages, IEC materials and support supervision to health facilities and community level.
» Scaling-up HPV vaccination for adolescent girls and women living with HIV
» Integrating literacy on HIV and NCDs among PLHIV in health education, psychosocial support initiatives at health facilities and community level. At community level, engage community actors such as Faith Based Organisations, traditional healers and community health cadres in early screening and referral of cases to health facilities.
» Strengthening the referral mechanisms for PLHIV to NCDs services for management and treatment
» Strengthening data systems to collect and utilise data on NCDs among PLHIV for programming.

7.4 HIV and RMNCAH and nutrition

Programme objective:

» To ensure at least 95% of women including women living with HIV receive integrated family planning and HIV prevention services by 2025
» To ensure 90% of sexually active adolescents and young people utilize at least one sexual and reproductive health service and right, including HIV prevention services.

Target population:

All women of reproductive age prioritising women living with HIV, adolescents and young people aged 10-24.

Situational analysis

A certain level of HIV services integration into RMNCAH / nutrition has been achieved in Zimbabwe. Both HIV and RMNCAH policies and guidelines include the provision of either service in both settings. Nutrition assessment is also included in PLHIV on ART. A focal person is in place at the MOHCC to coordinate the HIV/SRH integration. At facility level, PMTCT services are offered in the RMNCAH and nutrition continuum including post-partum care and growth monitoring. Health workers are using EPI outreaches to track and identify HIV exposed infants and refer them for EID. Post Sexual and Gender Based Violence services are also offered in RMNACH sites including HTS and PEP.

Gaps

» Sub-optimal integration of reporting tools for RMNCAH and nutrition and HIV service delivery.
» Skills gap in the provision of integrated HIV/ RMNCAH/Nutrition services. For example, in some OI/ART clinics, service providers lack skills to provide long term FP methods.
» Lack of information on appropriate nutrition and unavailability of the recommended foods
» Limited comprehensive HIV prevention programming, including re-testing, for pregnant and lactating women, including their male partners.
» Sub-optimal tracking of mother infant pairs resulting in low retention
» Sub-optimal coverage of CTX and prophylaxis for HIV exposed children.

Strategies

- Strengthening HIV/RMNCAH/Nutrition integration through updating and disseminating guidelines, SOPs and job aids
- Scaling-up the provision of integrated HIV/RMNCAH/Nutrition services in all facilities. Integrated services will include HIV and STI testing of mothers seeking FP, post-natal care and other related services in high to very high prevalent districts.
- Building the capacity of HCWs and community actors (such as mentoring mothers and male motivation champions) on HIV/RMNCAH/Nutrition assessment and service delivery
- Expanding HIV/RMNCAH/Nutrition integration to the private sector healthcare providers through training, dissemination of guidelines and job aids, as well as provision of reporting tools and extending support supervision
- Establishing case-based MTCT tracking mechanisms at facility and community levels through an electronic system and using community actors to ensure early booking for ANC, tracking of HIV negative pregnant women for HIV retesting and ensuring adherence to ART at ANC and PNC periods.

08

HIV programmes for vulnerable populations

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8.1 Vulnerable Populations

Objective:

To ensure 50% of vulnerable populations receive a defined package of combination prevention services by 2025.

Target population:

Vulnerable populations in the HIV response in Zimbabwe are small scale mineworkers, mobile and cross border populations, farm workers, fisher folks, persons with disabilities and informal sector groups. These are populations vulnerable to HIV infection, but have no specific interventions targeting them.

Situational analysis

The review of ZNASP III found that there was limited specific HIV interventions targeting the vulnerable populations listed above. There are also no data on the burden of HIV among these populations. However, the pattern of HIV infections show that these populations are vulnerable to HIV for various reasons. Mineworkers, farm workers, fishermen and people in informal businesses have disposable income and are potentially engaged in transactional sex. Mobile and cross border populations spend significant time away from their families. Persons with disability are exposed to double stigma and those HIV positive have difficulties accessing services. Although evidence on these vulnerability factors is limited, stakeholders identified these populations as those so far left behind in the HIV response. In line with the ZNASP IV focus will be on reaching those furthest behind. In order to reduce HIV infections, these populations will be prioritised in the next five years.

Gaps

» Limited interventions specifically targeting vulnerable populations.
» Lack of community-based systems to collect data on vulnerable populations.
» Lack of data on HIV epidemic and HIV service coverage among vulnerable populations.
» Lack of mobilisation strategies appropriate to these groups
» Weak coordination mechanisms for vulnerable populations

Strategies

» Generating age, location and gender disaggregated data on the HIV epidemic and vulnerability factors among the vulnerable populations
» Developing and delivering a defined package of acceptable, accessible, affordable and high-quality HIV services targeted at vulnerable populations
» Creating demand for HIV services among vulnerable populations.
» Integrating vulnerable populations into existing M&E systems
» High level advocacy for HIV services among vulnerable populations

8.2 HIV response in humanitarian and emergency settings

Objective:

To ensure continued delivery of HIV and AIDS life-saving services in humanitarian and emergency situations to at least 90% of the affected populations.

Target populations:

Displaced persons, PLHIV and all HIV vulnerable persons and key populations in humanitarian and emergency situations.

Situational analysis

Zimbabwe recently experienced major flooding and displacement of persons in the Eastern region due to Cyclone Idai. During this emergency, displaced persons had difficulties accessing HIV services especially those on HIV treatment and care. The healthcare system was equally affected by the cyclone as health facilities were destroyed and health workers were also displaced. A key lesson from this disaster was that unique capacities are required to respond to HIV needs during emergencies. Other humanitarian situations affecting the HIV response in Zimbabwe include prolonged drought resulting in food insecurity and harsh economic situation in the country. This makes it difficult for PLHIV to access health services and also increases vulnerability, especially among AGYW to risky sexual behaviour. There is a need to build national capacity to provide HIV services in humanitarian and emergency settings. ZNASP IV will strengthen the country's preparedness and capacity to respond during humanitarian emergencies.

Gaps

- Limited HIV mainstreaming in humanitarian and emergency settings including disaster risk reduction policies and strategies
- Lack of minimum package of HIV services in the humanitarian and emergency situations.
- Lack of a comprehensive HIV-sensitive country-level disaster preparedness and response plan

Strategies

- Establishing mechanisms for a coordinated HIV response during humanitarian emergencies including emergency coordination team, HIV surge response team, dissemination of SOPs, as well as strengthening linkages to the national disaster response coordination structure.
- Strengthening the country's preparedness capacity to provide HIV services in humanitarian emergency settings. This will involve conducting a disaster risk assessment and identifying HIV vulnerabilities during disasters; developing service providers and community actors' capacity in preparedness for HIV response during disasters; and developing guidelines and SOPs for ensuring HIV service continuity and responding to HIV service needs of those affected by disasters.
- Integrating HIV response into the overall country disaster preparedness and response policy, plan and systems. In this respect, mechanisms will be established for seamless provision of HIV prevention, care and support services during disaster situations through integrating HIV in the essential package for commodities and other services in humanitarian emergencies.

09

Strengthening social enablers

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9.1 Policies, laws and practices, and implementation

Objective:

To promote an environment that enables and protects human and legal rights and prevents HIV related stigma and discrimination

Target population:

Justice sector institutions, law enforcement agents, human rights institutions, leaders and policy makers and vulnerable and key populations

Situational analysis

Zimbabwe has ratified various international human rights conventions and has committed to achieving the SDGs and the Africa Union HIV and AIDS goals, which mainstream a human rights approach to HIV response. The country has also committed to attaining gender equality in the constitution and set up the Gender Commission to operationalise this provision.

The Legal Environment Assessment (LEA) for HIV, TB and SRH completed in 2019 found that Zimbabwe has protective provisions in existing laws and policies such as criminal laws protecting women against violence, legal protection, ensuring inclusion of people with disabilities in all sectors, child protection laws that guarantee the rights of orphans and vulnerable children and laws that protect employees against discrimination in the work place. Employment laws that are in place prohibit discrimination of employees because of several factors including health.

The Zimbabwe constitution contains various human rights provisions relevant to HIV and TB and for protecting the rights of vulnerable and key populations. These include equality and non-discrimination (section 56), rights to healthcare (section 76), labour rights (section 65), enforcement of fundamental human rights and freedoms (section 95), rights to privacy (section 57) and access to information (section 65).

Human rights obligations assumed by Zimbabwe at the regional and international level have been domesticated through the Constitution and other laws, policies and programmes such as the National AIDS Council of Zimbabwe Act, Criminal Law Act, National HIV and AIDS policy, national HIV strategic plans, national health strategic plans, labour, HIV and AIDS regulations and the Public Health Act.

The country has an institutional framework for enforcing and implementing the laws and policies relevant to HIV and TB. The Ministry of Justice, Legal and Parliamentary Affairs leads the review and updating of laws in the country and is also a coordinator for the justice system actors. Currently, the Ministry coordinates the implementation of guidelines and protocols for addressing sexual and gender-based violence. Parliament plays a key role in the enactment of laws and has in place the health committee, which leads on health and HIV issues. The law enforcement agencies, particularly the police, have in place the victim friendly unit which offers GBV saviours (among other clients) support to have access justice. In addition, National AIDS Council is mandated to monitor and facilitate the creation of an enabling environment in the provision of HIV services (as per the National HIV Policy), through working with government ministries and departments and non-state actors.

Gaps

- Weak enforcement of the existing laws and policies in place
- On-going efforts to review some laws and policies is slow
- Several existing protective laws and policies are not aligned to the constitution and do not specifically deal with HIV, AIDS, TB and inequalities and human rights violations experienced by PLHIV, vulnerable populations such as AGYW and key populations
- Existing laws and policies on health do not adequately protect and support people living with HIV, TB, women, people with disabilities and key populations, including young key

populations to access appropriate and affordable health/HIV services
» Laws and regulations regarding age of consent to sex and access to medical information, diagnosis, prevention, treatment and care impact negatively on access to health care services by young people
» Health care workers are not protected by laws when they exercise their discretion in providing services for people below the legal age.
» Existing laws criminalising same sex sexual behaviour, sex work, drug and substance use negatively impacts on the key populations' ability to access health services and exacerbate stigma and discrimination.

Strategies

» ZNASP IV will prioritise two aspects in the next five years: improving implementation of existing protective laws and policies and advocating for reviews of laws and policies impacting negatively on access to HIV and TB services.
» Continuously tracking and monitoring progress towards legal and policy reforms and identifying areas of reform. This will involve an audit of laws and law enforcement practices to assess the impact on the response to HIV and TB and advocate for legal and policy reform based on evidence.
» Reviewing and reforming laws that increase stigma and discrimination and hinder access to HIV services including age of consent ; HIV non-disclosure, exposure and transmission; and laws prohibiting selling sex.
» Empowering people living with, at risk or affected by HIV, including all key and vulnerable populations, to know their rights and to access health, justice and legal services.
» Enhancing understanding and appreciation of legal and policy challenges as they relate to HIV and health among policy makers including members of parliament, judiciary and law enforcement officers.
» Advocating for funding to be allocated towards human rights , law reform , legal aid and legal education

9.2 Reduction of HIV stigma and discrimination

Objective:

To eliminate all forms of HIV related stigma and discrimination in settings where it occurs

Target population:

PLHIV, Key populations, students, healthcare workers, leaders and communities

Situational analysis

There is paucity of data on stigma and discrimination. Data from stigma index carried out in 2014 found that 65% of people living with HIV experienced at least one form of discrimination. The ZDHS of 2015 shows that 22% of women and 20% of men were aware of discriminatory attitudes towards people living with HIV. More so, 6% of women and 9% of men did not think children living with HIV should be allowed to attend school with HIV negative children. Furthermore, 19% of women and 16% of men would not buy vegetables from a trader known to be HIV positive.

