Government of Zimbabwe

ZIMBABWE NATIONAL HIV AND AIDS STRATEGIC PLAN (ZNASP) IV ADDENDUM

Commitment Towards fast tracking 95 95 95 Targets by 2020 AND ENDING AIDS by 2030

ADDENDUM of ZNASP IV (2021-2026)

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Executive summary:

Introduction

The ZNASP IV Addendum was developed based on successes, gaps and challenges identified in the National HIV Strategic Plan (2021-2025) Mid-term review, consultation meetings, and updated epidemiology data gathered through national surveillance. The addendum to the ZNASP IV incorporates strategic framework of multi-sectoral partnership to help fast track progress in reducing stigma and discrimination, new HIV infections, new babies being born free of HIV, and AIDS-related deaths.

The Addendum is rooted in international and national commitments, priorities and strategies geared toward ending AIDS as a public health threat, such as the Sustainable Development Goals (SDGs) in line with the Agenda 2030; the United Nations General Assembly Special Session on AIDS (UNGASS), Global Fund to Fight AIDS, Tuberculosis and Malaria (GFTAM), the UNAIDS' 95.95.95 Initiative, The Universal Access, and the 2011 UN Political Declaration on HIV/AIDS.. Additionally, the Addendum was guided by national ownership, focus on people centred approaches that address equity and human rights, integration of HIV services into the national health system, and ending HIV/AIDS in Zimbabwe as a public health threats by 2030.

A key component of this ZNASP IV is the advocacy to shift from a centralized to decentralized approach; districts having some autonomy to develop and monitor localized strategic plans within the broader national strategic response that emphasizes provincial and district specific contexts, epidemic and priorities. Therefore, the decentralized approach will allow for the national strategies to be tailored to fit district specific contexts. Further, local government, CSOs, private sector and development partners will continue to provide support to these efforts.

Epidemic perspective:

Zimbabwe has made some gains responding to the HIV/AIDS epidemic, but it is essential that the national response is accelerated and its services better integrated into the national health system if the country is to achieve its set goals and objectives.

Between 2018 and 2021, HIV prevalence declined to 11.58%. This is a result of an aggressive national response to contain the spread of the HIV and to both diagnose and treat those infected. However, though some progress has been made, some key populations and vulnerable groups continue to be most impacted, underserved by the response and likely to transmit the virus, including sex workers, AGYW, and other key populations. The pandemic continues to be geographically unequally distributed with varying progress towards the 95-95-95 targets across the provinces, with Matabeleland Provinces being worst affected. This has led to the assertion that for there to be further meaningful gains, efforts and resources must be oriented toward these groups and geographical areas. Furthermore, the Addendum takes into consideration natural disasters and co-pandemics that have impacted on service delivery in recent years.

To achieve the Vision set out in ZNASP the impact indicators are extend to 2026 as follows:

- To reduce new HIV infections by 70% by 2026 from 2018 baseline.

- Halve AIDS-related deaths by 2025 from 2018 baseline and sustained in 2026.
- Reduce MTCT rate to less than 5% by 2025 and sustained in 2026; and,
- Reducing inequalities where less than 10% of PLHIV and KPs:
    - Experience Stigma and Discrimination
    - And Women and Girls experience gender-based inequalities and gender-based violence

To achieve those ends, the new strategic plan proposes 4 strategic shifts that focuses on:

- 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.

Collectively, these shifts centres on preventing new infections, enhancing treatment and care support, and reducing the impact of the epidemic. As such, the strategic plan developed pragmatic strategies that align with the aforementioned shifts to deliver the set goals through community ownership.

Addendum by Thematic Area

Combination Prevention Strategies

The Strategies defined in ZNASP IV continue to be relevant in the current context. The Addendum aligns its prevention programming to global strategies which include:

- Intensified, data driven and precision prevention approach with a focus on prevention through integrated people-centered services and strengthening community systems leadership in addressing their health challenges through increased investments in community systems.
- Intensified action to address inequities, human rights and gender-related barriers through increased investments in Social Enablers
- Breaking the dichotomy of prevention and treatment, adopting a status neutral approach leveraging on the synergies of combination prevention and treatment.
- Empower and resource young people to set new direction for the HIV response and in fighting inequalities.
- Triple elimination of the maternal transmission of HIV, Syphilis, and Hepatitis

HIV Testing Services*:*

Priority Strategies:

- Focus on men, young people and key populations so that they know their status, are offered and retained in quality, integrated HIV treatment and care.
- Scale up of HISVT and index testing.
- Increase Intimate Partner Violence Screening, effective counselling, linkages, and referral in the public sector.

Pre Exposure Prophylaxis (PrEP) Services:

Community awareness and knowledge on PrEP is still low and there is stigma and discrimination associated with accessing PrEP. Service provision is not co-located with other HIV preventive services at most facilities.

Priority Strategies:

- Embracing new biomedical HIV prevention and PrEP choices such as Cabotegravir injection and Dapivirine vaginal ring.
- Rebranding of PrEP from being a prevention option for those at "high-risk" to a "Normal Service" to reduce PrEP stigma.
- Integration of PrEP messaging with other services such as DREAMs, COVID-19, VMMC and ANC
- Incorporate community lay cadres and outreach teams to create demand for ALL services during community mobilisation
- Ensure that PrEP is readily made available at all key service delivery point so as to enhance bi-directional linkages between PrEP and other services

Post Exposure Prophylaxis (PEP) Services:

Delayed reporting by clients (healthcare workers, survivors of rape and sexual abuse and those engaging in high risk sexual encounters), beyond the recommended 72hrs, affecting uptake and completion and there is limited data availability on PEP.

Priority Strategies:

- Raise awareness about PEP.
- Integrate PEP services at all points of services.
- Strengthen Public Private Partnerships for PEP including training of private practitioners and reporting systems.
- Strengthen data systems to track exposure, uptake and completion rates for PEP across the different eligible population groups

Voluntary Medical Male Circumcision (VMMC)

There is a wide variation in VMMC coverage by age across the provinces and the achievements were below the set targets reaching only 26%.

Priority Strategies

- Strengthen demand creation through synergies with other sectors and organizations and the delivery of a men-friendly package of services.
- Integrate VMMC in the pre – service curriculum and provide online training services.
- Adopt Organisational Development to address integration and sustainability of VMMC and HIV prevention.

Key Populations (KPs) and Vulnerable Groups (VGs)

Targets for Female Sex Workers were reached, but challenges continue for Men having Sex with Men (MSM) and transgender people. All groups continue to experience stigma and discrimination, hence failure to access services.

Priority Strategies:

- Adopt precision prevention and data driven approaches, such as hot spot mapping to inform programming.
- Develop and implement an advocacy strategy for addressing policies and legal issues affecting access to services by KPs and VGs, including stigma reduction strategies.
- Strengthen systems for Intimate Partner Violence and Gender Based Violence (GBV) response including post violence care, through community engagement processes and training of service providers and community cadres.
- Build the capacity of service providers to deliver KP and VG friendly services through training and mentorship

Condom Programming

Though condom distribution is high, communities noted limitations in accessing condoms, where either location is not conducive to collect or there is no direct evidence of usage as unused condoms are easily thrown away.

Priority Strategies:

- Continue to advocate for domestic resource, including PPP, to support the national condom programme.
- Strengthen implementation of the condom demand generation strategy informed by the market segmentation study.
- Use of automated Condom (and other health products) dispensing machines for placement at private, strategic and convenient places

Sexually Transmitted Infections (STIs)

HIV testing rates among STI clients ranged from 55% to 83%, a low considering STIs are major drivers of HIV infections. More needs to be done to integrate STI clients into the HIV prevention and treatment cascade.

Priority Strategies

- Mobilise resources to ensure availability of STI medicines, diagnostic and monitoring services.
- Integrated messaging on Sexual Reproductive Health, HIV and condom use to empower youths, KPs, pregnant and lactating women and men to reduce self-stigma and increase demand for services.
- Engage male mobilizers to assist Village Health Workers with partner notification.

Elimination of Mother to Child Transmission (eMTCT)

The MTCT rate in the of 8.9% continues to be high. An analysis of the MTCT HIV infections in the country in 2021 revealed that the three interventions of initiating all the pregnant and lactating women living with HIV on ART, retaining them in care with viral suppression and offering PrEP to those that are HIV negative will lead to the reduction of MTCT to 859 infections (MTCT rate of 1,60%).

Priority Strategies

To compliment the triple elimination strategy, the country should strengthen the implementation of the four strategic pillars of the Global Alliance to end AIDS in Children, including

- preventing and detecting new HIV infections among pregnant and breastfeeding adolescents and women.
- closing the treatment gap for pregnant and breastfeeding women living with HIV and optimizing continuity of treatment towards the goal of elimination of vertical transmission.
- early testing and optimized comprehensive, high quality treatment and care for infants, children, and adolescents living with and children exposed to HIV.
- addressing rights, gender equality and the social and structural barriers that hinder access to services.
- In addition, the ZNASP emphasises the integration of HIV and Reproductive and Maternal, Neonatal and Child Health and Nutrition services

Adolescent Girls and Young People

Adolescent girls and young people constitute a large portion of the new infections in the "never married females" and "never married uncircumcised males" who are contributing 41% of the new infection. Inequalities of access to services for young people continue through laws and policies such as the age of consent that inhibit access to essential reproductive health services. Drug and substance abuse amongst the young people is known to be rampant but has not been quantified, and its contribution to HIV infections is yet to be verified.

Priority Strategies

- Scale up strategies that are integrated and layered for both AGYW and ABYM across sectors such as education and social services.
- Address laws and policies that increase inequalities amongst the young people particularly on access to reproductive health services, stigma and discrimination.
- Increase the flawless integration of HIV combination prevention services to treatment and care services for young people and reduce loss to follow-up.
- Quantify and incorporate drug and substance use strategies in the response.

Treatment

A significant proportion of PLHIV are still presenting late with advanced HIV disease based on CD4 testing and clinical staging. In addition, a significant proportion of (22%) of the people in care are people ageing with HIV who are at a higher risk of commodities such as non-communicable diseases. Other emerging priorities include mental health, including alcohol and substance abuse, hepatitis. Despite the transition to more optimised regimens, an increasing number of clients are failing on treatment. Furthermore, attrition remains a challenge with an increase from a baseline of 10% in 2018 to 16.46% in 2021 and was slightly higher among males compared to females.

Priority Strategies

- Scale up of peer-to-peer support through the CATS model, young mentor mothers, young mentor dads to enhance uptake, linkage and continuity in care including screening and management of common mental health disorders.

- Scale up Differentiated Service Delivery (DSD) models at community and facility level targeting different subpopulations such as men, adolescents and KPs, tailored to their needs and preferences Community ART initiation.
- Strengthen viral load demand creation activities through identification of clients due for VL through cohorting and use of appointment registers, enhancing the DSD model
- Mobilize resources to set up HIV DR testing and procurement of Analyzers and accessories.
- Capacity building of HCW for HIV DR monitoring (pre-treatment, PrEP users and 3rd line ART)
- Expedite the decentralization of third-line ART at central and provincial levels
- Build the capacity of health workers to manage advanced HIV disease, clients ageing with HIV and comorbidities including NCDs, cervical cancer, common mental health disorders.
- Improve, assure and manage the quality of care for HIV, hepatitis and STIs.
- Mobilise resources to ensure the continuous availability of HIV, STI and hepatitis medicines, related commodities including lab reagents and other consumables.

Services Integration

Integration of HIV services in routine care continues to be weak on the ground as characterised by lack of HIV data in various other care programmes. This paucity of data reflects the silos of programme services, where HIV services are not fully integrated in routine points of services.

Priority Strategies

- Actively engage Integration Services Specialist/Implementation Research expertise in ensuring HIV integration is realised on the ground.
- Capacitate primary level of care staff in the prevention, screening and management of mental health, hepatitis, non-communicable diseases and nutrition issues among PLHIV including children and adolescents
- Empower PLHIV and communities through literacy sessions, dialogues, digital and social media platforms to increase demand for comprehensive services for including ADH, NCDs, mental health and nutrition.