A KP/PLHIV stigma study carried out in 2019 found that key populations (LGBT and sex workers) experienced deep rooted stigma and discrimination. For instance, it was noted that 46% of the KPs reported having subjected to gossip and discriminatory comments, whilst 40.3% confirmed having been subjected to verbal abuse at the family level. Notably, the majority of the KPs (62.7%) reported having difficulties telling others about their HIV status and 69.3% hid their HIV status from others. It was also established that 45.9% of the KPs interviewed indicated that they had delayed HIV testing because they feared health workers' negative attitude towards PLHIV. More still, 22.5% of KPs delayed HIV testing due to a bad experience with a health worker, whereas 37.5% reported having tested and started ART the same day.

Table 14: Stigma and discrimination experienced by key populations (Stigma index 2.0, 2019)

Indicator	Transgender (including male and female transgender)	MSM (Including Gay and Bisexual men)	WSW (including lesbian and Bisexual Women)	Sex Workers (Included male, transgender and females)
% that experienced stigma due to their gender identity, sexual orientation or sexual behaviour in the last 12 months	90.48%	36.25%	46.94%	58.01%
% reporting self-stigma[27]	88.10%	61.42%	63.37%	58.36%
% experienced stigma in a health setting[28]	40.48%	14.61%	17.58%	17.08%

Some of the confirmed challenges that KPs face at the health settings include verbal abuse, involuntary disclosure of their HIV status by health workers and general negative attitude. Table 14 shows selected indicators for stigma and discrimination among key populations.

Stakeholders observed that stigma and discrimination permeate communities and hinder access to services across all programmes. Adolescents and young people have challenges accessing HIV and SRH services and adhering to treatment especially in school settings due to stigma; youths in tertiary institutions avoid college clinics to seek services in health facilities where they are not known; and stigma is a key hindrance for men seeking HIV services especially HTS.

There has been attempts to address stigma and discrimination within HIV prevention and treatment programmes. There is no comprehensive approach towards addressing stigma and discrimination holistically and data on stigma and discrimination is limited.

Gaps

» Existing programmes addressing stigma and discrimination are limited in scale and scope
» Pervasive stigma and discrimination in various sectors including health, education, the work place, justice system, families and communities
» Stigma continues to be a barrier to accessing HIV services

Strategies

» Generate data to support stigma and discrimination monitoring and programming. A key intervention will be to conduct a comprehensive stigma index survey to establish stigma and discrimination baseline information.
» Developing and implementing a comprehensive programme for reducing stigma and discrimination in health settings focusing on the following actions:
  – Monitoring levels of discrimination in healthcare settings including experiences of users and attitudes of service providers
  – Training and educating healthcare workers on human rights and medical ethics competencies related to HIV
  – Empowering service users through the provision of health literacy to ensure individuals and communities understand their rights and service quality standards
  – Engaging PLHIV, women, girls, boys and key populations within the health sector in the design, implementation and evaluation of services.
  – Strengthening monitoring and reporting mechanisms to inform implementation of non-discriminatory policies and programmes.

27 This is an aggregated score of negative experiences including diminished self-confidence, self-respect, respect to others, ability to cope, ability to have close secure relationships, ability to find love, desire to have children, achievement of personal goals, contribution to community and ability to practice religion.
28 This is an aggregated score of experienced stigma in health care including being talked about badly/ gossip, verbal abuse and telling others about ones status.

9.3 Access to justice for people living with and affected by HIV

Objective:

To increase and facilitate access to justice and redress for people living with and vulnerable to HIV

Target population:

Justice sector institutions, leaders and policy makers and people living with and affected by HIV and key and vulnerable populations

Situational analysis

The country has established one-stop service centres to support survivors of gender-based violence to seek justice in some districts. These centres provide all services required by GBV survivors including health, psychological counselling and justice in one setting. Interventions are also in place to sensitise communities on GBV and women rights to reduce rights violations, facilitate reporting of cases of rights violations including GBV and improve access to services especially among adolescents and young women. The DREAMs initiative also include a component of sexual and reproductive health rights which aims at empowering AGYW to be assertive and promote their rights.

Interventions targeting other vulnerable and key populations to protect their rights and seek justice are limited. The KP programme focuses more on the provision of HIV clinical services and less on removing structural barriers such as violence, stigma and discrimination. Interventions are in place to sensitise PLHIV on treatment literacy and less on their rights and how to access justice in case of rights violations. There are limited civil society organisations or community actors focused on promoting awareness and knowledge of the justice system to enable the vulnerable and key populations access justice. The justice system itself has systemic barriers including lack of legal aid and poor case management along the justice system institutions.

Gaps

- Limited legal literacy among PLHIV, vulnerable and key populations
- Systemic barriers to access to justice services by PLHIV, vulnerable and key populations
- Negative offensive attitudes of justice services providers including law enforcement agencies
- Weak capacity and lack of specific initiatives supporting PLHIV, vulnerable and key populations to access justice

Strategies

- Enhancing the rights based sensitive policing for law enforcement agencies and actors through training and sensitisin law enforcement agencies on HIV, law and policies and the human rights of people living with HIV and key and vulnerable populations
- Increasing legal and rights literacy for PLHIV, vulnerable and key populations.
- Scaling-up existing interventions to support vulnerable and key populations to access to services e.g. one stop shop centres

9.4 Gender mainstreaming including Male Engagement

Objective

- To promote effective gender mainstreaming to achieve gender equity and equality in the national HIV response
- To ensure 90% of boys and men at risk of HIV are reached with a package of HIV combination prevention by 2025

Target populations:

Men, Women, boys and Girls

Situational analysis

Gender and women rights

The country has adopted gender mainstreaming as a strategy aimed at addressing the gender inequality in the HIV epidemic. Women and girls, are disproportionately affected by HIV, pointing to entrenched gender inequalities, power imbalances between men and women and gender norms that perpetuate patriarchy and the subordinate position of women. An analysis of the epidemiological data reveals gender inequalities in the HIV epidemic. Although HIV prevalence has been declining in the country, prevalence among women remains higher than of men. As of 2018, HIV prevalence was estimated at 15.41% among women and 10.1% among men[29]. The 2017 Zimbabwe modes of transmission study revealed that more than 16,000 new infections a year were occurring among never married women. Table 15 shows the gender disparities in the epidemic.

29 Zimbabwe Demographic and Health Survey and HIV estimates data, 2018

Table 15: Key indicators by gender 2015-2018[30]

Key Indicator	Gender	2015	2016	2017	2018
HIV Population	Males	526,864	530,843	535,685	539,017
	Females	752,917	761,484	770,507	777,952
Number of new HIV infections	Males	19,437	18,693	18,036	17,133
	Females	24,749	23,861	23,044	21,902
HIV Incidence per 1000	Males	3.11	2.91	2.73	2.52
	Females	3.89	3.65	3.43	3.17
AIDS mortality per 1000	Males	163.1	154.21	149.93	140.69
	Females	171.52	154.52	153.45	142.28
ART coverage of all HIV+ adults (15+)	Males	60	64	74	67
	Females	70	76	85	81

30 National HIV Estimates, 2018

All the above HIV indicators show gender disparities in the HIV burden. Women bear the heaviest burden in terms of prevalence, incidence and AIDS mortality.

The data reflects the influence of gender norms in the epidemic related to GBV, failure to negotiate for safer sex and harmful practices such as early sexual debut and child marriages. More effort is needed to address the gender related inequalities within the HIV national response.

Although the disparities of the HIV epidemic by sex are well documented, gender mainstreaming within ZNASP has been beset with a number of challenges. There are no specific indicators used to track implementation of gender mainstreaming and progress in addressing gender inequalities within the HIV interventions. There are also no targets set to monitor mainstreaming activities. Without specific indicators, it is difficult to assess the extent to which gender norms are shifting from being negative to positive. Also, attitudinal

changes, the capacity of partners to mainstream gender and the extent to which gender barriers to accessing HIV services have been removed. Accountability for gender mainstreaming among stakeholders and implementing partners is limited, as they are not tied to specific gender equality results. Implementing partners reported that they lack capacity and tools to mainstream gender. As a result, very few of the HIV interventions were informed by a gender analysis.

The National Gender and HIV Implementation Plan (2017-2020) is in place to provide a simplified guide for the implementation of the HIV and Gender Programmes in line with the ZNASP III (2015-2020). The Implementation Plan, expected to provide guidance on gender mainstreaming within the national HIV/AIDS response exclusively focuses on women and girls and less on boys and men.

In terms of coordination, The Ministry of Women Affairs, Gender and Community Development has a mandate to lead gender mainstreaming through the TWG on Gender. The Ministry has however not taken a proactive role in leading mainstreaming gender in the HIV response partly due to limited human resources (only 3 staffers in the department of gender) and limited financial capacity.

Given that GBV is inextricably linked to HIV vulnerability, focus has been on the prevention of GBV and provision of services to survivors. GBV levels are still unacceptably high nationally. According to the ZDHS (2015), the proportion of ever-married or partnered women 15–49 years old who experienced physical or sexual violence from a male intimate partner was at 19.8%. One in every three women have experienced GBV in their lives. GBV initiatives are implemented under the DREAMS programme where partners are engaged on male mobilisation, in-school HIV and GBV awareness and prevention initiatives, community GBV prevention and post-GBV care, parenting and social protection.

Male Engagement

In Zimbabwe 8 out of 10 men are not tested for HIV with their partners during PMTCT. Only 17-23% of men accompany their partners during antenatal care, which is an indication of poor male involvement in ANC and PMTCT.[31] Yet, 80% of women and 62% of men have been tested for HIV and have received their results. Notably, 4 out of every 10 men have never tested for HIV. There are few specific indicators tracking male involvement in the HIV response, including a supportive environment and access to services specifically tailored to heir needs. There is a general perception among men that, some of the HIV interventions such as EMTCT are for women and men are only targeted by the programmes as secondary or indirect beneficiaries. Besides having limited services targeted at men at the local health centres, the health service providers do not offer "male-friendly services". Besides lack of services targeted at men, there are also concerns that the infrastructure at the health centres is not designed with men in mind. For example, there is a "mothers' shelter" for waiting mothers, but there is no "fathers' shelter" for men waiting for their wives. The clinic infrastructure layout and design are seen by men as potentially inappropriate and uncomfortable spaces for them.

The majority of community health workers are women, making it difficult for men to participate in discussions regarding SRH (e.g. VMMC) with these female health workers. Men would be more comfortable discussing sensitive HIV issues with fellow male health workers.

Gender norms and masculinities prevent some men from seeking HIV services. Gender norms considered pregnancy to be a woman's affair and men feared that their peers would consider them "weak" or "bewitched" if they accompany their partners for clinic visits. Men are considered as "vectors" of HIV transmission by their partners and fear being blamed when the HIV test comes

31 DHS (2015)

out positive and hence they shun being tested for HIV. Men are also viewed as key perpetrators and drivers of Gender Based Violence, and this further marginalises them from participating in programmes that protect and promote the rights of women. This resulted in men's perception that they are seen as perpetrators in the spread of HIV and AIDS.

Implementation of male engagement programmes is fragmented, uncoordinated and disjointed in terms of focus and thematic coverage. There is a lack of a standardised framework for male engagement and hence different partners use different approaches. There is limited sharing of lessons learnt among partners and documentation of what is working and what is not working. Most of the FBOs and implementing partners work in silos and messaging for male engagement is inconsistent.

Gaps

- Limited mainstreaming of Gender in HIV interventions
- Perpetuation of SGBV, harmful cultural practises and negative masculinity which all increase vulnerability to HIV infection and HIV-related deaths for men, women, boys and girls
- Poor participation of men and boys in HIV prevention and management programmes
- Weak coordination of Gender Mainstreaming and male engagement initiatives and mechanisms

Strategies

- Building gender analysis and programming capacity for implementing partners to enable them to implement gender mainstreaming in their work
- Conducting a comprehensive gender analysis of the national response to guide overall gender mainstreaming initiatives and ensuring that all HIV interventions are gender-responsive.
- Establishing and scaling-up a comprehensive SRHR/ HIV male engagement programme targeting men and boys in high-risk groups and those in high prevalence/new infections settings.
- Strengthening gender-mainstreaming coordination through building the human and financial capacity of the Ministry of gender to execute its mandate of leading gender mainstreaming with the national HIV response and improving gender mainstreaming coordination at provincial and district levels.
- Developing monitoring tools such as community score cards and integrate gender into other community based monitoring tools.

10

Health and community systems strengthening

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This section outlines the gaps and strategies for strengthening health systems and community systems to deliver integrated HIV services. It covers the components of the health and community systems.

Human Resources for Health

Adequate, motivated and skilled human resources are key in the delivery of quality HIV and STIs interventions. Zimbabwe has made progress in strengthening her human resources for HIV service delivery including implementing a task shifting approach, maintaining a competent workforce through capacity building approaches such mentorship and other learning methods such as performance-based approaches to increase staff motivation.

Gaps

» High staff shortage resulting from the freezing of employment by government and inequitable distribution of health settings.
» Demotivated health workers resulting in high attrition rates
» Inadequate skills among health workers to provide specialised services such as PrEP and KP services
» High numbers of partner seconded staff at both national and sub-national levels and at service delivery points, thereby creating sustainability risk in the HIV and STI response in the event of a pull out by partners

Strategies

» Developing healthcare workers skills in both the public and private sector based on comprehensive needs assessment
» Developing the skills of community care cadres so that they are able to provide integrated HIV services
» Improving staff motivation and retention through advocating for additional staff recruitment and developing innovative staff motivation and retention schemes
» Developing and implementing a transition plan for donor seconded or supported staff

10.2 Procurement and supply chain management

» Uninterrupted availability of quality HIV commodities and supplies is necessary for HIV effective service delivery. Zimbabwe has made progress in procurement and supply chain management for HIV and STIs commodities and supplies. Notable achievements include:
» An efficient National Pharmaceutical Company responsible for procurement and supply of HIV and STI commodities exists
» A functional National Medicines and Therapeutics Advisory Committee that provides leadership in the selection of HIV and STIs commodities to be procured.
» A routine nationally implemented bi-annual quantification of health commodities with pipeline monitoring
» A coordinated procurement plan for HIV commodities
» Availability of strong partner support for HIV commodity procurement
» A Government commodity funding approach using the National AIDS Trust Fund (NATF) and the existence of a Health Levy that facilitates procurement of ARVs
» Improved infrastructure for storage of HIV commodities

Gaps

» High donor dependency for HIV commodity procurement
» Inadequate storage capacity in some health facilities
» Inadequate skills in HIV commodity forecasting, quantification and management especially at facility level
» Occasional stock outs of essential commodities including condoms, drugs for STI treatment and paediatric ART formulations
» Multiple logistics systems that are not interoperable including Zimbabwe Assisted Pull Systems (ZAPS), Zimbabwe ART Distribution Systems (ZADS) and Zimbabwe

Laboratory Commodities Distribution Systems (ZILACODS)
» Non operational commodity logistics information management system
» Unreliable transportation systems for the last mile distribution of emergency supplies.

Strategies

» Procurement of adequate and quality HIV and STIs commodities and supplies
» Strengthening storage, inventory management and distribution of HIV commodities and supplies
» Rolling- out the logistics management in formation systems to all health facilities
» Mobilising resources for procuring HIV and STIs commodities and supplies

10.2 Laboratory systems

Strong laboratory capacity is essential in the provision of quality HIV prevention and treatment services. The HIV programme review identified the following as being the key strengths of the country's laboratory systems.

» Strong laboratory assurance systems and practices in place with the national microbiology reference laboratory accredited by ISO15189. Six other laboratories have been recommended for accreditation.
» Existence of a functional sample referral system from rural health settings to the laboratory at both the national and internationally level
» Several laboratory platforms including GeneXpert present an opportunity to be used for multiple purposes
» Routine viral load monitoring has been rolled out in most health facilities
» Integrating TB/Viral load/EID through use of the GeneXpert though not at scale
» Rolling out POC testing in some districts

Gaps

» Low coverage of laboratory external quality assurance (EQA) assessment.
» Long turn-around time for VL and EID with some sites reporting a TAT of 6 months
» Weak sample transportation system. Guidelines for sample transportation are yet to be rolled out to most facilities.
» Inadequate funding leading to stock out of laboratory supplies including POC cartridges
» Erratic supply of electricity and water negatively impacting on delivery of quality laboratory services
» Weak coordination of partners supporting laboratory services
» Laboratory Information Management Systems not interfaced with lab machines, clinic electronic patient records and other MoHCC health information systems
» Poor laboratory waste management with most laboratories having limited capacity for management of liquid waste

Strategies

» Strengthening coordination in the provision of HIV laboratory services
» Strengthening quality laboratory assurance in the provision of HIV and STI laboratory services
» Increasing coverage of HIV laboratory services with special focus on VL testing and EID using, among others, point of care technologies
» Strengthening HIV laboratory infrastructure and maintenance
» Improving laboratory information management systems
» Integrating sample transportation

Community systems strengthening

Objective: To ensure that at least 30% of HIV services are community-led by 2025

Target groups: Community Systems Strengthening (CSS) encompasses PLHIV, NGOs, CSOs, CBOs, FBOs, Private Sector and Informal economy, People with disabilities and all non-state actors.

Situational Analysis

Community systems strengthening includes four key components: community-based monitoring, community led advocacy and research, social mobilisation and linkages, and institutional capacity development. The situational analysis with regard to each of these components is as follows:

i) Community Based Monitoring Systems

Community-based monitoring involves the users of targeted populations collecting, analysing and using information themselves to access quality services. It has a dimension of social accountability and empowerment. Community based monitoring systems aim at achieving two goals:

- Monitoring of health services which involves community members monitoring the flow of health services and resources. They assess whether services are available, accessible and meeting quality standards by identifying and documenting gaps and discrepancies in service provision and through appropriate mechanisms, providing data to service providers for them to make informed decisions surrounding service delivery.
- Monitoring of local conditions: communities are engaged in monitoring of local conditions or barriers that undermine or hinder the delivery of health services. For example, incidents of human rights abuses, genderbased violence, stigma and discrimination, criminalization of sex work, discriminatory drug policies, poverty and homelessness facing marginalized communities, are the typical areas of focus. Figure 34 below illustrates the various models of community-based monitoring.

Figure 34: Various models of community-based monitoring.

MODEL 1	MODEL 2	MODEL 3	MODEL 4
DOWNWARD ACCOUNTABILITY Services incorporate mechanism to allow service users to provide feedback, and for feedback to be acted upon. (e.g complain handling systems)	CITIZENS AS SERVICE DELIVERY WATCHDOG Citizens are mobilized to provide independent monitoring of services. (eg reporting stock outs of essential drugs)	LOCAL HEALTH GOVERNANCE MECHANISM Monitoring roles are given to existing formal health governance structures which include community representatives (e.g Local Health Councils, i.e community health communities/ rural health committees/ dispensary management committees)	SOCIAL AUDIT Community members are trained and supported to assess health facilities and hold public hearings in order to hold office-bearers to account. This is a comprehensive approach incorporating a variety of tools and processes. In some cases, government mandated

Currently, there are three community-based monitoring initiatives in Zimbabwe. Two of the three initiatives were supported by PEPFAR while one was supported by NAC and also by NGOs. One of the PEPFAR supported pilot was rolled out in five districts and its successor is being rolled out from 2020 in five districts. In addition, information on existing community-based monitoring tools is available but not being utilized by all CSOs, hence these innovative CBMS initiatives remain limited to the PEPFAR supported programmes and not utilized nationally. The data from these platforms have informed policy level advocacy limited to a few advocacy coalitions in their engagement with PEPFAR, the Parliament and Ministry of Health and Child care. However, there is limited or no linkage of the community-based monitoring to DHIS.

Gaps

» Weak monitoring of community activities with limited existing community-based monitoring systems and tools
» Limited social accountability and capacity to conduct community monitoring by service users and local communities to hold service providers and decision makers accountable.
» Lack of community led monitoring that ensures monitoring of the supply side of the response by the community itself.

Strategies

» Establishing existing community-based monitoring systems and tools including the lessons learnt from them and best practices
» Building the capacity of community actors and platforms to undertake community-based monitoring. Capacity building will be informed by the findings of the CBMS mapping exercise
» Prioritising, developing and implementing community- based monitoring tools: given the limited existence of these tools, the starting point will be to pilot selected tools for selected groups and locations.
» Establishing community engagement with and representation in relevant governance and oversight mechanisms
» Establishing a technical support mechanism for a community-based monitoring system to enable community actors to navigate through the CBMS cycle – from conceptualisation to data use.

ii) Community-led advocacy and research

Advocacy is key to critical consciousness and empowers communities to have a voice and demand availability, accessibility and quality services as well as holding office bearers to account. In Zimbabwe NGOs/CSOs/CBOs and religious organizations have been in the forefront of raising awareness of public health issues and challenges and advocating for appropriate responses. However, there is little research evidence in context indicating the advocacy strategies/activities are research driven. Whereas past advocacy efforts have focused on broader issues like human rights violations, stigma and discrimination, confidentiality, age and gender inequities, and sustainable financing, legal and policy reform, there is no systematic advocacy agenda let alone a unified community-led advocacy plan.

Gaps

» Limited skills to generate and use evidence. The community has limited requisite knowledge and skills for data generation and utilization of the evidence generated for robust advocacy.
» Systemic barriers to accessing data. This is exacerbated by red tape from higher governing structures that impede access to data at lower levels.
» Weak capacity to hold organizations to account, including lack of peer accountability among CSOs.
» Weak governance structures e.g. at local level which are ineffective in addressing issues e.g. health centres committees) challenges in accessing higher level governance structures because of bureaucracy, including lack of peer accountability among CSOs.
» Weak enabling environment for advocacy

(relationship between CSOs and GOVT is not conducive for advocacy due to suspicion and lack of trust)

Strategies

» Developing community advocacy agenda and plan to guide the operationalisation of advocacy activities
» Capacity building of CSOs to generate evidence and to develop and undertake evidence-based campaigns, advocacy and lobbying
» Engaging and building relationships among community actors, local governance structures and other stakeholders. This includes identifying community champions to lead and be accountable for advocacy initiatives
» Building the capacity of local governance structures through community advocacy
» Establishing a technical support mechanism for community led advocacy (in data analysis and development of advocacy products)

iii) Social mobilization, building community linkages and coordination

» Social mobilization include activities that particularly target marginalized, underserved and key and vulnerable populations to participate in the HIV response. The activities address barriers to accessing health, other social services and social determinants of health.
» A number of different mobilization strategies are in place to mobilize different sub groups of the population in the response. At community level, these include:
» Men's groups initiatives that bring men together to discuss men's health and participating in the HIV response
» HIV response champions that visit men in households and social places to create awareness
» Incentives for men accompanying pregnant women to the health facilities
» Brother to Brother initiative modelled around the sister to sister approach and boys club which brings boys to together to discuss sexual and reproductive health and rights
» Supporting groups for pregnant women
» KP Community engagement, peer-based models, navigators
» Use of sports to mobilize boys and girls
» HIV sensitive social protection programmes that integrate with the MOPSLSW

Gaps

» KP have limited technical capacity to engage effectively and participate in programming
» Low participation of AGYW in the development of initiatives targeting them
» Weak capacity (human and financial) to undertake social mobilization
» Mobility of the targeted populations e.g. youths, KPs, informal traders affects social mobilization
» Weak link between community and national level planning processes such that the needs and issues expressed by the target populations do not systemically reach at national level
» Limited funding for social mobilisation programmes

Strategies

» Developing and operationalising indicators for measuring performance of social mobilization initiatives
» Implementing social mobilization for vulnerable and key populations

iv) Institutional capacity building, planning and leadership development

Institutional capacity building, planning and leadership development encompasses activities that support the establishment, strengthening and sustainability of community-led or community-based organizations and networks that could be either informal or formal. Specific emphasis and attention is given to those organizations serving marginalized, underserved and key and vulnerable

populations. Non State Actors (NSA) within Zimbabwe are not at the same level of technical and institutional capacity. Some NSA have been in existence for over a period of time and might have acquired the necessary skills needed to effectively conduct their mandate. However, others are still in their infancy and have limitations that need to be addressed through skills strengthening in leadership.