Social Enablers

Laws and Policies

ZNASP IV is up to date with Zimbabwe's laws towards the access to services, where there are still limitations due to policy limitations such as the age of consent which limit the services that young people can access. More needs to be done towards policies that are limiting access to services particularly for AGYP and key populations.

Stigma

Stigma continues to be a contributing factor towards inequalities in ending HIV/AIDS. The recent stigma index study shows the Stigma experienced by PLHIV in Zimbabwe was as high as 69.7%.

Priority Strategies

- Develop appropriate targeted comprehensive stigma reduction programmes in health care settings

Gender Including Male Involvement

There is now a rallying call for gender inclusivity that places emphasis on GBV, IPV and violence against KPs as these enhance inequalities in the fight against HIV. Gender responsive programming that challenges harmful gender norms and stereotypes and support community-led advocacy to strengthen laws and, policies protective of survivors to violence.

Priority Strategies

Communities must be empowered to monitor, document and report cases of violence, ensuring referral and protective services and justice

Community Systems Strengthening

CSS complemented contributions to ZNASP IV through decongesting health facilities over-burdened by HIV and offering vital services to communities . The objective of CSS is to ensure that at least 30% of HIV services are community led by 2025. On the ground there is absence of a CSS Capacity Building Plan, CSS Guidelines to guide communities, community advocacy and research agenda.

Priority Strategies

- Develop more appropriate indicators and data collection mechanisms to track CSS.
- Develop a Community Capacity Building Plan that is supported by a comprehensive guidelines.

Monitoring and Evaluation

Unavailability of quality, timely and granular data on size estimates, the burden of disease, coverage and access to HIV and STI services by different groups to inform programming, decision and improvement efforts.

Priority Strategies:

- Develop and implement an HIV prevention package and roadmap based on data driven assessment of HIV prevention needs and emphasises the adoption of precision prevention approach.
- Strengthen and integrate data systems to track clients horizontally across all service points, integrating HIV services to other services.
- Identify and strengthen research priorities across all thematic areas as part of data driven programming.

Resource needs estimates:

The total estimated resource needs for the next 3 years is U$1.7 billion. It increases from US$572 million in 2024 to US$579 million in 2026. Prevention costs are expected to fall from $160 million in 2024 to 135 million in 2026 due to lower targets in key programs such as VMMC as it approaches saturation. Treatment care and support costs are forecasted to range from $192million in 2024 to $209 million in 2026. Treatment, Care, and support commands an average of 35% of the resource requirements per year, followed by prevention at 25% and program management and support at 22%. Domestic public funds will average $64 million per year which is approximately 11% of total annual resource requirements. External resources from developmental partners are forecasted to contribute an average of $361 million per year representing approximately 64% of resource requirements per year. The financial gap is expected to range between 23% and 26% and average 25% over the period 2024 to 2026. Due to

external funding decreasing, government funding needs to increase to reduce the financial gap.

Conclusion:

The ZNASP IV has generated some optimism about the national response and its ability to eliminate HIV/AIDS and STIs as a public health threat by 2030. The current ZNASP strategies are yielding results and are still relevant for the future. The addendum has forged an alignment of the current strategy to the global targets. The strategic plan has outlined pragmatic strategies that could leave a lasting impact in the fight to eliminate HIV/AIDS and STIs as a public health threat in Zimbabwe; however, it is imperative that emphasis be placed on the building upon the gains made, investing in the response, and supporting a collaborative environment.

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Acronyms

List Acronyms

AGYP	Adolescent Girls and Young People
AGYW	Adolescent Girls and Young Women
AHD	Advanced HIV Disease
ANC	Antenatal Care
ART	Antiretroviral therapy
CATS	Community Adolescent Treatment Supporters
CLM	Community Led Monitoring
COVID-19	Coronavirus Disease of 2019
CSI	Coping Strategy Index
CSS	Community Systems Strengthening
DREAMs	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
DSD	Differentiated Service Delivery
EID	Early Infant Diagnosis
eMTCT	elimination of Mother-to-Child Transmission
FSW	Female Sex Workers
GBI	Gender Based Inequalities
GBV	Gender Based Violence
GDP	Gross Domestic Product
GF	Global Fund
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HCW	Healthcare Workers
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HRH	Human Resources for Health
HTS	HIV Testing Services
IPV	Intimate Partner Violence
KP	Key Population
LMIS	Logistic management information systems
M&E	Monitoring and Evaluation
MSM	Men who have sex with Men
MoHCC	Ministry of Health and Child Care
MOT	Modes of Transmission
MOU	Memorandum of Understanding
MTCT	Mother-to-child transmission
MTR	Medium Term Review
NAC	National Aids Council
NATF	National AIDS Trust Fund
NCDs	Non-Communicable Diseases
PBFW	Pregnant and Breastfeeding Women
PEP	Post Exposure Prophylaxis

PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider-Initiated Testing and Counselling
PLHIV	People Living with HIV
PNC	Postnatal Care
PrEP	Pre-Exposure Prophylaxis
PWDs	People with Disabilities
RSSH	Resilient and Sustainable Systems for Health
SASA	Start Awareness Support Action
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender Based Violence
S2S	Sister to Sister
SRH	Sexual and Reproductive Health
SSA	Sub-Saharan Africa
STI	Sexually transmitted infections
SWs	Sex Workers
TB	Tuberculosis
TGW&GQ	Transgender Women and Gender Queer
TLD	Tenofovir, Lamivudine, and Dolutegravir
TSC	Technical Support Committee
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
VAT	Value Added Tax
VHWs	Village Health Workers
VL	Viral Load
VMMC	Voluntary medical male circumcision
ZimPHIA	Zimbabwe Population-based HIV Impact Assessment
ZNASP	Zimbabwe National HIV and Aids Strategic Plan

1. Introduction

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 five years. The vision of the strategic plan is centred on Ending AIDS as a public health threat through accelerating the scale up of HIV programmes and transitioning the HIV response into a sustainable phase.
The ZNASP IV places 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.

It is against these strategic shifts that guided the review to take stock of the progress to date and realign if necessary to attain the intended targets, hence the Midterm review (MTR).

1.1 Motivation of the MTR

The purpose of the MTR was to take stock of progress (what is working and not working) including the country's alignment to changes in the global response and the impact of the response in the country. The Mid-term review was crucial to re-align the ZNASP targets to end Inequalities and Pandemics. The implementation of the ZNASP was affected by COVID-19 pandemic and guidelines were put in place to provide HIV services in COVID-19 environment. Due to these changes in programming, most of the results in the ZNASP have been lagging in progress or overtaken by events. This therefore called for the need to review and re-align the strategy accordingly and guided by emerging strategic information. Thus MTR will lead to reprioritization, retargeting and the revision of the Results Framework, Monitoring and Evaluation Plan, Research Agenda and addition of other strategies in the plan basing on the lessons learnt and new proposed indicators. The MTR for the ZNASP IV will be an opportunity for joint review of the HIV response considering the impact of Covid-19 and allow for setting targets and priorities for the year 2026.

1.1.1 The effect of Inequalities

The ZNASP IV aimed to align its strategies to the new Global AIDS Strategy (2021–2026) which seeks to reduce the inequalities that drive the AIDS epidemic and put people at the centre. Programming experience and evidence from the country's HIV response show that intersecting inequalities are preventing progress towards ending AIDS as a public health threat by 2030. The gaps in HIV responses and resulting HIV infections and AIDS related deaths lie upon fault lines of inequality. From its beginning, the HIV epidemic has represented an acute

health inequality, affecting some key populations much more disproportionately. Inequalities illustrate why the HIV response is working for some people, but not for others. Structural Inequalities and determinants of health like education, occupation, income, home and community all have been found to have direct impact on health and HIV outcomes.

In the current MTR, it was noted that men are less likely than women to access HIV services and have poorer HIV-related outcomes, including lower rates of antiretroviral therapy (ART) initiation and viral suppression. Children are also being left behind a clear testimony of inequalities among the targeted population.

1.1.2 Changes in Global Strategies

The best of the global AIDS response to date has shown us the absolute necessity of both leadership and partnership. It draws on lessons from the country specific past experience to map out the path for the future. Above all, it calls on all sectors of society to show leadership in galvanizing the response to HIV/AIDS — among provinces, districts, towns and villages, young people and those not so young, companies and community organizations, countries and continents.

The changes in the global strategies also guides the changes in country specific strategies (ZNASP IV). The changes in strategic shifts for global strategy are unpacked and summarized as:

- **Less than 10%** of people living with HIV and key populations experience stigma and discrimination by 2025
- **Less than 10%** of people living with HIV, Women and Girls and Key Populations experience Gender Based Inequalities (GBI) and Gender Based Violence (GBV) by 2025
- **Less than 10%** of countries have punitive laws and policies by 2025

The Strategy's three strategic priorities are reflected in the three categories of the targets and commitments: *comprehensive, people-centred HIV services; breaking down barriers by removing societal and legal impediments to an effective HIV response; and robust and resilient systems to meet the needs of people.* The Strategic shift identifies ***where, why and for whom the response is not working***. Drawing on key lessons learned from the intersecting AIDS and COVID-19 pandemics, the Strategy leverages the proven tools and approaches of the HIV response and prompting the MTR to align direction on the changes needed.

1.1.3 Disaster Preparedness

ZNASP IV also highlight strategies to address HIV in humanitarian and emergency settings**.** These 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 like the Cyclone IDAI and Covid-19; and integrating the HIV response into the overall country disaster preparedness and response plan and systems. They are also emerging disasters that are affecting different populations. These include drug use and sex parties that are affecting young people as they exacerbate the risks of HIV infections. Based on this there

is need to develop a preparedness plan as a country to see what mitigatory measures can be put in place in case of any emergencies and or disaster.

1.1.3.1 Impact of Covid-19 to the HIV response under ZNASP IV

The COVID-19 pandemic has threatened continued access to public health services worldwide, including HIV prevention and care. In Zimbabwe COVID 19 disrupted health service delivery due to lock-downs which restricted movement of patients and implementers. The lock-downs worsened economic well-being of the largely informally employed population working in a sector that did not provide social protection. The proportion of households with acceptable coping strategy index (CSI) fell from 60% in 2019 to 39% in 2020 before recovering to 64.4% in 2021[1]. It measures behaviours of households when faced with difficulty in covering their food needs and thus, the decline of the acceptable CSI during the first year implies compromise in nutrition for HIV, TB, and co-infection patients.

Other disrupted services include TB and VMMC. Households TB Treatment Coverage fell from 72% in 2019 to 54% in 2021. Access to ARVs was erratic for patients while provision of ARVs in the open spaces breaching confidentiality caused psychological issues among PLWHIV. VMMC procedures declined from 24 000 in 2020 to a few hundred[2]. Co-morbidities such as TB and cancer were affected with patients failing to get scheduled treatment. About 60% of PLWHIV could not get key SRH supplies such as contraceptives and condoms. At least 55% PLWHIV were unable to get psychosocial support while Early Infant Diagnosis (EID) also declined in 2020. AIDS related deaths increased from 20 100 in 2019 to 22 200 in 2020 while quality adjusted life years were also lost due to disability from COVID 19[3]. The implementation of adolescent girls and young women (AGYW) and key population (KP) community activities stalled due to lock-downs[4].

Comprehensive Sexuality Education (CSE) reach for young people 10-24 was zero percent as schools were closed in 2020. Lockdown measures negatively impacted prevention activities in the sister to sister (S2S) program, especially HIV testing. AGYW school dropout rates increased from 0.43% to 3% in 2020. Teenage pregnancies were reported to be very high during lockdown. The government reported 5,000 cases of teenage pregnancies in Jan and Feb of 2021[i]. These numbers are reported in the media as an underestimate of the cases. Restrictions in movement limited sex workers from accessing prevention services such as condoms, PrEP, as well as ART which increased the risk of new infections and viral load suppression[5]. Movement restrictions meant stiffer competition in their local areas which reduced bargaining power in relation to safe sex[6]. Social and economic marginalization also increased for sex workers (SWs) as their trade does not offer social protection. Some were forced to defer lockdown rules increasing chances of COVID 19 infection while on the other

[1] UNDP (2021) ZRBF Outcomes monitoring survey.

[2] Haacker and Obst. 2021. Economic Implications of Covid-19 for HIV and the HIV Response in Zimbabwe

[3] Madzima, et al 2022. The impact of the COVID-19 pandemic on people living with HIV in Zimbabwe. *African Journal of AIDS Research*, *21*(2), pp.194-200.

[4] UNDP 2021. GF PMU annual report 2021

[5] Museva, et al. 2021. Sex workers and livelihoods under the COVID-19 pandemic in the city of Masvingo, Zimbabwe. Mankind Quarterly, 62(1).

[6] Machingura, et al. Potential reduction in female sex workers' risk of contracting HIV during coronavirus disease 2019. Aids, 35(11), pp.1871-1872.

hand, increasing their vulnerability to harassment, sexual and physical violence, and incarceration[7].

1.1.3.2 The effects of COVID 19 on Community Systems Strengthening (CSS)

CSS implementation was affected by the Covid 19 pandemic, and most interventions were not implemented, if implemented not documented. COVID 19 resulted in some instances halt in CSS operations due to national lock-downs and restrictions.

Despite the negative impacts of COVID 19 on health service delivery systems, the MTR documented positive aspects of COVID 19, which led to the activation of CSS engagements and support. Community cadres and community platforms became the main source of information and support for service users particularly in the area of HIV and TB response. Flexibility, proximity and access to technology in some of the country brought to the fore the importance and relevance of robust local level support structures and systems as a key response mechanism to HIV. The activation of CSS engagement needs to be supported and reinforced between now and the end of ZNASP IV. The only threat to CSS documented by the MTR is financial sustainability to ensure community cadres continue playing a pivotal role in their communities. Financial support is key in covering per-diems and allowances while technical and capacity building support will be essential for deployment of a knowledge and technically competent cadre. There is need to regularly replace and support those cadres who will have resigned or retired

2. Economic impact of COVID-19 on the HIV response

Understanding the economic implications of COVID-19 for the HIV epidemic and response is critical for designing policies and strategies to effectively sustain past gains and accelerate progress to end these colliding pandemics. While considerable cross-national empirical evidence exists at the global level, there is a paucity of such deep-dive evidence at national level. COVID 19 led to a decline of 5.9% in GDP across the globe in 2020. Government revenues declined by 8.8% during the same year. Zimbabwe's GDP fell by 4.1% in 2020 before recovering to 8.5% in 2021. This economic decline affected the country's ability to increase domestic resource mobilization. The government provided an economic stimulus package amounting $424.3 million[8] with $182 million allocated to health sector support and COVID - 19 social protection. The government continued to finance COVID-19 social protection for all workers including healthcare staff.

COVID 19 disrupted health service delivery due to lock-downs which restricted movement of patients and implementers. The lock-downs worsened economic well-being of the largely informally employed population working in a sector that did not provide social protection which compromised nutrition for HIV, TB, and co-infection patients. Other disrupted services include TB and VMMC. Households TB treatment coverage fell from 72% in 2019 to 54% in 2021. Access to ARVs was erratic for patients while provision of ARVs in the open spaces breached confidentiality and causing psychological issues among PLHIV. VMMC procedures declined from 24 000 in 2020 to a few hundred[9]. Co-morbidities such as TB and cancer were

[7] https://esaro.unfpa.org/sites/default/files/pub-pdf/covid-19_sex_workers_report-ia.pdf

[8] GoZ. Economic And Fiscal Report For Year 2020 '2020 Annual Budget Review'. Harare May 2021. Exchange rate of 51.329 applied.

[9] Haacker and Obst. 2021. Economic Implications of Covid-19 for HIV and the HIV Response in Zimbabwe

affected with patients failing to get scheduled treatment. 60% of PLWHIV could not get key SRH medications such as contraceptives and condoms. At least 55% PLWHIV were unable to get psychosocial support while EID also declined in 2020. AIDS related deaths increased from 20 100 in 2019 to 22 200 in 2020 while quality adjusted life years were also lost due to disability from COVID 19[10]. PrEP initiation declined by 4 times from 880 in Mach 2020. The implementation of AGYW and KP community activities stalled due to lock-downs[11]. CSE reach for young people 10-24 was zero percent as schools were closed in 2020. Lockdown measures negatively impacted prevention activities in the sister to sister (S2S) program, especially HIV testing. AGYW school dropout rates increased from 0.43% to 3% in 2010. Restrictions in movement limited Sex workers from accessing prevention services such as condoms, PrEP, as well as ART which increased the risk of new infections and viral load suppression[12]. Movement restrictions meant stiffer competition in their local areas which reduced bargaining power in relation to safe sex[13]. Social and economic marginalization also increased for SWs as their trade does no offer social protection. Some were forced to defy lockdown rules increasing chances of COVID 19 infection while on the other hand, increasing their vulnerability to harassment, sexual and physical violence, and incarceration[14].

2.1. The effects of COVID 19 on HIV Expenditure

Dozens of front-line workers were infected, affected and died due to Covid-19 since 2020 This led to increased shortage of HRH and temporary clinic closures[15]. Planned activities such as trainings, community testing and voluntary medical male circumcision, especially travel related, were suspended due to immobility of clients, safety concerns of HRH staff, and prioritization of COVID 19 related services[16]. Implementing partners found alternative low cost means to reach out to clients such as virtual contact (NAC 2022). Budget execution for 2021 was thus affected with PEPFAR executing 84% of planned expenditure in 2021 while Global Fund budget execution fell as low as 71%[17]. Coupled with the war in Ukraine, operational costs went up particularly fuel which increased from an average budgeted cost of $1.40 to $2.00. Costs of accommodation, labour, and community cadre monthly allowances also went up buy up to 40% during this period.

2.2 The effects of COVID 19 on Supply Chain and Logistics

HIV programs experienced stock outs of drugs and condoms in some healthcare facilities (PEPFAR 2022; NAC 2022). There were delays in delivery of health products because of global logistic challenges related to freight and referrer containers (UNDP 2022). A particular

[10] Madzima, et al 2022. The impact of the COVID-19 pandemic on people living with HIV in Zimbabwe. *African Journal of AIDS Research*, *21*(2), pp.194-200.

[11] UNDP 2021. GF PMU annual report 2021

[12] Museva, et al. 2021. Sex workers and livelihoods under the COVID-19 pandemic in the city of Masvingo, Zimbabwe. Mankind Quarterly, 62(1).

[13] Machingura, et al. Potential reduction in female sex workers' risk of contracting HIV during coronavirus disease 2019. Aids, 35(11), pp.1871-1872.

[14] https://esaro.unfpa.org/sites/default/files/pub-pdf/covid-19_sex_workers_report-ia.pdf

[15] PEPFAR (2022). ZIMBABWE Country Operational Plan (COP) 2022. Strategic Direction Summary (SDS) April 2022

[16] NAC (2022). Annal Report 2021.

[17] UNDP (2022). GF PMU annual report 2021.

example relates to shortages in PrEP commodities in late 2020 months[18] due to supply chain disruptions[19].

2.3 The effects of COVID 19 on Laboratory Services

COVID 19 led to a backlog of 140 000 viral load tests by June 2021 due to stock outs in testing reagents. COVID 19 affected the supply chain which led to delayed shipments of these reagents. Lab services and cervical cancer screening were halted because of lock downs and safety concerns. This also reduced expenditures in these services and consequently, lower budget execution.

2.4 Progress Overview

Zimbabwe has made tremendous progress towards attaining the UNAIDS 95-95-95 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 95 % in 2020. The country has achieved and surpassed the second 95 now reported to be more than 95 %. 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.

3. HIV Epidemic Context at MTR

HIV prevalence

Since the inception of ZNASP, HIV prevalence in Zimbabwe has continued to decline over time but still remains high (see Figure 1). In 2018 HIV estimates (NAC, MoHCC and UNAIDS, 2019), prevalence among adults 15-49 years was 12.78% in 2018 and this declined to 11.8% in 2020 (ZimPHIA 2020) at MTR. The HIV Estimates Report of 2021 has HIV prevalence amongst adults 15 to 49 years at 11.58% (see Table 1)

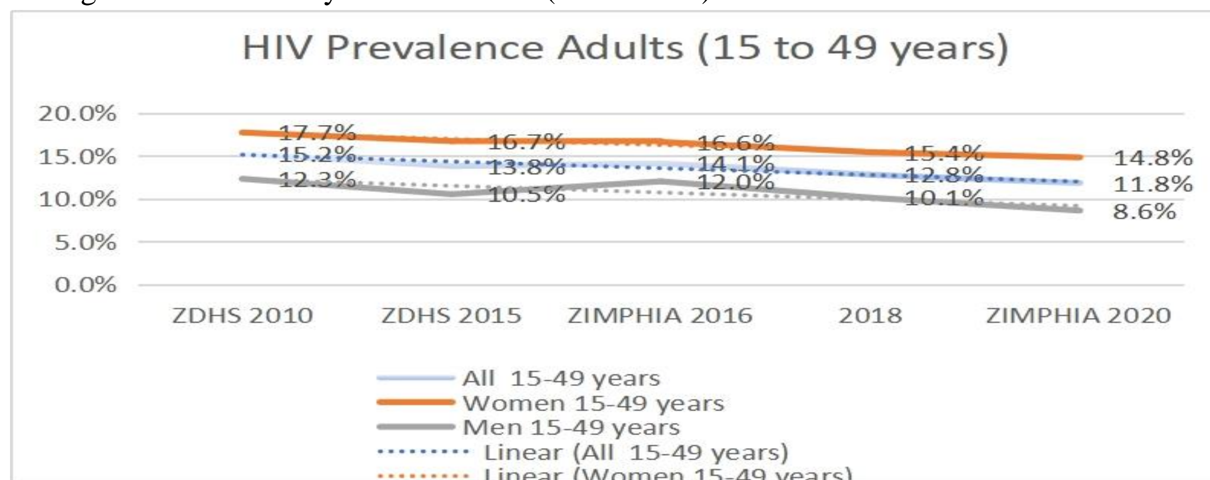

Figure 1: HIV Prevalence Trends to 2020

[18] Matambanadzo et al 2021. "It went through the roof": an observation study exploring the rise in PrEP uptake among Zimbabwean female sex workers in response to adaptations during Covid-19. Journal of the International AIDS Society, 24, p.e25813.

[19] Draft Inequalities report 2023.

The prevalence among 15-24 year olds is 3.68, and 1.06 among children at MTR. In all cases of adult infections is higher in females compared to males. In all cases, it has continued to decline since the 2018 baseline.

Table 1:HIV Prevalence in different population groups

HIV Prevalence	2018 % (95% CI)	2019 % (95% CI)	2020 % (95%CI)	2021 % (95%CI)
Prevalence adult 15-49 years	13 (11.42-14.3)	12.54 (11.01-13.79)	12.07 (10.6-13.28)	11.58 (10.16-12.73)
HIV Prevalence 15-24 years	4.63 (3.09-6.24)	4.3 (2.86-5.79)	3.98 (2.65-5.36)	3.68 (2.45-4.96)
Prevalence males 15-24 years	3.14 (2.32-4.04)	2.96 (2.18-3.8)	2.78 (2.05-3.58)	2.63 (1.94-3.38)
Prevalence females 15-24 years	6.12 (3.45-8.59)	5.63 (3.18-7.91)	5.17 (2.92-7.26)	4.73 (2.67-6.65)
Prevalence children 0-14 years	1.42 (1.2-1.63)	1.29 (1.09-1.48)	1.17 (0.99-1.34)	1.06 (0.9-1.22)

In this MTR, there continue to be geographical variations in HIV prevalence across provinces. At inception of ZNASP IV, the prevalence was ranging from 10.46% in Manicaland to 19.43% in Matabeleleland South Provinces. In 2021, the prevalence had decreased to 9.38 in Manicaland and increased to 19.58% in Matabeleland South (see Figure 2 below).