Gaps

- Limited funding poor/ resource mobilization: this is exacerbated by limited skills in grant writing and a fractured CSO body that is not coordinated. Harmonization of CSOs allows for pulling of resources and creating funding opportunities, for example through a social contracting framework, a mechanism that allows funds to be disbursed directly to the community actors
- Weak mentorship and organizational leadership resulting in lack of skills that are key to strengthening community systems. Mentorship can be improved through adopting models such as The School Without Walls i.e. peer mentorship
- Programme Management: gaps in programme management skills among the non-state actors need to be identified and technical capacity developed using cost effective models of training.
- Poor financial systems in organisations: the key to survival of any organization is the efficient allocation and effective use of resources to ensure accountability and these should be in place in any organization
- Governance structures for non state actors are at different levels of growth, with some having weak boards and rendering accountability a challenge
- Weak human resources in terms of skills and numbers. CSOs have challenges in attracting, recruiting and retaining skilled human resources in adequate numbers due to lack of financial resources

Strategies

- Developing and rolling out a results based social contracting framework strategy
- Building the capacity of coordination structures
- Establishing a coordination and accountability mechanism for all capacity building initiatives for civil society to mitigate duplication and overlaps to maximize outcomes (who is building whose capacity)
- Developing cost efficient training capacity building modalities (moving away from classroom-based approaches) to strengthen capacity for CSOs in programme management, programme design, implementation and evaluation, fund raising, grant writing and grant management among others.

11

Coordination, strategic information and financing of the response

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11.1 Coordination of the HIV response

Objective: To Improve the efficiency and effectiveness of coordination structures and processes to contribute to attainment of ZNASP IV results

Target institutions: All organisations and stakeholders supporting and implementing the HIV response at all levels

Situational analysis

The coordination of the HIV response is led by the National AIDS Council (NAC). NAC was established by an Act of Parliament in 1999 to lead a multisectoral HIV response involving all sectors (public, private and civil society as well as development partners) at national, provincial and district levels. To this end, NAC has put in place coordination focal points for HIV prevention, HIV treatment and care, gender and making engagement, public and private sector and M&E and research. It also coordinates the development and implementation of the "one strategic framework" and the "one M&E framework" for the HIV response. A national M&E Advisory Group is in place to lead coordination of the M&E and research component of the response.

NAC's other roles include policy guidance and resource mobilisation. A National HIV Policy is in place and provides guidance on policy issues. NAC continuously monitors the policy environment and advises government and stakeholders on emerging policy issues that need to be addressed. Further, NAC manages the National AIDS Trust Fund which was set up in 2000 to mobilise domestic funding for the HIV response. In addition, NAC mobilises funds from external sources.

NAC has cascaded the coordination structures to the provincial and district levels. All 10 provinces in the country have Provincial AIDS Action Committees (PAACs) and all districts have District AIDS Action Committees (DAACs) which bring stakeholders and implementers together at these two levels to review the response and address emerging issues.

For the last five years, notable progress has been made in strengthening coordination in line with the way the HIV response is evolving. Some of the key improvements in coordination are as follows:

Establishment of coordination mechanisms for the Key Populations Programme. These include the Key Population Forum which brings together KP led organisations and implementers to review progress in the implementation of the programme and addressing of the needs of KPs. A KP TWG which reviews technical issues with regard to planning, implementation and monitoring of the programme and advises on strategic and programmatic issues, was also set up. The Technical Support Unit, which is a team of technical experts that brings technical advice, innovation and recommends adoption of best practices into the programme for quality improvement, is also a significant structure for the KP programme. Focal persons coordinating the KP programme are also in place at NAC and MoHCC.

Strengthening private sector coordination structures: two boards have been set up to coordinate private sector response, with NAC providing secretariat services. The Private Sector Coordination Board was established to coordinate formal private sector firms in providing HIV services. The Informal Economy Council was also established to coordinate informal private sector HIV interventions. Members of the Council are informal private sector associations. An informal sector HIV strategic plan was developed to guide this response.

Programmatic TWGs are also in place (some under NAC and others under MOHCC) to lead technical implementation of the response. The TWGs are largely functional and play a key role in HIV programming.

Gaps

- Lack of an over-arching platform which brings together all TWGs to review ZNASP implementation and making necessary strategic adjustments. TWGs do meet regularly but a forum to bring the TWGs together for accountability and strategic review is lacking.
- Sector coordination structures have weak capacity to effectively coordinate their constituencies. The Private Sector Coordination Board does not have funding and has operational difficulties which limits its ability to reach private firms. The Informal Sector Council does not have a direct relationship with informal sector businesses given that its members are informal sector associations. The informal sector strategic plan has not been implemented as expected due to inadequate funding. Civil society and public sector coordination platforms have limited funding and human resource capacity. The public sector also faces challenges whereby the MOHCC budget line for HIV is often spent on other non-HIV activities due to the perception that HIV is no longer a priority. Development partners work with specific entities aligned to their funding objectives and due to the reduction of the number of development partners over time, donor coordination has weakened.
- The coordination structures have also not evolved in tandem with the changes in the HIV response. The structures, including the TWGs are focusing on the traditional HIV prevention and treatment, care and support programmes, while mechanisms for coordination of emerging priorities such as social enablers, AGYW, male engagement and sustainable HIV financing have not been established.
- Lack of systematic operationalization of ZNASP.
- Limited dissemination and use of the national strategy

Strategies

- Under ZNASP IV, deliberate effort will be made to strengthen coordination at district level given that the response will be location (district) and population specific, while coordination structures at national level will be reconfigured to coordinate emerging priority programmes such as AGYW, male engagement, populations left behind, social enablers and community response. In this respect, the strategies for strengthening coordination will be as follows:
- Establishing a bi-annual ZNASP joint review and supervision platform to bring together all TWGs to review ZNASP progress and enhance accountability
- Rationalising, reconfiguring and resourcing TWGs in line with ZNASP outcomes. This process will involve streamlining TWGs to be in line with the priority programmes of ZNASP including having TWGs set up for programmes lacking coordination mechanisms.
- Developing and disseminating coordination guidelines to operationalise the changes made in coordination structures above and also to ensure effective operationalisation of ZNASP. These guidelines will spell out the updated roles of the coordination structures and how to improve the quality of their meetings.
- Supporting the rolling out of the CSO charter, engagement and accountability framework to improve civil society coordination
- Building the capacity of coordination structures to effectively coordinate ZNASP especially at district level
- Strengthening supportive supervision of the coordination structures at provincial and district levels from the national level

11.2 Strategic Information and research

Objective: Make available quality, timely and complete data and strategic information to inform policy, programming and service delivery at all levels

Target: All organisations implementing and supporting the HIV response

Situational analysis

Monitoring and evaluation of ZNASP IV is anchored on the "three ones" principle as the "one M&E framework' linked to M&E systems in all sectors implementing the HIV response and reporting on ZNASP IV indicators. These include the health sector Health Management Information System (HMIS), the National AIDS Reporting Form used mainly by civil society, M&E systems of other government ministries and private sector. These systems provide routine reporting on implementation and service delivery across all programmatic areas. The system also comprises surveys, surveillance and evaluations that track ZNASP outcomes and impact and generates evidence to inform programming.

The country has made significant investments in health information systems (HIS) for the HIV response. Achievements in improving HIS so far include the rolling out of various electronic systems including District Health Information Systems (DHIS), Electronic Patient Management Systems (ePMS), electronic health records (EHR), electronic medical records system (ePOC) and logistics management information systems (LMIS), macro database and Integrated HIV Situation room.

The strengths and weaknesses of the national M&E system for the HIV response are as follows:

- Organisational structure within M&E: M&E staff complement is well established at national and provincial level but not at district level. Staff at the district level are overwhelmed with the M&E tasks and hence provide limited capacity building in M&E to implementing partners. There are a few implementing organisations with M&E staff at sub-national level.
- Human capacity for M&E: HR capacity is severely limited especially among implementing partners where personnel collecting and interpreting data are not trained; implementing organisations have limitations due to untrained personnel or high staff turnover. Alliances with institutions of higher learning that would support capacity development are also lacking.
- M&E partnerships: The National Monitoring and Evaluation Research Advisory Group (NMERAG) brings together partners to coordinate M&E activities at national level but communication of feedback to lower levels is weak.
- National multi-sectoral HIV M&E plan: The M&E plan is in place but it is hardly known by implementers resulting in partners developing plans that do not communicate to the national strategic plan.
- Annual costed HIV M&E Plan: The plan was not costed, and is not updated annually. Also, it has no elaborate mechanism for updating ZNASP indicators annually.
- Advocacy, communication and culture for M&E: The M&E culture is mature with partners taking note of the value of data in informing programming.
- Routine HIV programme monitoring: Routine reporting system is well understood and tools are in place. However, the tools are paper based and difficult to use by those with no prior training. Further, the tools do not disaggregate data by service delivery points, and data for some indicators such as for GBV and other community level interventions are not captured.
- Surveys and surveillance: The country lacks an inventory of surveys carried out and those planned to be conducted. Also, there is no clear mobilisation strategy for resource mobilisation for surveys.
- National and sub-national databases: The data management system is weak given that data is captured in excel sheet and consolidated at provincial and national levels; there is no data validation mechanism. There are no linkages

with other information systems and there is no on-line platform, which could be used to submit data electronically.

» Supportive supervision and data auditing: there is no consistent and clear guidelines for supportive supervision and data auditing.
» HIV evaluation and research: A research agenda is in place and a number of researches have been supported. However, information on the research is not publicly available and dissemination of research beyond technical meetings is limited.
» Data dissemination: this is a key limitation. Performance of the response is not shared annually; performance against indicators is not shared with partners annually while the NAC annual report is not readily available to partners in the field. Feedback processes of data and progress reports is limited to implementing partners, with no feedback to communities.