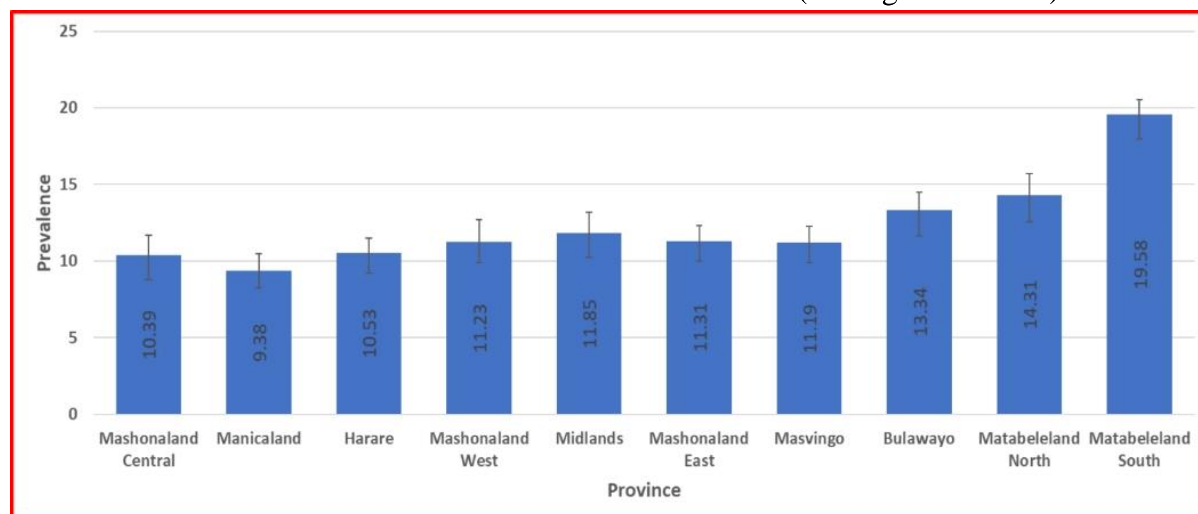

Figure 2: HIV Prevalence by Province

At district level, there is a shift in the most affected districts. At inception, the highest was 23.1% in Lupane district and the lowest (5.7%) in Gokwe district. At MTR the highest was Bulilima (Matabeleland South) at 22.8% and lowest was Mbire (Mashonaland Central province) at 5.4%. Geographical variation in prevalence continues to be a key factor in targeting HIV interventions. According to the Global AIDS Strategy 2021-2026 HIV/AIDS has populations disproportionately across the various social groups with the fault lines being defined across education, occupation, income and the community. The distribution of the epidemic across the districts shows the various inequalities driven by separated families in border communities (Bulilima and Beitbridge), low income in Matabeleland Provinces and low education levels.

HIV Incidence and New Infections

The number of new infections per 1000 uninfected people (HIV incidence) has remained steady in ZimPHIA surveys of 2016 and 2020 (0.42% in 2016, 0.45% in 2020 (ZimPHIA)) HIV incidence rate in females is almost double (2016) to triple that in males in 2020 (figure 3). The HIV Estimates (2021) data presents a more conservative incidence rate of 0.24% in 2021.

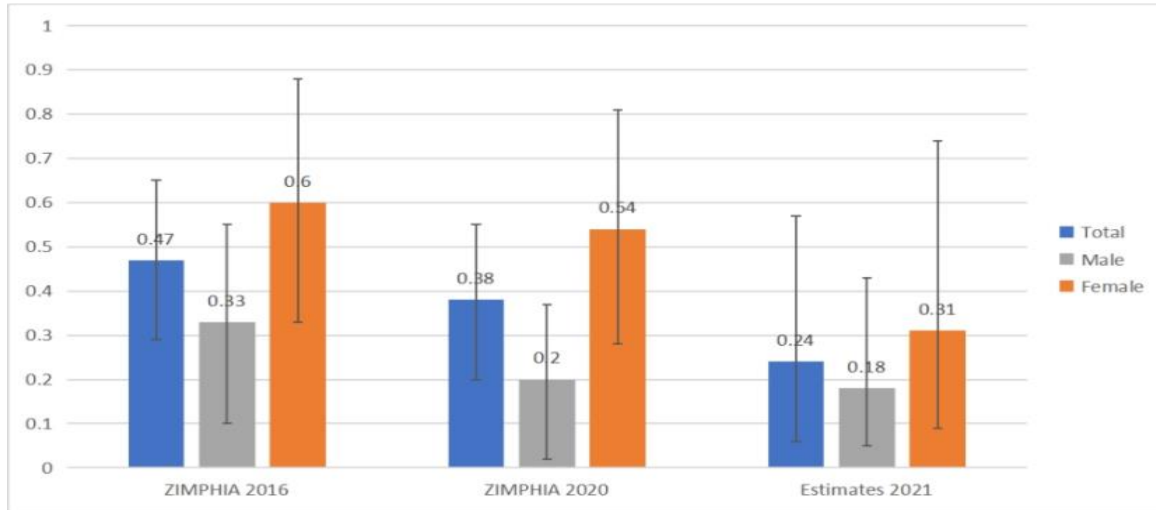

Figure 3: HIV Incidence point estimates

HIV incidence is high in females for 15-29 years age group. Among the 15-19 years the incidence among females is 6 times higher than their male counterparts. Incidence among 0-4 was due to mother to child transmission.

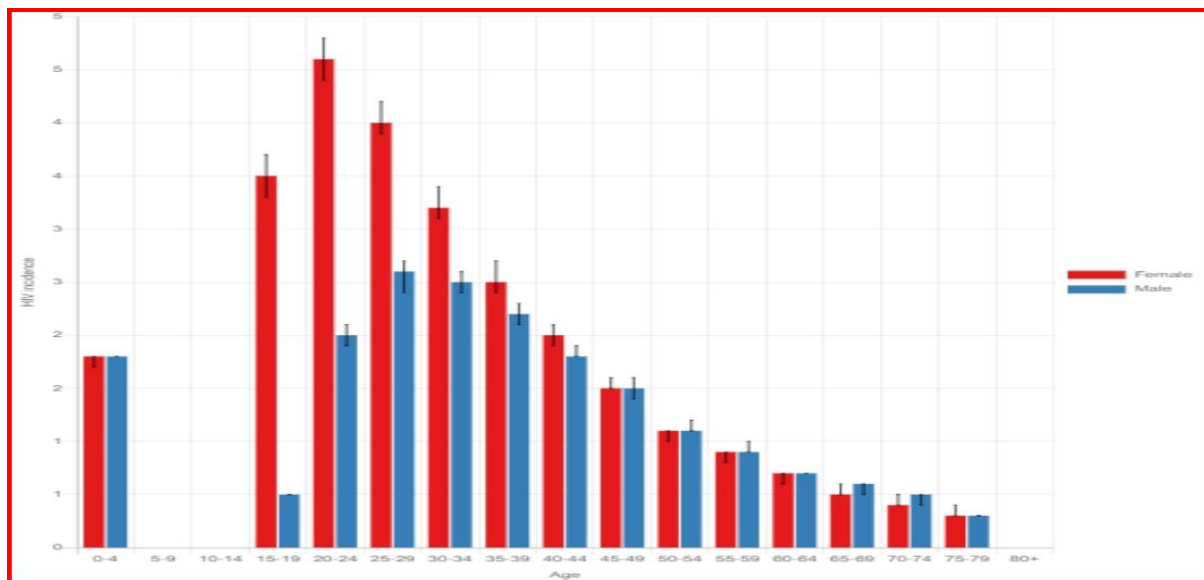

Figure 4: Age distribution of HIV Incidence 2021

New HIV Infections

The absolute number of new HIV infections has continued to decline over time. However, the new infections among adults 15+ years have been higher than the targets initially set in ZNASP IV. Hence as previously noted the new infections are not declining fast enough to achieve the globally agreed Fast-Track target of a 75% reduction by 2020 from the 2010 baseline, a target which has not been met.

Table 2: New HIV Infections by 2022

Indicator	Disaggregated	Baseline(2018)	Target 2020	Reported 2020	Target 2021	Reported 2021	Target 2022	Reported 2022
HIV New Infections	Total	39000	21400	24900	18900	22761	16400	21571
	Female	22000	11900	15136	10500	13779	9100	13233
	Male	17000	9500	9759	8400	8982	7300	8338
HIV New Infections 0 to 14 years	Children	5000	5000	4742	4600	4785	4000	3286
HIV New Infections 10 to 19 (adolescents)		5500	3100	3040	2700	2704	2300	2741
HIV New Infections 15 to 24 years	Total	13500	7600	7671	6700	6794	5800	6838
	Female	9200	5100	5870	4500	5209	3900	5257
	males	4300	2500	1801	2200	1585	1900	1581
HIV New Infections 15 to 49 years		32500	15400	19243	13600	17171	11800	17454

Source: NAC, (2022).

At inception, ZNASP had targeted a decline in new infections to 15 730 new infections by 2020 and flattening this to 6 292 by 2025 to 2030. However at MTR the new infections in 2020 are at 24 900 for all ages and 19 200 for those aged 15 to 49 years (figure 5).

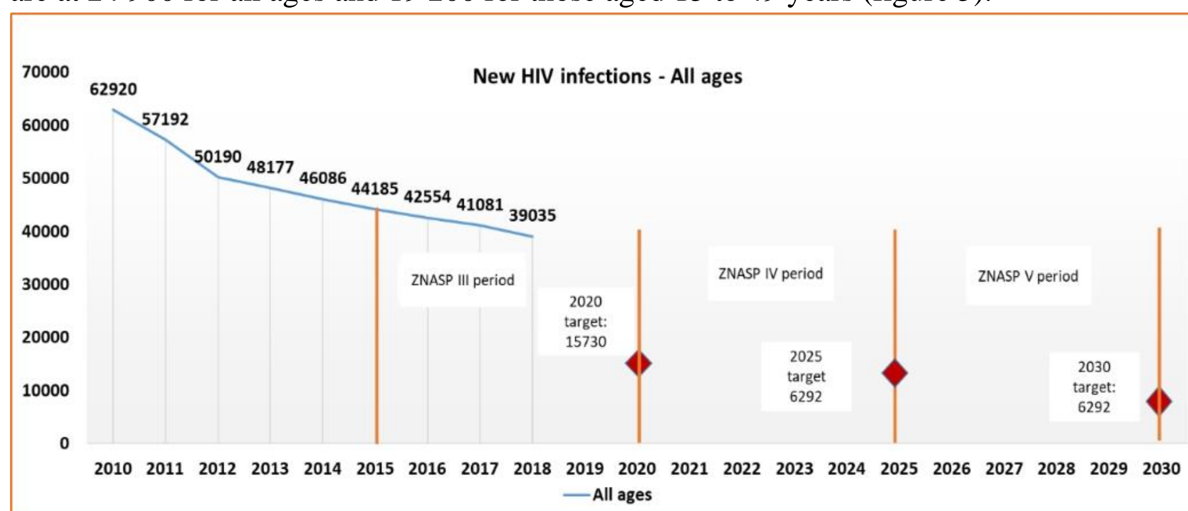

Figure 5: Projected rate of decline in New Infections 2018 to 2030

Source ZNASP 2021-2025

Distributing the absolute numbers of new HIV infections across the districts has shown a shift from 2018 to 2021 as shown in the two figures below. Absolute numbers of new HIV infections vary across districts with Harare and Bulawayo continuing to have the highest number partly due to their relatively large population size, while Mbire, Kariba and Rushinga have the lowest number of new infections. In 2018 six districts that accounted for 28% of the new infections were Harare, Bulawayo, Mberengwa, Kwekwe, Gokwe South and Chiredzi. The same districts have maintained their high numbers except an increase in new infections from Seke, Chitungwiza and Gweru . These variations affirm the need for interventions that are focused on districts with varying intensity and scale. The 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 is critical.

Figure 6: HIV infections by District 2018

Figure 7: HIV new infections by District in 2018

Overall, the rate of new infections has been plateauing, a result of a combination of prevention strategies but continues to be insufficient to achieve the set targets. In line with the ZNASP strategies innovative strategies must continue to be developed and maintained in order to reach

the set targets. Community involvement strategies and reductions of inequalities must be strengthened. These strategies as informed by the Global Strategy include:

- Targeting 95% of people at risk of HIV infection using appropriate, prioritized, person-centred and effective combination prevention options.
- The adoption of people-centred and context-specific integrated approaches that support the achievement of 2025 HIV targets and result in at least 90% of people living with HIV and individuals at heightened risk of HIV infection linked to services for other communicable diseases, non-communicable diseases, sexual and gender-based violence, mental health and other services they need for their overall health and well-being is critical.

The Incidence Patterns Modelling (NAC and UNAIDS, 2017 and 2021), estimating the proportion of new infections attributed to each source of infections and its contribution to the total new HIV infection, consistently notes that "never married females" (who are mainly adolescents girls and young women) contributed the highest proportion (24% in 2017 and 28% in 2021). Mother To Child Transmission contributed to 22% of new infections in 2021. Previously married men who are uncircumcised contributed 19% in 2017 but this has decreased significantly in 2021, however "never married men who are uncircumcised" accounted for 19% new infections in 2017 and 13% of new infections in 2021. The three groups i) Never Married Females, ii) Mother To Child Transmission and iii) Never Married Uncircumcised Males account for 63% of new HIV infections.

Key populations (Female Sex Workers and Men who have sex with Men) also continue to contribute a significant proportion of new HIV infections relative to their population size. The Global Strategy 2021-2026 notes that young people (15 to 24 years) represent about 15% of the global population, but accounted for an estimated 28% of new HIV infections. Hence the proposed strategies aimed at these target populations must be strengthened. These include

- Targeting 95% of women of reproductive age to have their HIV and sexual and reproductive health service needs met.
- Tailored, integrated and differentiated vertical transmission and paediatric service delivery for women and children, particularly for adolescent girls and young women in locations with high HIV incidence.
- Primary HIV prevention for key populations and other priority populations, including adolescents and young women and men in locations with high HIV incidence.
- Adolescents, youth and adults living with HIV, especially key populations, and other priority populations, know their status and are immediately offered and retained in quality, integrated HIV treatment and care that optimize health and well-being.
- Young people fully empowered and resourced to set new direction for the HIV response and unlock the progress needed to end inequalities and end AIDS.

AIDS-related deaths

AIDS-related mortality declined by 59.8% from 54,200 in 2010 to 21,800 in 2018 and is now at 20,200 in 2021. The decline is largely attributed to the success of the HIV treatment programme. In 2018, men were the face of AIDS deaths, at MTR this is changing with more women succumbing to HIV/AIDS at 52% of the total deaths. Table 3 below shows the declining trend of AIDS related deaths among all age groups.

Table 3: Trend in AIDS related deaths, 2015 - 2018

Indicator	2015	2016	2017	2018	**2021**
Annual AIDS deaths (adults and children – Total)	23,852	22,575	22,779	21,801	21,000
Annual AIDS deaths - (adults and children – Male)	11,339	11,011	10,998	10,598	10,000
Annual AIDS deaths - (adults and children – Female)	12,513	11,563	11,781	11,203	11,000
Annual AIDS Deaths (15-24 years) – Total	2,305	2,263	2,299	2,346	2,100
Annual AIDS deaths (15-24 years) – Male	2,305	2.263	2,263	1,061	1,000
Annual AIDS deaths (15-24 years) – Male	1,302	1,238	1,265	1,286	1,000
Annual AIDS Deaths 0-14 years	4,909	3,869	4,130	3,298	2,800
Annual AIDS deaths (10-19 years)	2,241	2,032	1,845	1,704	1,400

The trend in AIDS deaths shows that the country is not likely to achieve Fast Track Target – a 75% reduction in AIDS deaths by 2025 relative to 2010 baseline - at the current level of programming.

The figure 8 below shows the trend in AIDS deaths at MTR against the targets identified in ZNASP IV and 2030 targets.

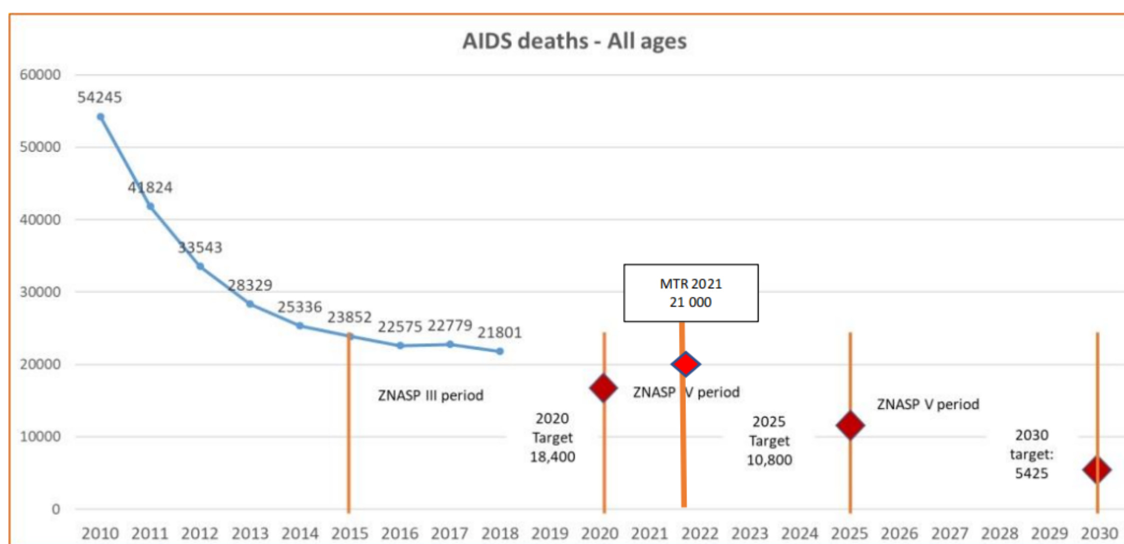

Figure 8:Trend in AIDS deaths against Fast-Track targets, 2010 – 2030.

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 9 below shows among 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, treatment literacy and care programme in all districts.

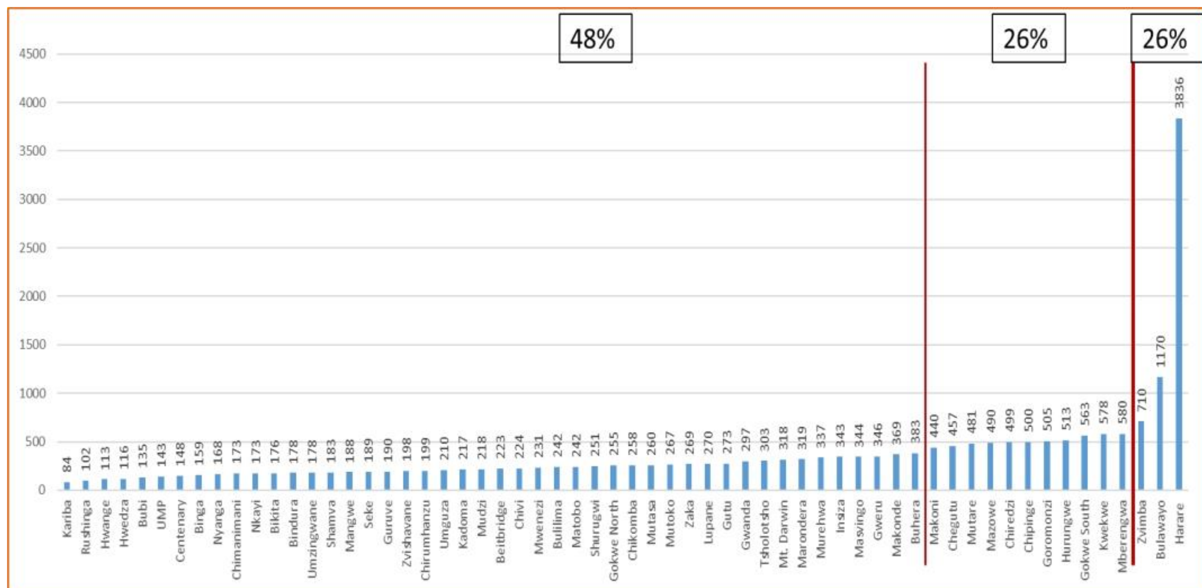

Figure 9: Estimated AIDS related deaths among adults by district, 2018

HIV stigma and discrimination

Another aspect of the HIV epidemic is stigma and discrimination. The review of ZNASP III found that progress has been made to reduce 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. Key populations indicated they resort to underground healthcare markets to avoid stigma and discrimination but at the same time, incurring high risks with unlicenced treatments[20]. While still unacceptably high, discriminatory attitudes towards PLHIV have declined.

The 2015 Stigma Index Study report showed 65.5% of PLHIV experienced one or more forms of HIV-related stigma and discrimination. The Zimbabwe Stigma index 2.0 of 2021 which showed that 32 of 33 transgender respondents, 77% of sex workers, and 13 of 21 MSM experienced stigma due to HIV status. Internal stigma was experienced by 48.4% of female respondents, 52% of male respondents, 57.5% of people 19 years or younger, 90% among migrant workers, and 80.5% PWDs. Stigma at healthcare facilities was experienced by 17 of 33 transgender respondents, 28 of 49 MSM, and 35.7% of sex workers. Almost 18% of the respondents went on to withdraw from ART due to stigma at healthcare facilities. Seventy six percent of MSM respondents indicated that they have experienced fear of seeking healthcare worrying that someone may discover that they are gay whilst 26% went on to avoid seeking healthcare for the same reason. About 10.2% sex workers experienced fear of seeking healthcare while 8.8% went on to avoid healthcare facilities completely. About 12.03% PWID feared seeking healthcare and 11.3% avoided the healthcare facilities[21]. To accelerate progress, ZNASP IV prioritises the development of a comprehensive stigma and discrimination reduction programme.

[20] Draft Inequalities report (2023)
[21] Draft Inequalities report (2023)

3.1 ZNASP IV Strategic Shifts at MTR

The HIV response must refocus on how to extend life-saving services to all who need them, in every community in Zimbabwe. In fact the ZNASP IV should align its strategic thinking in order to accelerate the shift from more siloed interventions to more integrated, people-cantered models of prevention, treatment and care, so that individuals' holistic health needs are met. The implementation partnership should be qualified by introducing an explicit objective to maximize the engagement and leadership of affected communities, to ensure that ***"no one is left behind"***, and that services are designed to respond to the needs of those most at risk (DSD models). This principle, that communities are at the centre of everything we do, is core to the strategic shifts.

Strategies should also be data driven to inform evidence-based programming so as to maximize health equity, gender equality and human rights by deepening the integration of these dimensions into our key interventions. At the core is the use of data to identify and respond to inequities, scaling up comprehensive programs to remove human rights and gender-related barriers. The MTR recognizes the need to mobilize increased resources, particularly in light of the reverses resulting from COVID-19.