Gaps

» Inadequate strategic information human resources capacity
» Lack of community based HIV response
» information system
» Lack of unique identifiers resulting in weak tracking and reporting of false defaulters
» Inadequate strategic information infrastructure such as lack of computers, unavailability of internet and electricity connectivity
» Lack of inter-operability between different electronic strategic information platforms
» Weak/or no reporting from private sector and uniformed service facilities
» Largely paper based system which is prone to errors

Strategies

» Migrating from aggregate to patient level reporting to support patient tracking to community level taking into account data protection and confidentiality of the reporting system
» Establishing real-time, user-friendly, visualization information management system
» Integrating qualitative monitoring into the current M&E system: The current system reports mainly quantitative data. There is need to monitor whether services are appropriate for clients and risks and to integrate the rights-based monitoring mechanisms into the M&E system
» Strengthening the systems for collecting granular data: the current system reports district level data. The systems should be strengthened to monitor geo-location of services offered or cases identified in order to track patients by service.
» Adopt electronic patient level information system: develop a community based electronic client level monitoring system that interacts closely with aggregate information system.
» Establishing a system to collect data at community level
» Strengthen the capacity of community level information systems: Develop a standardised M&E curriculum and collaborate with national institutes to build capacity of personnel at community level.
» Strengthening data dissemination and use with improved data quality:
» Developing community-based monitoring tools to provide demand side/client data.
» Incorporating indicators to provide data on vulnerable populations– people with disabilities, farm workers, small scale mineworkers, mobile populations, cross border populations, fisher folks and informal private sector
» Strengthening data linkages – strengthening systems to clearly document, disseminate and distribute data to implementing partners using standard data management and reporting processes
» Piloting innovative big-data and artificial intelligence-driven real-time monitoring of the HIV epidemic and/or response.
» Developing and rolling-out unique identifier code (UIC)
» Improving interoperability of the existing data systems
» Implementing regular Bio-Behavioural and Size estimates for Key populations
» Strengthening evaluation, surveillance and operational research

11.3 Financing of the HIV response

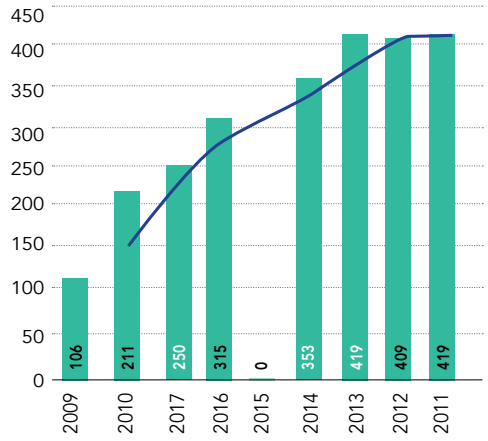
Objective:

To sustainably close the funding gap for the HIV response

Situation analysis

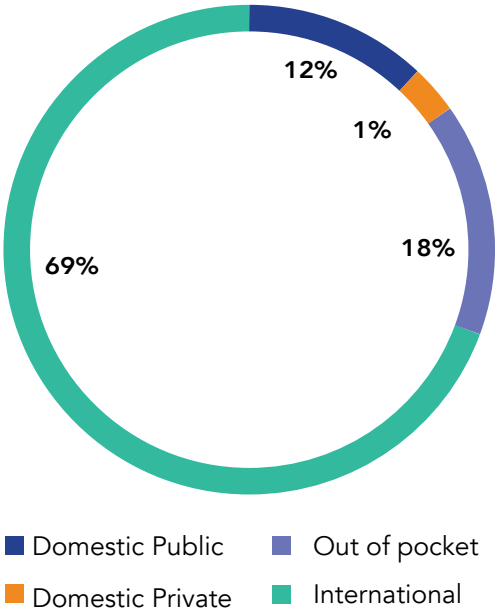
Zimbabwe has been a global trailblazer in financing the national HIV response. Through the globally acclaimed AIDS levy, substantial domestic financial resources have been mobilised. As Figure 36 shows, while investments in the national HIV response have substantially increased over the last decade, they have plateaued over the course of ZNASP III.

Figure 35: HIV investments in Zimbabwe, 2009 – 2017 (in US$)



The funding landscape of the national HIV and AIDS response is dominated by external funding which accounts for 69% of the expenditure on HIV response while domestic resources account for 31% (NAC, 2019). It is worth noting that 97% of external funding is from two sources: The Global Fund and PEPFAR. It is important to note that in-kind contributions by GoZ are excluded in the above analysis. Also, for the domestic investments, a substantial proportion is out-of-pocket (OOP) from individual with deleterious impoverishing consequences.

Figure 36: Funding by sources, 2017



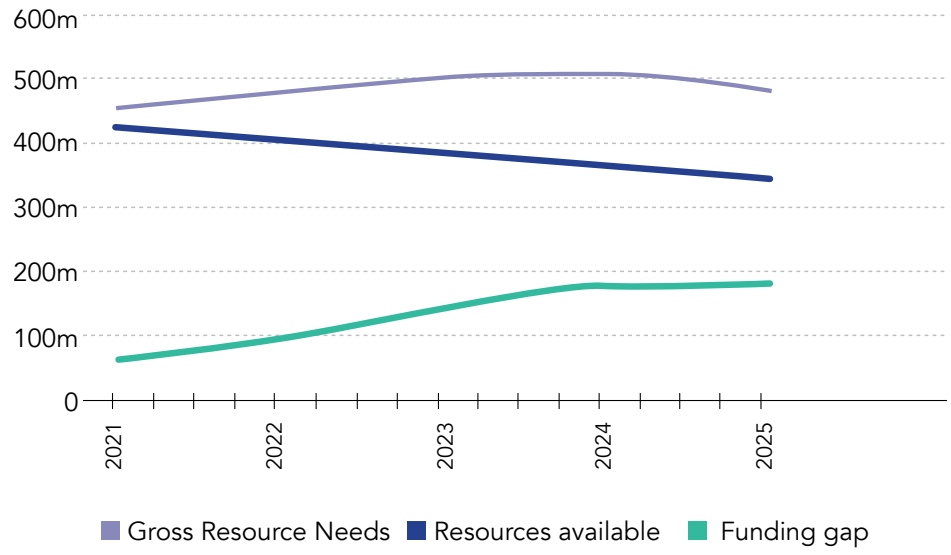
In terms of funding by programmatic expenditure, there is dismal investments in the core pillars of HIV prevention – far below the recommended Quarter for Prevention. The same is true for investments in social enablers. Given that the bulk of investments are committed to HIV treatment, this reflects limited room for improving allocative efficiencies.

Given the likelihood of donor funding flat-lining or even declining, sustainability of the results of some of the key programmes is threatened. These include condom procurement and VMMC. The country is also planning to continue initiating people on ART to reach 95% target by 2025 and this will require additional funds. In order to reducing new infections, ZNASP IV has prioritised implementing at scale, primary prevention programmes such as condoms, VMMC, interventions for AGYW, EMTCT, key populations programmes; developing interventions targeted at populations left behind, and investing in social enablers, community systems, coordination structures at district level as well as re-configuring M&E to provide granular and patient level data as well as community monitoring. These strategic shifts will require additional resources.

Resource needs for ZNASP IV

The total gross resource need is estimated at US$ 2.5 billion for the five-year period. As Figure 10 shows, comparing resource needs and projected resources available over the same period reveals a significant and growing funding gap – averaging US$ 95 million per annum. To close this resource gap, the ZNASP IV shall seek to realise efficiencies identified, implement high-impact interventions that will subsequently reduce need for services, and promote innovative and domestic financing of the response by leveraging private-public partnerships in health such as social contracting with civil society using revenues from the AIDS levy.

Figure 37: Resources needed to implement ZNASP IV, including projected resources available and corresponding funding gap (in US$)



Gaps

- Flat-lining of external funding for HIV globally and the likelihood of a decline of external funding for HIV at country level
- Insufficient funding for the HIV response, especially to combination HIV prevention.
- Inequitable allocation of funds across HIV programmes
- Limited fiscal space, including limited domestic funding for HIV response

Strategies

- Given the limited fiscal space in the country and likely flat-lining of donor funding, the strategic option left for the country is to increase efficiency of the HIV response through more effective targeting and innovative modes of service delivery.
- Strengthening public private partnerships to increase domestic resources for HIV. This will involve cooperating with private sector to increase private pharmacies' access to low priced HIV drugs which will in turn reduce cost

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Implementation of ZNASP IV

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ZNASP IV will be implemented through a multi-sectoral approach. NAC will play its core mandate of coordinating all sectors at all levels (civil society, government, private sector and development partners) to implement the strategic plan. The implementation will also be guided by the "three ones principle" where by "one M&E framework" will guide the data collection and reporting on ZNASP performance under the auspices of NAC.

Implementation processes for ZNASP will be as follows:

» Development of ZNASP IV operational plan: this plan will define the activities for ZNASP IV strategies for the first two years of implementation, identifying the lead implementers of the strategies and activities and costing for the activities. The operational plan will guide the annual periodic reviews of ZNASP implementation. It is expected that lead implementers for the ZNASP strategies and activities will ensure these activities are reflected in respective programme plans across all sectors.

» Development of district ZNASP targets: the ZNASP results framework will be cascaded to districts by having each district develop its targets. District targets will mainly be output level targets against output indicators outlined in ZNASP IV results framework. District targets will be set through a participatory processes involving implementers from all sectors, leaders and other community stakeholders and using district specific data.

» District work plans: the district workplan will include district level targets that will be used to determine gaps and prioritization of services. These work plans will set out key activities for coordinating implementation, reporting and regular reviews of progress towards achieving district targets. The stakeholders participating in setting district targets will also be involved in developing a coordination work plan to ensure they all work towards achievement of the targets. The process for developing the district targets and coordination work plans will take place concurrently.

» Development of ZNASP IV M&E Plan: this plan will operationalise the ZNASP IV results framework by identifying the M&E systems to collect and report on the ZNASP indicators as well as defining other processes for evaluation, surveillance and research. The M&E plan will include an M&E activity plan. This will ensure the M&E plan itself is implemented.

Progress in implementation of ZNASP IV will be reviewed through the following mechanisms:

» NAC will establish a joint review platform where representatives of all TWGs meet to present reports on progress of their respective programmes and also review of the overall ZNASP. This meeting will improve accountability for ZNASP results. The meetings will take place annually.

» District ZNASP progress reviews: the reconfigured DAACs will hold review meetings quarterly to assess progress towards district targets. Guidelines to define how these reviews will take place will be developed.

» Support supervision to provincial and district coordination structures: these supervision missions will be guided by a supervisory tool and will aim at identifying challenges in district level coordination and seek ways of addressing them using local solutions. NAC will lead the joint support supervision. Post supervision action plans will be developed to improve coordination.

» Real time feedback to districts and assessment of performance of district HIV responses: the situation room to be established by the strategic information management team will be utilised to engage district coordination structures and leaders real-time across all districts in order to assess the performance of ZNASP. Given the large number of districts, NAC will engage with a cluster of districts using the situation room technology at a time.

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Annexes

Annex: 1 ZNASP IV COSTING

MODULE	2021	2022	2023	2024	2025
Prevention	$ 130,144,570	$ 138,052,997	$ 145,712,636	$ 153,994,146	$ 146,239,996
VMMC	$ 33,015,667	$ 35,232,743	$ 37,366,371	$ 37,566,695	$ 17,584,762
KP	$ 25,248,714	$ 29,980,384	$ 34,551,067	$ 41,640,951	$ 52,864,664
AGYW	$ 59,241,482	$ 60,160,783	$ 61,080,037	$ 61,999,191	$ 62,918,191
Condoms	$ 12,638,707	$ 12,679,088	$ 12,715,162	$ 12,787,309	$ 12,872,378
STIs	$ 1,266,550	$ 1,265,820	$ 1,265,090	$ 1,264,360	$ 1,263,630
Differentiated HTS	$ 41,647,146	$ 42,504,698	$ 42,233,773	$ 41,893,911	$ 42,767,459
PMTCT	$ 1,565,338	$ 1,546,863	$ 1,531,618	$ 1,515,495	$ 1,492,211
Treatment Care and Support	$ 214,794,419	$ 217,336,514	$ 221,172,375	$ 223,819,502	$ 226,192,427
TB/HIV	$ 20,028,256	$ 25,675,608	$ 32,716,775	$ 37,321,170	$ 42,199,521
Service Integration	$ 1,627,154	$ 1,622,265	$ 1,617,329	$ 1,716,294	$ 1,815,104
Programme Managent & Cordination support	$ 93,137,907	$ 96,979,252	$ 101,118,247	$ 104,584,365	$ 104,690,082
Enabling environment	$ 12,330,703	$ 12,839,265	$ 13,387,235	$ 13,846,121	$ 13,860,117
Program management	$ 32,881,873	$ 34,238,041	$ 35,699,293	$ 36,922,988	$ 36,960,311
Research	$ 2,055,117	$ 2,139,878	$ 2,231,206	$ 2,307,687	$ 2,310,019
Monitoring and evaluation	$ 14,385,820	$ 14,979,143	$ 15,618,441	$ 16,153,807	$ 16,170,136
Strategic communication	$ 2,055,117	$ 2,139,878	$ 2,231,206	$ 2,307,687	$ 2,310,019
Logistics	$ 6,165,351	$ 6,419,633	$ 6,693,617	$ 6,923,060	$ 6,930,058
Program-level HR	$ 16,440,937	$ 17,119,021	$ 17,849,646	$ 18,461,494	$ 18,480,156
Training	$ 1,972,912	$ 2,054,282	$ 2,141,958	$ 2,215,379	$ 2,217,619
Laboratory equipment	$ 4,850,076	$ 5,050,111	$ 5,265,646	$ 5,446,141	$ 5,451,646
Grand Total	$ 504,211,340	$ 524,984,017	$ 547,367,844	$ 566,109,242	$ 566,660,429

ANNEX 2 ZNASP IV Results Framework

Framework	Indicator	Category	Level	Source of Data	Frequency	Disaggrega-tion
Impact	Reduced total HIV New Infections as a percentage of 2010 levels	Impact	Impact	HIV estimates	Annual	Total
			Impact	HIV estimates	Annual	Female
			Impact	HIV estimates	Annual	Male
	Reduced HIV New Infections in children 0 to 14 years as a percentage of 2010 levels	Impact	Impact	HIV estimates	Annual	Children
	Reduced HIV New Infections in adoles-cents (10 to 19) as a percentage of 2010 levels	Impact	Impact	HIV estimates	Annual	Total
	Reduced HIV New Infections 15 to 24 years as a percentage to 2010 levels	Impact	Impact	HIV estimates	Annual	Total
		Impact		HIV estimates	Annual	Female
		Impact		HIV estimates	Annual	Male
	Reduced New HIV infections per 1000 population reduced from 2.85 in 2018 to 0.57 by 2025	Impact		HIV estimates	Annual	
	Reduced New HIV infections per 1000 population reduced from 2.85 in 2018 to 0.57 by 2025		Impact	HIV estimates	Annual	
	Reduced AIDS deaths per 100,000 population	Impact	Impact	HIV estimates	Annual	
	Reduce Annual total AIDS deaths	Impact	Impact	HIV estimates	Annual	Total
		Impact		HIV estimates	Annual	Female
		Impact		HIV estimates	Annual	Male
	Reduced annual AIDS deaths among children 0 to 14 years	Impact	Impact	HIV estimates	Annual	Total
	Reduced AIDS deaths for adults (15+ years) from 18500 in 2018 to 8400 by 2025	Impact	Impact	HIV estimates	Annual	Total
	Reduced Under 5 AIDS related mortality	Impact	Impact	Special Studies	Annual	
Primary Prevention						

Baseline (2018)	2020	2021	2022	2023	2024	2025	Assumptions
39,000	45.10%	51.50%	57.90%	62.80%	66.20%	67.70%	Based on an 80% reduction from a reference year of 2010 (62920 new infections). Targets are based on 2018 estimates
22,000	45.90%	52.30%	58.60%	63.20%	66.40%	68.20%	Based on an 80% reduction from a reference year of 2010 (62920 new infections). Targets are based on 2018 estimates
17,000	44.10%	50.60%	57.10%	62.40%	65.90%	67.10%	Based on an80% reduction from a reference year of 2010 (62920 new infections). Targets are based on 2018 estimates
5,000	0.00%	8.00%	20.00%	30.00%	36.00%	38.00%	Based on an 80% reduction from a reference year of 2010 (62920 new infections). Targets are based on 2018 estimates
5500	43.60%	50.90%	58.20%	61.80%	65.50%	67.30%	Based on an 80% reduction from a reference year of 2010 (62920 new infections). Targets are based on 2018 estimates
13500	43.70%	50.40%	57.00%	62.20%	65.20%	66.70%	Based on an 80% reduction from a reference year of 2010 (62920 new infections). Targets are based on 2018 estimates
9,200	44.60%	51.10%	57.60%	63.00%	66.30%	67.40%	
4,300	41.90%	48.80%	55.80%	60.50%	62.80%	65.10%	
2.85	2.48	1.23	1.07	0.94	0.75	0.57	
2.85	2.48	1.23	1.07	0.94	0.75	0.57	
141.5	4.20%	7.80%	20.10%	29.30%	35.50%	38.60%	
21,800	15.60%	25.20%	35.30%	42.70%	47.70%	50.50%	
11,200	11.60%	22.30%	33.00%	40.20%	45.50%	48.20%	
10,600	19.80%	28.30%	37.70%	45.30%	50.00%	52.80%	
3300	12.10%	39.40%	51.50%	57.60%	57.60%	57.60%	Targets have been surpassed. Used 2018 estimates
18500	22.70%	31.90%	41.10%	47.60%	52.40%	54.60%	
				53.40%		61.40%	

Framework	Indicator	Category	Level	Source of Data	Frequency	Disaggrega-tion
HTS	Increased proportion of men and women, living with HIV who know their HIV status		Outcome	HIV estimates	Annual	Total 15+years
						Female
						Male
	Increased proportion of children (0 to 14 years), living with HIV who know their status		Outcome	HIV estimates	Annual	
	Increased proportion of people 15 to 24 living with HIV who know their HIV status		Outcome	HIV estimates	Annual	
		Outcome		HIV estimates	Annual	Female
		Outcome		HIV estimates	Annual	Male
	Increased proportion of women and men aged 15-49 who received an HIV test in the last 12 months know their HIV status		Outcome	MICS 2019 Men:		Annual
	Number of men and women who were tested and received their results increased		Output	Programme	Annual	Total
						Female
						Male
	Quantity of blood units screened for HIV increased		Output	Programme	Annual	
	Percentage of HIV positive results among the total HIV tests performed during the reporting period maintained		Output	Programme	Annual	

Baseline (2018)	2020	2021	2022	2023	2024	2025	Assumptions
90%	91%	92%	93%	94%	95%	95%	UNAIDS Baseline 2018
90%	91%	92%	93%	94%	95%	95%	UNAIDS Baseline 2019
90%		92%	93%	94%	95%	95%	UNAIDS Baseline 2020
68%	70%	80%	90%	95%	95%	95%	UNAIDS Baseline 2021
No data	90%	93%	93%	94%	95%	95%	
no data	90%	93%	93%	94%	95%	95%	
No data	90%	93%	93%	94%	95%	95%	
61%	60%	65%	70%	80%	90%	95%	
47%	60%	65%	70%	80%	90%	95%	
3,011,027	2,580,149	1,769,084	1,805,214	1,793,079	1,777,957	1,814,657	2020 is derived from Global Fund Performance framework 2018 to 2020. 2021 to 2025 are based on projected number of professional use RDTS
1,959,193	1,625,494	1,096,832	1,101,181	1,075,847	1,048,994	1,052,501	Disaggregation is based on
1,051,834	954,655	672,252	704,033	717,232	728,962	762,156	Males from 2021 are being increased by 1% for annually from 37% to 42% 2025
82257	98000	103000	108000	113500	119200	125300	
6%		5%	5%	5%	5%	5%	

Framework	Indicator	Category	Level	Source of Data	Frequency	Disaggrega-tion
Pre-exposure Prophylaxis	People at substantial risk of HIV infection reached wth PrEP increased	Pre-exposure prophylaxis	Outcome	Programme Data	Annual	
	Total number of high risk (SDCs, FSWs,MSM,AGYW, High risk men and women, PWID,Transgender, pregnant and lactating women) populations on PrEP increased	Pre-exposure prophylaxis	Output	Programme Data	Annual	Total
						Sero-discor-dant couples (SDCs)
						FSW
						MSM
						PWID
						AGYW (15-19)
						AGYW (20-24)
						Transgender
						Pregnant and Lactating women
Post exposure prophylaxis	All health staff or those potentially exposed to HIV through sexual assault (rape, intimate partner violence, or sexual abuse) or through a high risk unprotected sexual encounter reached with PEP within 72 hours of exposure	Post-exposure prophylaxis	Outcome	Programme Data	Annual	
	Health Staff reached with PEP within 72 hours of exposure		Output	Programme Data	Annual	
	Sexual and gender-based violence vic-tims reached with PEP within 72 hours of exposure increased		Output	Programme Data	Annual	
	People engaged in high risk unprotected sex reached with PEP within 72 hours of exposure		Output	Programme Data	Annual	
	Sexually abused clients received PEP (HIV, STI, ECP) within 72 hrs	Post-exposure prophylaxis	Outcome	Programme Data	Annual	
VMMC	Increased proportion of men 15 to 49 who are circumcised from 43% in 2018 to 80% by 2025	VMMC	Outcome	Programme Data	Annual	
	Increased number of men aged 15+ years circumcised as part of the minimum package of male circumcision for HIV prevention services	VMMC	Output	Programme Data	Annual	Men aged 15+ years

Baseline (2018)	2020	2021	2022	2023	2024	2025	Assumptions
Not available	65%	70%	75%	80%	85%	90%	
6528	10536	50990	79502	108818	166965	281482	
	4400	6417	6609	6676	6742	6810	
1570	2475	5940	6213	6456	6785	7122	Based on 90% of HIV negative FSWs
749	1326	1474	1637	1819	1969	2028	
124		20	44	92	194	386	
No data	1,034	13442	20,863	24909	29,694	34,148	
No data	658	16,450	36,190	60,075	111,954	212,713	
		150	206	280	462	769	Target is 90% of the eligible should have access to PrEP
		6543	7557	8693	9660	18208	
No data	100%	100%	100%	100%	100%	100%	All of these must be given PEP
	200	200	200	200	200	200	This is estimated at about 0.05 of the total Human Resources for Health (nurses and doctors)
2356	7700	8100	8500	9000	9500	10000	
No data	3000	5000	7000	9000	11000	12000	This is estimated at targeting all projected annual new infections in the age group of 15-24 years. To be finalised with programmes
25%	100%	100%	100%	100%	100%	100%	
43%	50%	60%	65%	70%	75%	80%	
299,302	330,178	331,000	370,369	4095,122	463,448	175,211	