Some Key strategies to be refocused and adopted in line with Global strategies are:

- accelerating access to and use of precision combination HIV prevention, tailored to individuals' risks and local contexts.
- Supporting improved well-being for PLHIV, prevention of premature mortality, and elimination of HIV transmission by scaling up accessible, quality, people-centered HIV diagnosis, treatment and care services
- supporting and incentivizing action to eliminate HIV-related stigma, discrimination, and criminalization to reduce human rights and gender-related barriers to accessing HIV services, leveraging community-led monitoring (CLM) and advocacy.
- Refocusing on other priority populations, such as adolescent girls and young women in the country.
- Addressing societal and structural factors that increase HIV vulnerability and diminish people's abilities to access and effectively benefit from HIV services.
- Addressing equal access to HIV services and the full protection of human rights for all people

3.2 ZNASP IV Impact Targets at MTR

To achieve the Vision set out in ZNASP the impact indicators are extend to 2026 as follows:

1. To reduce new HIV infections by 70% by 2026 from 2018 baseline.
2. Halve AIDS-related deaths by 2025 from 2018 baseline and sustained in 2026.
3. Reduce MTCT rate to less than 5% by 2025 and sustained in 2026; and,
4. Reducing inequalities where less than 10% of PLHIV and KPs:
    a. Experience Stigma and Discrimination

b. And Women and Girls experience gender-based inequalities and gender-based violence

3.3 ZNASP IV Thematic Areas Focus 2023 to 2026

3.3.1 Combination Prevention

ZNASP IV emphasizes the need to focus on prevention strategies tailored to district stratification (high, medium, low) disease burden, populations with highest risk of new infections and elimination of Mother To Child Transmission. Adaptation of the prevention roadmap focusing on the following key strategies is critical to getting to zero new HIV infections in the country: data driven assessment of HIV prevention needs; adoption of precision prevention approaches; community led services; removal of social and legal barriers; integration of HIV prevention with essential services; rapid introduction of new HIV prevention technologies; establishing real time prevention programme monitoring systems and strengthening accountability of all stakeholders. Further to these Strategies, the addendum aligns its programming to global strategies which include:

- Intensified focus on prevention through integrated people-centered services and strengthening community systems leadership in addressing their health challenges through increased investments in community systems.
- Intensified action to address inequities, human rights and gender-related barriers through increased investments in Social Enablers
- Breaking the dichotomy of prevention and treatment, leveraging on the synergies of combination prevention and treatment.
- Empower and resource young people to set new direction for the HIV response and in fighting inequalities.
- Triple elimination maternal transmission of HIV, Syphilis, and Hepatitis

3.3.1.1 HTS

Situational Analysis at MTR: At MTR, the percentage of adults living with HIV who know their status increased from a baseline of 90% in 2018 to 97% in 2021 according the recent HIV Estimates Report (2021), surpassing the set target of 92% (97% for men and 96% for women). However, the percentage of children (0-14 years), living with HIV who know their status increased from 68% to 73% over the same period, missing the set target of 80%. As noted in global reports, children continue to miss the 95 95 95 targets hence this addendum will increase focus on increasing access to children and women to integrated prevention and care services. ZNASP IV has identified high value investment areas in increasing surveillance to identify undiagnosed PLHIV (the weakest link in the treatment cascade) as well as provide an opportunity for those testing negative to access prevention services. It emphasizes HTS models with high yield which include facility and community index testing, PITC, HIV partner self-testing and HIV testing for key populations, TB and STI patients among others.

The country has continued to implement these strategies. Facility and community-based testing strategies were employed including index case testing, HIV self-testing (HIVST), provider-initiated testing and counselling (PITC), and targeted mobile and outreach HTS. Decline linked to COVID-19 as well as a shift towards HIV Self-testing (HIVST), where guidance was given

to health facilities to prioritize providing HIVST to clients, while conventional testing would be utilized for clients with reactive results.

Key gaps at MTR

- HTS programme not adequately reaching adolescents, young people, KPs and other VGs including men despite higher positivity rate: only 24% of clients tested and received results were males with 8% positivity rate compared to 5% for females
- There are gaps in the HIV self-testing and index testing cascades, with 12% of index cases declining contact tracing, 59% of contacts not followed up, 4% of the contacts identified not tested and 6% of those testing positive not linked to treatment.

Additional proposed Strategies:

Further to these the ZNASPIV at MTR compliments this work with focusing on increasing follow-ups on young people and key populations know theirs status and are offered and retained in quality, integrated HIV treatment and care.

- Develop and implement an HIV prevention package and roadmap based on data driven assessment of HIV prevention needs and emphasises the adoption of precision prevention approaches; community led services; removal of social and legal barriers; integration of HIV prevention with essential services; rapid introduction of new HIV prevention technologies; establishing real time prevention programme monitoring systems and strengthening accountability of all stakeholders.
- Use of data from situational analysis and other studies eg HIVST study aimed at optimizing facility-based distribution at 10 facilities across the country, validation of the adult screening tool with plans for scale-up to inform programme improvements
- Establishment of community posts
- Scale up of HISVT and index testing.
- Updated HTS guidelines for adults, children, and adolescents to align with the new strategic direction of targeted testing.
- Intimate Partner Violence Screening, effective counselling, linkages, and referral in the public sector

3.3.1.2 PrEP

Situational Analysis: From the MOT 2021 the high risk groups where new HIV infections are occurring are "Never Married females", "Never married uncircumcised males", "Concordant Uncircumcised males", and "female sex workers". These continue to be the focus groups for PrEP. Data collected in Harare and Bulawayo showed that an average of 42.2% and 63.4% of MSM and TGW&DQ people, respectively, had ever heard of PrEP[22]. Only 11.8% of MSM had ever taken PrEP while 22.7% of TGW&GQ had ever taken prep. NAC program data showed that in 2021, 56.6% of sex workers took PrEP. There is no data on how many prisoners took PrEP. Of those testing HIV negative, 57% were initiated on PrEP. The biggest gap, thus, seems to be on PrEP uptake and provision for female sex workers. Stakeholders consulted indicated that product knowledge was an important

[22] https://icap.columbia.edu/wp-content/uploads/Zimbabwe-IBBS-Report_Final_17Aug20.pdf pp 41

determinant of utilization as somewhere not aware whilst some were worried that their clients would fail to distinguish between PREP and ARVs leading to stigma. In addition to that, the knowledge about HIV as well as stigma and their determinants explained before also explain low uptake.

At MTR from 2018, more than 120,000 clients were initiated on oral PrEP in the country. Annual initiations increased from 6,528 in 2018 to more than 53,000 in 2022. Female sex workers and AGYW account for the majority (69%) of clients initiated on PrEP.

Key Gaps:

- Community awareness and knowledge on PrEP is still low and to reduce stigma and discrimination associated with accessing PrEP.
- The majority of public sector facilities have PrEP provided at one or two service delivery points within facilities.
- Low numbers of PrEP trained service providers in the Private Sector yet approximately 30% of population interface with private providers
- PrEP service provision is not co-located with other HIV preventive services at most facilities with PrEP provided at one or two

Additional Strategies:

- Integration of PrEP messaging and specific programs such as DREAMs, COVID-19, VMMC and ANC.
- Integration of community lay cadres (mobilisers, Microplanners etc) clinicians and outreach teams to create demand for ALL services during community mobilisation
- Utilization of PrEP treatment literacy sessions to create demand for PrEP
- Use of PrEP champions and PrEP mobilisers to specifically target their peers who are at a higher risk of contracting HIV
- Adopt mobile platforms with PrEP messaging services targeting young people.
- "Normalize PrEP and rebranding of PrEP from being a prevention option for those at "high-risk" and re-frame risk
- Ensure that PrEP is readily made available at all key service delivery point so as to enhance bi-directional linkages between PrEP and other services.
- Introduction and scale up of new biomedical HIV prevention methods such as the vaginal ring and cabotegravir injection

3.3.1.3 PEP

Situational Analysis at MTR: The targets for PEP for health workers and those exposed to HIV through sexual assault, or through high risk unprotected sexual encounters had not been met at MTR. Only 31% of the target 100% of the population were reached.

Key gaps:

- Delayed reporting by clients, beyond the recommended 72hrs, affecting uptake.
- Data is not readily available on those eligible for PEP on time.

Additional Strategies

- Integrate PEP services at all points of services.
- Raise awareness and address myths, misconceptions and stigma associated with PEP

- Strengthen data systems to track exposure, uptake and completion rates for PEP across the different eligible population groups
- Strengthen PPPs for PEP including training of private practitioners and reporting systems

3.3.1.4 VMMC

Situational Analysis at MTR: VMMC, alongside other effective behavioral and biomedical HIV prevention interventions, remains important in the ongoing effort to achieve zero new HIV infections and end the AIDS epidemic. The achievements reported at VMMV were below the set targets at 25% of the target in 2020 and 26% in 2021. According to the 2021 national HIV estimates, 38% of men aged 15-49 years are circumcised.

There is a wide variation in VMMC coverage by age across the provinces. For the priority age group15-29 years, the highest coverage is in Matebeleland North province (96%) and lowest in Harare (33%). Only three provinces (Matabeleland North, South and Mashonaland Central) managed to reach the overall target of 80% VMMC coverage.

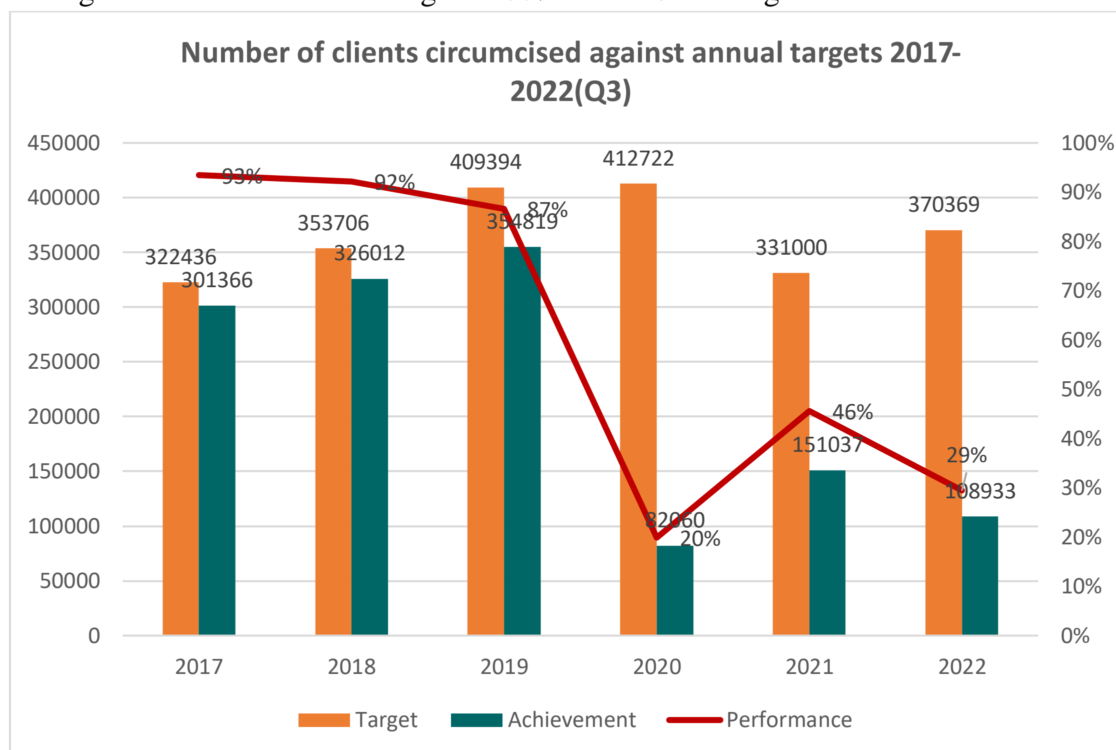

Figure 10: Number of clients circumcised against annual targets 2017-2022(Q3)

Strategies defined in ZNASP IV that include scale up VMMC and integrate VMMC as part of routine services continue to remain in relevant and in line with global calls of integration of services in health services. In addition, the addendum calls for increased engagement of the Zimbabwe Private Sector Partnerships on VMMC through going the Last Mile for HIV control program. Further the addendum calls for:

- The adaptation/adoption of online training hub for training clinicians and non-clinicians
- Integrate VMMC in the pre – service curriculum.
- Adoption of the ShangRing Method of circumcision.
- Strengthen demand creation through synergies with other sectors and organizations and the delivery of a men-friendly package of services.

3.3.1.5 Key Populations

Situational analysis at MTR: The number FSWs reached with defined package of HIV combination preventions services increased from 30% of the intended target in 2020 to surpassing the target to 167% in 2021. For MSM, the number reached declined from 99% of the target in 2020 to 60% of the target in 2021. It is noted KPs including transgenders, inter-sex communities continue to suffer from inequalities brought about by stigma, discrimination, and all forms of violence. Hence programmes must integrate these services in the HIV prevention and care continuum.