Framework	Indicator	Category	Level	Source of Data	Frequency	Disaggrega-tion
Key Pops	Increased proportion of KP reached with the package of HIV combination preven-tion services	Key Populations and Vulnerable Groups	Outcome	Programme Data	Annual	FSW
						MSM
						Transgender
	Key populations living with HIV who know their status increased		Outcome	Programme Data	Annual	FSW
						MSM
					Annual	Transgender
	Increased proportion of Key populations who received ART	Key Populations and Vulnerable Groups	Outcome	Programme Data		FSW
						MSM
						Transgender
	FSW reached with the defined package of HIV combination prevention services increased		Output	Programme Data	Annual	Population size estimates 45 000
	MSM reached with the defined package of HIV combination prevention services increased		Output	Programme Data	Annual	Population size estimates
	Transgender reached with the defined package of HIV combination prevention services increased		Output	Programme Data		Annual
Prisons	PLHIV in prisons know their status increased		Outcome	Programme Data	Annual	
	Increased proportion of PLHIV in prisons are on ART		Outcome	Programme Data	Annual	no data
	All Prisons implementing an effective TB screening		Outcome	Programme Data	Annual	
	All Prisoners with active TB infection initi-ated on appropriate TB treatment		Outcome	Programme Data	Annual	
	PLHIV in prisons know their status		Output	Programme Data	Annual	
	PLHIV in prisons are on ART		Output	Programme Data	Annual	
	Prisoners screened for TB		Output	Programme Data	Annual	
	Prisoners with active TB infection initiated on appropriate TB treatment		Output	Programme Data	Annual	
Vulnerable groups	Vulnerable groups reached with the defined package of HIV combination prevention services increased	Key Populations and Vulnerable Groups	Outcome			
	Vulnerable populations reached with a defined packaged of combination pre-vention service increased	Condom Pro-gramming	Outcome	ZIMPHIA 2016	Annual	Total

Baseline (2018)	2020	2021	2022	2023	2024	2025	Assumptions
no data	75%	80%	85%	85%	90%	90%	
no data	65%	75%	85%	90%	90%	90%	
no data	40%	65%	75%	85%	90%	90%	
93.60%	95%	95%	95%	95%	95%	95%	
50%	65%	70%	75%	80%	85%	90%	
no data	65%	70%	75%	80%	85%	90%	
71.90%	75%	80%	85%	90%	95%	95%	
77%	80%	90%	95%	95%	95%	95%	
no data	50%	90%	95%	95%	95%	95%	
19800	33750	36000	38250	40500	42750	42750	
no data	8000	10000	12000	13000	14000	15000	The assumption is based on population size estimates done in Harare and Bulawayo (IBBS-2019)
no population size estimate							
28%	100%	100%	100%	100%	100%	100%	The assumption here is 28% of the prison population is Positive and they know their status. Hence, we want 100% knowledge in all cases of positivity
	65%	70%	75%	80%	85%	90%	
no data	100%	100%	100%	100%	100%	100%	
0.40%	100%	100%	100%	100%	100%	100%	This is to say that of all cases of TB they must be put on treatment
5572	5572	5572	5572	5572	5572	5572	The assumption here is 28% of the prison population is Positive and they know their status. Hence, we want 100% knowledge in all cases of positivity
	5572	5572	5572	5572	5572	5572	This follows the test and treat principle
	19000	19000	19000	19000	19000	19000	Assumes you screen every prisoner
22	80	80	80	80	80	80	This is to say all cases of TB must be put on treatment. This is based on TB prevalence of 0.4%
no data	10%	20%	30%	40%	50%	50%	Vulnerable groups farm workers, artesanal miners, people with disabilities, mobile and cross border populations, and fishermen)
25900	36000	41000	46000	51000	56000	60000	Artesanal miners data is available, PWD should be available, ILO should have data

Framework	Indicator	Category	Level	Source of Data	Frequency	Disaggrega-tion
Condom Pro-gramming	Increased proportion of men and women (15-49) engaged in multiple relationships in the last 12 months reporting condom use during the last sexual intercouse		Outcome	ZIMPHIA 2016		Total
						Female
						Male
	Increased proportion of men and wom-en(15-49) who reported using a condom during the last sexual intercourse with a none marital, non cohabitating partner					Female
						Male
	Increased condom use in paid sex among men and women 15 - 49 years	Key Populations and Vulnerable Groups	Outcome	ZDHS	5 years	Total
						Male
						Female
	Key populations reporting the use of a condom with a regular or steady partner increased	Condom Pro-gramming	Outcome	ZDHS	5 years	
	Key populations reporting the use of a condom with their most recent partner increased		Outcome	ZDHS	5 years	
	Increased proportion of women and men in sero-discordant relationships who reported using condoms consistently in the last sexual intercourse in the last 12 months	Condom Pro-gramming	Outcome	ZDHS MICS ZIMPHIA	5 years	Total
						Female
						Male
	Increased proprotion of young men and women aged 15-24 who can access condoms	Condom Pro-gramming	Outcome	ZDHS Male	5 years	Female
						Male
	Increased Male/female condoms distrib-uted	Condom Pro-gramming	Output	Programme Data	Annual	Female
						Male
STI	Men and women (15-49years) who had an STI in the last 12 months (by age and gender) reduced	Condom Pro-gramming	Outcome	Programme Data	Annual	Female
						Male
	Reduced new STI cases reported		Output			
	All cases of STI treated		Output			

Baseline (2018)	2020	2021	2022	2023	2024	2025	Assumptions
55%	65%	70%	75%	80%	85%	90%	
44.20%	65%	70%	75%	80%	85%	90%	
65.70%	65%	70%	75%	80%	85%	90%	
66.70%	70%					90%	
85.30%	86%					90%	
90%						95%	
90%						95%	
90%						95%	
no data						95%	
96%						95%	
25%						90%	
25%							
25%							
48.20%						90%	
86.40%						95%	
134,000,000	116m	116m	122m	128m	134.4m	141.1m	The assumption is each male condom will have its lubricant
5,000,000	4.8m	5M	5.2m	5.46M	5.733m	6m	
2.60%	2%	1.50%	1.20%	1%	<1%	<1%	
2.20%	2%	1.50%	1.20%	1%	<1%	<1%	
174,818	174,500	173,500	173,400	173,300	173,200	173,100	
	174,500	173,500	173,400	173,300	173,200	173,100	

Framework	Indicator	Category	Level	Source of Data	Frequency	Disaggregation
EMTCT	Reduced infants born to HIV-positive mothers infected by HIV	EMTCT	Outcome	HIV estimates	Annual	
	Increased proportion of pregnant women attending at least one ANC visit	EMTCT	Outcome	Programme Data	Annual	
	Pregnant women with known HIV status	EMTCT	Outcome	Programme Data	Annual	
	Pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months increased	EMTCT	Outcome	Programme Data	Annual	
	HIV positive pregnant and lactating women who received anti-retroviral therapy increased	EMTCT	Outcome	Programme Data	Annual	
	Increased proportion of Infants born to HIV positive mothers receiving ARV prophylaxis for prevention of MTCT		Outcome	Programme Data	Annual	
	Infants born to HIV-positive women received a Virological (DNA PCR) test for HIV within 2 months of birth increased	EMTCT	Outcome	Programme Data	Annual	
	Pregnant women tested for syphillis increased	EMTCT	Outcome	Programme Data	Annual	
	Pregnant women, syphillis positive, treated for syphillis increased	EMTCT	Outcome	Programme Data	Annual	
AGYP	People with comprehensive correct knowledge of HIV&AIDS increased	Behavioural Change Communication	Outcome	ZDHS	5 years	Female
						Male
	Young women and men aged 15-24 who have had sexual intercourse before the age of 15 reduced	Behavioural Change Communication	Outcome	ZDHS	5 years	Female
						Male
	Adolescents and young people reached with comprehensive HIV prevention packages	Youth	Outcome	Programme Data	Annual	Female
						Male
	Girls and boys in school reached through HIV and AIDS life-skills education	Youth	Output	Programme Data		Female
						Male
						Total
	Youth out-of-school reached with HIV&AIDS education	Youth	Output	Programme Data	Annual	Female
						Male
						Total
	Youth in tertiary institutions reached with HIV&AIDS education	Youth	Output	Programme Data		Annual
						Male
						Total

Baseline (2018)	2020	2021	2022	2023	2024	2025	Assumptions
7.80%	7%	6.5%	6.08%	5.7%	5.2%	4.8%	
93.50%	94%	94%	95%	96%	96%	97%	
99%	99%	99%	99%	100%	100%	100%	
22%	25%	26%	27%	28%	29%	30%	
93.50%	94%	95%	95%	95%	96%	97%	
72.00%	75%	77%	80%	83%	85%	85%	
63%	65%	70%	77%	85%	87%	90%	
91%	95%	95%	95%	95%	95%	95%	
80%	95%	95%	95%	95%	95%	95%	
54.60%					95%	95%	
55.70%					95%	95%	
5%						<1%	
6%						<1%	
						90%	
						90%	
1,000,000	1,010,000	1,020,000	1,030,000	1,040,000	1,050,000	1,060,000	
990,000	1,000,000	1,010,000	1,020,000	1,030,000	1,040,000	1,050,000	
1990000	2010000	2030000	2050000	2070000	2090000	2110000	
118000	123000	128000	133000	138000	143000	148000	
115000	120000	125000	130000	135000	140000	145000	
233000	243000	253000	263000	273000	283000	293000	
35000	40000	45000	50000	55000	60000	65000	
5000	6000	7000	8000	9000	10000	11000	
40000	46000	52000	58000	64000	70000	76000	

Framework	Indicator	Category	Level	Source of Data	Frequency	Disaggregation
Treatment	Increased proportion of PLHIV who are receiving ART Treatment	Treatment	Outcome	Programme Data	Annual	Total Adults
						Female
						Male
						Children
						Female 15-24
						Male 15-24
	Increased proportion of adults and children with HIV known to be on treatment 12 months after initiation of ARVs	Treatment	Outcome	Programme Data	Annual	Total
						Female
						Male
						Children
	PLHIV enrolled: outreach, facility, CARG(Community ART Refill Groups) , FARG(Family ART Refill Group) - Differentiated Service Delivery (DSD) Model		Outcome	Programme Data	Annual	Total Adults
	PLHIV on ART who are tested for viral load increased	Treatment	Outcome	Programme Data	Annual	Female
						Male
						Total Adults
						Female 15-24
						Male 15-24
	Increased proportion of PLHIV on ART who have a suppressed viral load Treatment	Treatment	Outcome	Programme Data	Annual	Total
						Female
						Male
						Female 15-24
						Male 15-24
						Total Adults
	PLHIV on ART		Output	Programme Data	Annual	Total Population
						Female Adults+15
						Male Adults+15
						Children 0-14
						Female 15-24
						Male 15-24
	Private sector (key definition) health facilities dispensing ART based on the national guidelines	Treatment	Outcome	Programme Data		Annual

Baseline (2018)	2020	2021	2022	2023	2024	2025	Assumptions
85%	91%	92%	93%	94%	94.50%	95%	
88%	93%	93%	93%	94%	94.50%	95%	
82%	91%	94.50%	93%	95%	94.50%	95%	
67%	69.80%	81%	75.40%	83.80%	81%	83.80%	
88%	93%	94.50%	93%	95%	94.50%	95%	
90%	91%	94.50%	93%	95%	94.50%	95%	
90%	91%	92%	93%	93%	94%	95%	
90%	91%	92%	93%	93%	94%	95%	
90%	91%	94%	93%	95%	94%	95%	
92%	92%	94%	93%	95%	94%	95%	
35%	55%	60%	65%	70%	75%	80%	
	50%	60%	70%	80%	85%	90%	
	50%	70%	80%	85%			
44.00%	70%	75%	80%	85%	90%	95%	Baseline 2018: There were 502 000 viral load tests done in 2018. With 1,2 million people on ART
no data	80%	92%	93%	94%	95%	95%	
no data	80%	92%	93%	94%	95%	95%	
85.30%	90%	90%	93%	94%	95%	95%	
86.1%	90%	90%	93%	94%	95%	95%	
75.10%	80%	92%	93%	94%	95%	95%	
no data	80%	92%	93%	94%	95%	95%	
no data	80%	92%	93%	94%	95%	95%	
no data	80%	92%	93%	94%	95%	95%	
1,146,532	1,220,757	1,241,360	1,262,033	1,282,279	1,295,565	1,308,194	
668,322	712,061	718,324	724,682	738,841	749,151	758,930	
419,038	454,196	470,063	486,697	495,751	502,330	508,483	
59,172	54,500	52,973	50,654	47,687	44,084	40,781	
76,215	77,145	73,742	71,052	69,730	68,744	67,903	
34,041	42,781	41,916	41,489	41,306	41,297	41,145	
no data	50%	65%	75%	85%	95%	100%	