Strategies defined in ZNASP IV remain relevant to the KP programme in Zimbabwe and globally. The addendum advocates KP Programme objectives to include:

Less than 10% of KPs experience stigma, discrimination, gender-based inequalities and violence by 2026.

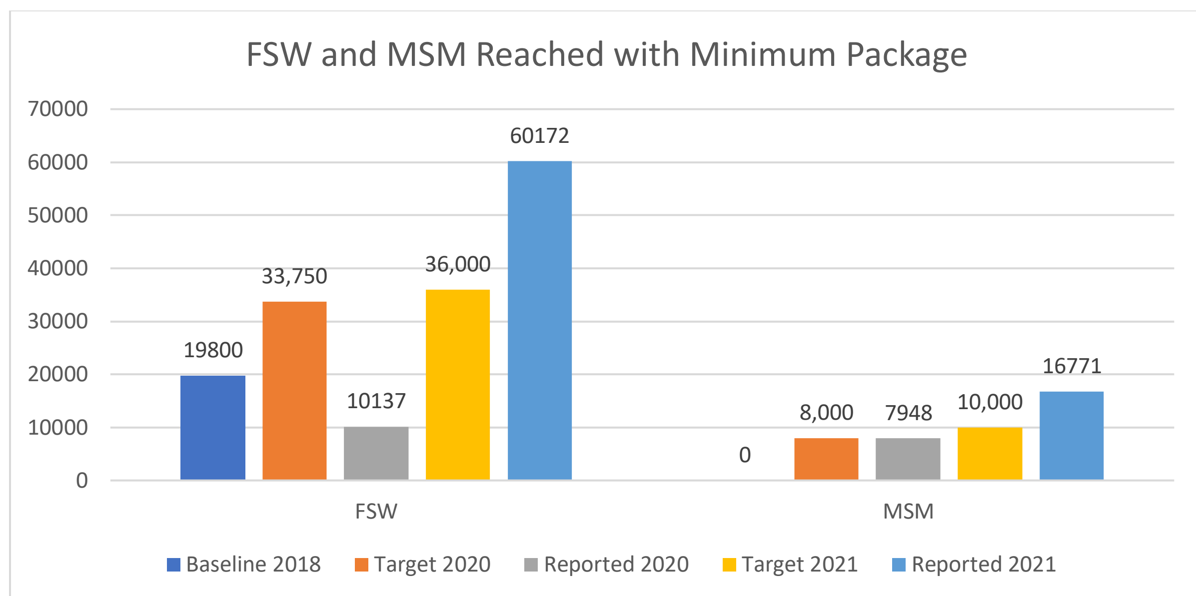

Figure 11: FSW and MSM Reached with Minimum Package

3.3.1.6 Prisons

Situational Analysis at MTR: Data on HIV and integrated services offered to prisoners has continued to improve at MTR although not all is available. Size estimates of PLHIV in prisons has been reported as 4846 in 2021. The percentage of PLHIV who know their status is 98% (4762/4846). Those on treatment is 100%. However, data on TB integration is still scarce.

Table 4: Summary of HIV and TB indicators among Prisoners

Indicator	Baseline 2018	Target 2020	Reported 2020	Target 2021	Reported 2021
Percentage of PLHIV in prisons know their status	28%	100%	no data	100%	98%
Percentage of PLHIV in prisons are on ART		65%	no data	70%	100%
Percentage of prisons implementing an effective TB screening	no data	100%	no data	100%	no data
Percentage of prisoners with active TB infection initiated on appropriate TB treatment	0.40%	100%	no data	100%	no data
Number of PLHIV in prisons know their status	5572	5,572	470	5,572	4762
Number of PLHIV in prisons are on ART		5,572	470	5,572	4762
Number of prisoners screened for TB		19,000	no data	19,000	
Number of prisoners with active TB infection initiated on appropriate TB treatment	22	80	no data	80	145

The gap of access to data on services offered to prisoners needs to be continually addressed.

3.3.1.7 Vulnerable Groups

Situational Analysis at MTR: Vulnerable groups are defined as farm workers, artisanal miners, people with disabilities, mobile and cross border populations, and fishermen. Data on these groups is not readily available. There are outreach HIV prevention programs targeting these groups, but data on the reach is not available. Yet these communities constitute populations facing inequalities and are likely to be facing a higher burden of disease and constitute a group that is being left behind.

Key gaps

- Intersectional stigma and discrimination against KPs and VGs affecting access and effective utilization of services
- Policies and laws that negatively affect access to HIV and STI services such as age of consent and criminalisation
- Limited resources for KP and VG programming affecting capacity building for service providers, stock levels for commodities such as test kits, condoms and STI treatment
- Service provider values and attitude affecting the delivery of quality, person centred and friendly services
- Unavailability of quality, timely and granular data on size estimates, the burden of disease, coverage and access to HIV and STI services by different KP and VGs to inform programming, decision and improvement efforts.

Strategies:

- Develop and implement a national HIV prevention roadmap operational plan aligned to the Global targets including granular national and subnational targets

- Strengthen and expand community-led HIV prevention services and set up social contracting mechanisms
- Develop and implement an advocacy strategy for addressing policies and legal issues affecting access to services by KPs and VGs, including stigma reduction strategies
- Strengthen systems for IPV and GBV response including post violence care, through community engagement processes and training of service providers and community cadres
- Build the capacity of service providers to deliver KP and VG friendly services through training and mentorship
- Promote the integration of HIV prevention into essential related services so they respond to people's needs, and are convenient and easy to use and improve outcomes
- Strengthen client tracking systems including the use of the biometric system to track clients across borders

3.3.1.8 Condom Programming

Situation Analysis at MTR: Condoms are highly effective in preventing HIV when used consistently and correctly. Condoms are a low-cost option that also has other sexual and reproductive health benefits, including the prevention of other STIs and unintended pregnancies. The promotion and distribution of male and female condoms as well as lubricants continues to be a key pillar in the national HIV response. Interventions include enhanced demand creation, procurement and supply of male and female condoms as well as lubricants through free distribution, social marketing and private sector sales to ensure full-scale access. Three condom markets are currently active in the country: public sector; social marketing and commercial sector. There is an urgent need to achieve a healthy condom market in which condoms are available, affordable, accessible and all sectors thrive without dependence on donor funding. Condom use remains generally low:

- Condom use at last higher risk sex with non-marital non cohabiting partner at 67% and 85% among 15-49 years aged men and women respectively.
- Condom use among sex workers, MSM and transgender people at 43%, 69% and 82% respectively (UNAIDS Data 2021)

Male condom distribution declined in 2020 to 72% of the target in 2020 and increased to 103% in 2021. However, for female condoms, the numbers are low and the supply is less than 60% of the targets. Community engagement noted limitations in accessing condoms, where either location is not conducive to collect or there is no direct evidence of usage as unused condoms are easily thrown away.

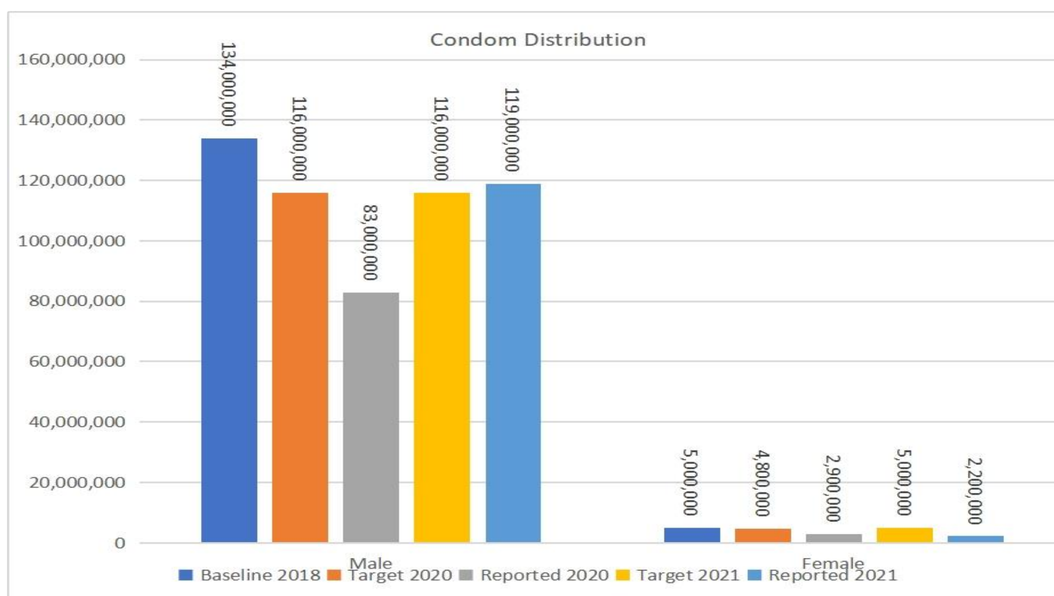

Figure 12: Trends in Condom distribution from 2018-2021

Strategies defined in ZNASP IV on sustainability and equity remain critical at mid-term. In addition to these strategies the Addendum advocates for:

- High level advocacy meetings to mobilize resources, increase domestic funding and review of fiscal policies such as VAT and duty free on condoms.
- Use of automated Condom (and other health products) dispensing machines for placement at private, strategic and convenient places.
- Strengthen implementation of the condom demand generation strategy informed by the market segmentation study.
- Strengthen private sector engagement and role in condom programming, distribution, coordination of pricing of condoms and targeted demand creation.

3.3.1.9 Sexually Transmitted Infections

Situational analysis at MTR: Sexually transmitted infections (STIs) are a major public health problem in Zimbabwe. The syndemics of HIV and the other STIs have high co-prevalence and socio-behavioral elements, especially among key and vulnerable populations. In Zimbabwe, high HIV prevalence was reported among women (47.3%) and men (34.8%) who were diagnosed with STIs (Kilmarx 2018). As such, the prevention, diagnosis and management of STIs is an important pillar of the national HIV response. The percentage of sexually active men and women who reported having an STI in the last twelve months has been declining since 2005. In 2015, 2.6% of sexually active men and 2.3% of sexually active women in Zimbabwe reported having an STI in the last twelve months. The high number of STIs reported could be linked to increased awareness and more people seeking care or actual increases in new cases are occurring. In 2022 (Q1-Q3), only 54% (89,606) of the total STI cases reported received an HIV test, with a positivity rate of 6% (5,196). HIV testing rates among STI clients ranged from 55% in Harare to 83% in Bulawayo. HIV positivity rates among STI clients were highest in Harare (9%) and lowest in Masvingo (4%).

During the same period, 60% of the STI patients were tested for syphilis and 6% were positive. All the patients who tested positive for syphilis were successfully linked to treatment. Syphilis testing rates among STI clients ranged from 55% in Mashonaland West to 94% in Matabeleland North province.

Anecdotal reports indicate an increase in STIs among clients on PrEP. More needs to be done to ensure STI clients are linked to ART if HIV positive and PrEP if negative. Similarly, clients on ART and PrEP should be screened and managed for STIs routinely.

Strategies defined in ZNASP IV calling for increased funding on STI programmes, strengthening STI M&E, surveillance and research especially on those who report and get access to treatment and the prevalence of STIs amongst PrEP clients are paramount. Further to these at MTR, there should be:

- Development of STI online mentorship program clinicians in primary facilities.
- Development and piloting of STI mentorship to mitigate restrictions in movement and physical meetings as was the cased during COVID-19
- Update /review current STI guidelines in line with WHO 2021 guidelines.
- Integrated messaging on SRH, HIV and condom use to empower youths, KPs, pregnant and lactating women and men to reduce self-stigma and increase demand for services
- Engage male mobilizers to assist VHWs with partner notification

Elimination of Mother to Child Transmission

Mother-to-child transmission (MTCT) of HIV continues to contribute a significant (21%) number of new HIV infections in the country. In 2021, there were an estimated 4,785 new HIV infections due to vertical transmission in the country translating to an MTCT rate of 8.9%. The country is committed to the dual elimination of MTCT (eMTCT) of HIV and syphilis and is aiming attaining the Gold Tier of eMTCT of HIV and congenital syphilis which includes a MTCT Rate of <5%, reduction of new paediatric HIV Cases to <250 per 100,000 live births, and reduction of new cases of congenital syphilis to <50/100,000 live births. An analysis of the MTCT HIV infections in the country in 2021 revealed that the three interventions of initiating all the pregnant and lactating women living with HIV on ART, retaining them in care with viral suppression and offering PrEP to those that are HIV negative will lead to the reduction of MTCT to 859 infections (MTCT rate of 1,60%).