Framework	Indicator	Category	Level	Source of Data	Frequency	Disaggrega-tion
Meaningful Involvement of People Living with HIV/AIDS	PLHIV in support groups 15-24		Output			Female
						Male
						Total
	PLHIV in support groups 25-49		Output			Female
						Male
						Total
	Adolescents living with HIV received support from CATS - Adherance monitoring		Output			Female
						Male
						Total
Services Integration						
TB	Increased proportion of PLHIV patients who were screened for TB in HIV care or treatment settings in the last visit	Integration of Services	Outcome	Programme Data	Annual	
	TB patients who are HIV positive enrolled on ART	Integration of Services	Outcome	Programme Data	Annual	
	PLHIV diagnosed of TB put on TB treated.	Integration of Services	Outcome	Programme Data	Annual	
	PLHIV newly enrolled in HIV care started on TB preventive therapy (TPT)	Treatment	Outcome	Programme Data	Annual	
	PLHIV completed TB preventive therapy (TPT)	Treatment	Outcome	Programme Data	Annual	
	TB patients tested for HIV		Outcome	Programme Data	Annual	
	TB patients enrolled on ART		Outcome	Programme Data	Annual	
	PLHIV in care screened for TB during their last clinical visit		Output	Programme Data	Annual	
	TB patients, who are HIV positive, enrolled on ART		Output	Programme Data	Annual	
Cervical Cancer	Women living with HIV (30 to 49 years) screened for cervical cancer	Integration of Services	Outcome	Programme Data	Annual	
	Women living with HIV (30 to 49 years) treated for cervical cancer	Integration of Services	Outcome	Programme Data	Annual	
	Women living with HIV (30 to 49 years) screened for cervical cancer		Output	Programme Data	Annual	
	Women living with HIV (30 to 49 years) diagnosed for cervical cancer		Output	Programme Data	Annual	
	Women living with HIV (30 to 49 years) treated for cervical cancer		Output	Programme Data	Annual	

Baseline (2018)	2020	2021	2022	2023	2024	2025	Assumptions
8000	21373	20812	20575	20494	20596	20501	Based on 30% of the 15-24 living with HIV as the target
6000	12184	12090	12257	12544	12544	12610	
14000	33557	32665	32751	33140	33140	33111	
25000	30000	180855	179817	178485	176869	174501	Calculated at 30% of the total people living with HIV as the target.
11000	26000	112827	111793	110717	110717	109179	
32000	56000	292644	290279	287586	287586	283680	
36000	37000	42000	47000	52000	57000	62000	
30000	35000	45000	50000	55000	55000	60000	
62000	72000	92000	102000	112000	112000	122000	
95%	100%	100%	100%	100%	100%	100%	
85%	90%	95%	95%	95%	95%	100%	
95%	100%	100%	100%	100%	100%	100%	
2%	50%	70%	75%	80%	85%	90%	
77%	80%	85%	90%	95%	95%	95%	
90%	100%	100%	100%	100%	100%	100%	
67%	100%	100%	100%	100%	100%	100%	Assumption is all cases of TB must be screened for HIV
37141	670000	800000	940000	1100000	1200000	1300000	This is calculated as 50% to 95% of the PLHIV and are on ART
45000	50000	55000	60000	65000	70000	75000	This is an estimated figure of 5000 person increaments
		50%	70%	80%	85%	90%	
		50%	70%	80%	85%	90%	
76000	81000	86000	91000	96000	101000	106000	
3800	4300	4800	5300	5800	6300	6800	Estimated at 500 increments
no data	4300	4800	5300	5800	6300	6800	Target is to treat all diagnosed

Framework	Indicator	Category	Level	Source of Data	Frequency	Disaggrega-tion
Mental Health	PLHIV screened for mental health	Integration of Services	Outcome	Programme Data	Annual	
	PLHIV diagnosed mental health					
	PLHIV treated for mental health	Integration of Services				
	PLHIV screened for mental health		Output			
	PLHIV diagnosed mental health					
	PLHIV treated for mental health					
Hepatitis	PLHIV screened for Hepatitis B		Outcome	Programme Data	Annual	
	PLHIV treated for Hepatitis B					
	PLHIV screened for Hepatitis B		Output			
	PLHIV treated for Hepatitis B					
	PLHIV screened for Hepatitis C					
	PLHIV treated for Hepatitis C					
	PLHIV screened for Hepatitis C					
	PLHIV treated for Hepatitis C					
Reproductive Health	Reduced unmet need for family planning among women living with HIV	EMTCT	Outcome	ZDHS	5 years	
	Contraception used among women living with HIV	EMTCT	Outcome	ZDHS	5 years	
	Women living with HIV received HIV / SRH services		Output	Programme Data	Annual	
Nutrition	Reduced proportion of PLHIV who are malnourished	Integration of Services	Outcome	Programme Data	Annual	
	PLHIV received nutritional care and support	Integration of Services	Output	Programme Data	Annual	
Social Enablers (PoliciesLaws, access to justice, stigma)						
Laws, Policies, Practices and Enforcement	Laws and policies related to HIV and TB reviewed and harmonised		Output	Programme	Annual	
	People affected/infected with HIV successfully sorted legal redress		Output	Programme	Annual	

Baseline (2018)	2020	2021	2022	2023	2024	2025	Assumptions
no data		50%	70%	80%	85%	90%	
no data		50%	70%	80%	85%	90%	
no data		50%	70%	80%	85%	90%	
no data	500	1000	1500	2000	2500	3000	
all diagnosed	all diagnosed	all diagnosed	all diagnosed	all diagnosed	all diagnosed	all diagnosed	
all diagnosed	all diagnosed	all diagnosed	all diagnosed	all diagnosed	all diagnosed	all diagnosed	
no data	10%	15%	20%	25%	30%	35%	
3%	3%	3%	3%	3%	3%	3%	This is the positivity rate of HPV B. GAM
1500	2000	2500	3000	3500	4000	4500	
50	67	83	100	117	133	150	Maintaing the same 3% positivity rate
no data	10%	15%	20%	25%	30%	35%	Estimated percentage
	<1%	<1%	<1%	<1%	<1%	<1%	Based on the positivity rate
100	150	200	250	300	350	400	
<10	<10	<10	<10		<10		
10%						6.50%	
67%						68%	
no data	375000	455000	537000	620000	706000	752000	This is based on the number of women living with HIV and increased from 50% for 2020, by 10% to 95% 2025
9%	8%	7%	6%	5%	5%	5%	
117000	104000	91000	78000	65000	65000	65000	

no data	2	2	2	2	2	2	
no data							

Framework	Indicator	Category	Level	Source of Data	Frequency	Disaggregation
Stigma	PLHIV reporting internalized stigma in the past 12 months reduced		Outcome	ZDHS	5 years	
	Percentage of PLHIV reporting anticipated stigma in the health facility		Outcome			
	Reported discriminatory attitudes towards people living with HIV, including 1) would not buy fresh vegetables from a shopkeeper or vendor who is HIV-positive and 2) think children living with HIV should not be allowed to attend school with children who do not have HIV reduced		Outcome	MICS/ZDHS/ ZIMPHIA	3-5 years	Females 15-24
						Males 15-24
						Females 15-49
						Males 15-49
	Reported stigma by key populations in health care settings		Outcome	Programme	Annual	
	Health workers reached with stigma reduction interventions		Output	Programme	Annual	
	Vulnerable and key populations reached with stigma reduction interventions		Output	Programme	Annual	
Gender including Male Engagement	Reduced proportion of women in or out of union age 15-49 who have experienced physical or sexual violence in the 12 months preceding the survey		Outcome	MICS/ZDHS/ ZIMPHIA	5 years	
	SGBV cases reported		Output			
	Programmes conducted gender analysis		Output			
	Programmes with gender responsive indicators and repored on them		Output			
Community Systems Strengthening	Communities leading the response		Outcome			
	Clients receiving HIV and AIDS services satisfied with quality of service		Output	Programme	Annual	
	Districts with community led initiatives		Output			
	Increased rate of retention of nurses at primary health care facilities		Outcome	Programme	Annual	
	Districts with ward based community based monitoring systems and tools in use		Output	Programme	Annual	

Baseline (2018)	2020	2021	2022	2023	2024	2025	Assumptions
no data						<10%	
no data						<10%	
40%						<10%	
45%				<10%			
28%				<10%			
31%				<10%			
no data						<10%	
no data	1000	1500	2000	2500	3000	3500	This is an estimated figure
no data	10000	11000	12000	13000	14000	15000	This is an estimated figure
18.70%						8%	
no data							
no data	13	13	13	13	13	13	
no data	13	13	13	13	13	13	
no data	10%	15%	20%	25%	30%	30%	
no data	50%	70%	80%	85%	90%	90%	
	30	40	50	60	63	63	
97%	100%	100%	100%	100%	100%	100%	2016 programme data baseline
to get number of implement-ing partners	10	15	30	40	50	63	

Framework	Indicator	Category	Level	Source of Data	Frequency	Disaggrega-tion
Procurement and Supply Chain	Health facilities with a functional electronic Logistics Information Management System		Output	Programme	Annual	
	Health facilities reported a stock out of the recommended first-line HIV drugs					
Laboratory Services	Laboratories accredited according to national or international standards	Laboratory Services	Output	Programme		Annual
	Lower level laboratories covered with quality assurance services		Output			
Strategic Information	ZNASP indicators reported according to reporting time frames		Output			
	Districts with district specific targets		Output			
	Percentage of district specific targets reported on		Output			
	Health facilities with functional patient level electronic reporting systems	Monitoring and Evaluation	Output	Programme		Annual
	Functional community based electronic systems (ward level)	Monitoring and Evaluation	Output	Programme		Annual
	Research and Surveillance projects conducted		Output	Programme		Quaterly
	Increased proportin of HMIS or other reporting units submitting timely reports according to national guidelines		Output	Programme		Quaterly
Coordination	ZNASP progress review conducted		Output			Biannual
	District ZNASP progress review conducted	Coordination	Output	Programme		quarterly
HIV Financing	Funding gap closed					
Local funds mobilized to support the national HIV response		HIV Spending	Output	Programme		

Baseline (2018)	2020	2021	2022	2023	2024	2025	Assumptions
5	100	600	1350	1600	1600	1600	
<1%	<1%	<1%	<1%	<1%	<1%	<1%	
1	4	4	4	7	7	11	
	100	600	1350	1600	1600	1600	
Not applicable	100%	100%	100%	100%	100%	100%	
	100%	100%	100%	100%	100%	100%	
	100%	100%	100%	100%	100%	100%	
39%	50%	60%	70%	80%	85%	90%	
Not applicable	15	30	60	63	63	63	
Not applicable	4	4	4	4	4	4	
98.97%	100%	100%	100%	100%	100%	100%	
Not applicable	2	2	2	2	2	2	
Not applicable	4	4	4	4	4	4	
40%						20%	this is 50% of the funding gap which is 100% (in this case 40% of total funding)
30%							

AIDS & TB PROGRAMME
MINISTRY OF HEALTH AND CHILD CARE