Table 5: Summary of Indicators on PMTCT target versus Achievements

Indicator	Baseline 2018	Target 2022	Achievement 2022
Proportion of women who attend at least one ANC visit	93.5%	95%	91%
Proportion of pregnant women who know their HIV status	99%	99%	97%
Proportion of women whose male partners tested for HIV in ANC in the last 2 months	22%	27%	13%
HIV positive pregnant and lactating women who received ARV medicines to reduce MTCT	93.5%	95%	90%
Proportion of infants born to HIV-positive women receiving a virological (DNA PCR) test for HIV within 2 months of birth	63%	77%	89%
Proportion of infants born to HIV positive women receiving ARV prophylaxis for prevention of MTCT	72%	80%	73%
Proportion of infants born to HIV positive women started on cotrimoxazole	65%	80%	70%
Proportion of pregnant women tested for syphilis	91%	95%	92%
Coverage of syphilis treatment in ANC	80%	95%	97%

Strategies

In line with the global vision of "every infant free of HIV, hepatitis B and syphilis" and the goal of achieving and sustaining elimination of mother-to-child transmission (EMTCT) of HIV, hepatitis B and syphilis and achieve better health for women, children and their families through a coordinated approach and efforts by 2030, the country should shift focus from dual elimination to the triple elimination agenda. This calls for a shift towards mother-new born and child-centred care, universal health coverage for quality and equitable care and multistakeholder including community involvement. As such, a key recommendation is to develop, implement and monitor a "triple elimination" strategy building on the lessons learned and experiences from the implementation of the HIV/Syphilis dual elimination plan. The scope of the strategy should include but not limited to antenatal care coverage; skilled birth attendance; antenatal HIV, hepatitis and syphilis screening; treatment coverage for HIV and syphilis and hepatitis B vaccinations.

- To compliment the triple elimination strategy, the country should strengthen the implementation of the four strategic pillars of the Global Alliance to end AIDS in Children, including 1) early testing and optimized comprehensive, high quality treatment and care for infants, children, and adolescents living with and children exposed to HIV 2) closing the treatment gap for pregnant and breastfeeding women living with HIV and optimizing continuity of treatment towards the goal of elimination of vertical transmission 3) preventing and detecting new HIV infections among pregnant and breastfeeding adolescents and women and 4) addressing rights, gender equality and the social and structural barriers that hinder access to services. Strengthen DSD models for ANC, PMTCT and male partners including after hours and weekends
- Multi-modal HIV testing including community case finding like door-to-door screening, testing, and referral. Include HIV testing and linking to care among high-risk population groups.
- Strengthen the integration of management of AHD, mental health screening, IPV screening in ANC and PNC.
- Advocate for formulation of legislation mandating reporting from private sector and capacity building of the private sector on the national guidelines and reporting tools.

- Raise awareness, create demand and promote condom and uptake of PrEP choices among PBFW and their partners throughout the continuum of care
- Strengthen peer-peer models (including for young mothers and male partners) and collaboration with community partners and community health workers in following up and linking clients to care using available defaulter tracking tools.

3.3.1.10 Adolescent Girls and Young People

Situational Analysis at MTR: Adolescent girls and young people constitute a large portion of the new infections in the "never married females" and "never married uncircumcised males" who are contributing 41% of the new infection. The overall incidence by age group as shown again in the figure below emphasizes the challenges of infections, where females 15 to 34 are the highest incidence groups.

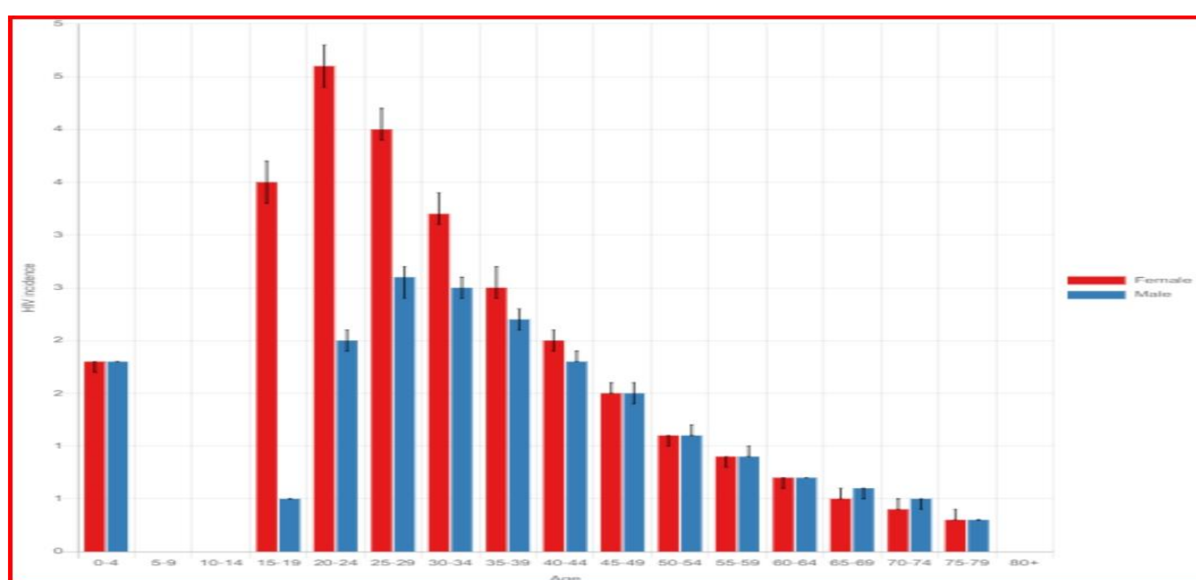

Figure 13: HIV incidence by age group and Gender

At MidTerm Review the indicators tracking Adolescent girls and young people both in and out of school have been below target in 2020 and 2021.

Table 6: AGYP Performance Indicators

Indicator	Disagg	Baseline 2018	Target 2020	Reported 2020	Target 2020	Reported 2020
Number of girls and boys in school reached through HIV and AIDS life-skills education	Female	1,000,000	1,010,000	596,973	1,020,000	743,675
	Male	990,000	1,000,000	543,335	1,010,000	705,723
	Total	1990000	2,010,000	1,140,308	2,030,000	1,449,398
Number of youths out-of-school reached with comprehensive sexuality HIV&AIDS education	Female	118000	123,000	21520	128,000	27417
	Male	115000	120,000	20024	125,000	21794
	Total	233000	243,000	41544	253,000	49211

Number of youths in tertiary institutions reached with HIV&AIDS education	Female	35000	40,000	13278	45,000	*8838*
	Male	5000	6,000	15825	7,000	8294

Interventions such as Sister 2 Sister, Brother 2 Brother, CATS, SASA, and DREAMS offering mentorship programmes continue to offer services to AGYP.

Anecdotal reports from FGDs point to drug use being rampant amongst AGYPs and likely accelerating the occurrence of new infections. High unemployment and useful engagement of young people has been noted to be major contributing factors to drug use.

Key gaps:

- Inequalities of access to services for young people continue through laws and policies such as the age of consent that inhibit access to essential reproductive health services.
- Reaching adolescents and young people in and out of school with information on HIV and AIDS education and life skills continues to be low.
- Adolescent girls and young women are three times likely to acquire HIV infection than male peers their own age.
- Data on young people 15 to 24 who know their HIV status is not readily available.
- Drug abuse amongst the young people is known to be rampant but has not been quantified, and its contribution to HIV infections is yet to be verified.

Strategies: The key strategies identified in ZNASP IV must be strengthened. In addition, addendum proposes that:

- Increase empowerment schemes for in- and out- of school AGYW to reduce transactional sex.
- In line with a people centered approach, young people be fully empowered and resourced to set a new direction for the HIV response as they see appropriate.
- Efforts be made to increase the flawless integration of HIV combination prevention services to treatment and care services for these young people and reduce loss to follow-up.
- Data systems focused on tracking these interventions be strengthened and be made more granular at community level.
- Quantify and incorporate drug use strategies in the response.
- Address laws and policies that increase inequalities amongst the young people particularly on access to reproductive health services, stigma and discrimination.
- Standardise the need-based intervention package for AGYW with layering of appropriate and preferred services across all districts in the country to reduce inequities and inequalities

3.3.2 Treatment

Contextual analysis: Zimbabwe has made significant progress in scaling up access to HIV treatment and care services with the number of patients on ART increasing from 1,15 million

in 2018 to 1,29 million in 2022 (Q3). However, the average monthly ART initiations declined from 9,199 to 6,036 over the same period. The proportion of PLHIV receiving ART increased from a baseline of 85% in 2018 to 95% in 2022 for adults and from 67% to 71% for children over the same period. The ART coverage in 2022 was higher among adult females 15+ years (96%) and young women 15-24 years (93%) compared to their male counterparts at 93% and 85% respectively. Lower ART coverage rates were also reported for sex workers (59%) and MSM (73%) (UNAIDS Data 2021).

- The median linkage rate per month was 95.5% in 2022.
- 61% of the clients on ART in 2022 were females and 4% were children aged 0-14 years whilst 22% are ageing clients 50+ years old
- 95.8% of patients on ART are on first line regimens, 4.1% on second line and 0.04% on third line
- 71% of the patients on ART are on the TLD regimen. The proportion of clients transitioned to TLD ranged from 61% in Mashonaland Central to 80% in Masvingo province. Stock out of TLD and unavailability of VL results affected the transition of clients to the optimized regimens
- Almost 80% of the clients on ART are managed at primary care level and 16% at secondary level

A significant proportion of PLHIV are still presenting late with advanced HIV disease based on CD4 testing and clinical staging. The proportion of clients presenting with advanced HIV disease declined from 49% in 2015 to 20% in 2021. The majority of patients with AHD were diagnosed through clinical staging. Only 13% of the clients had a baseline CD4 test done.

Attrition in adults increased worryingly from a baseline of 10% in 2018 to 16.46% in 2021 against a target of 8%. Attrition was slightly higher among males compared to females. DSD models are client-centred services that have the potential of meeting the preferences of PLHIV for service delivery whilst reducing unnecessary burdens for the health system. The DSD coverage among recipients of care (RoC) increased from 32% in 2019 to 40% in 2021. 61% of RoC in DSD models were females whilst 4% were children aged 0-14 years. The most common DSD models are fast track (38%), community ART refill groups (25%) and family ART refill groups (17%).

Viral load testing coverage among PLHIV on ART improved from 44% in 2018 to 71% in 2021. The improvement is linked to decentralization of testing services, expansion of the integrated sample transportation to all the districts, use of the electronic results transmission through the LMIS, capacity building interventions for health workers and treatment literacy interventions among patients and community members. Among the clients who had a viral load test done and received results, suppression rates increased from 85% in 2018 to 95% in 2022 (Q3). The VL suppression rates in 2022 were higher among adult females 15+ years (95%) and adult males 15+ (94%) compared to young women (89%) and men (85%) aged 15-24 years as well as children (84%).

Across all provinces, the VL suppression rates are generally lower among children, ranging from 80%-89% compared to adults, ranging from 94-96%.

Strategies

- Strengthen patient education and literacy.
- Diagnostic Network Optimization (placement and utilization of point-of-care machines) and roll-out of LIMS for expedited results return.

- Introduce and scale up child-friendly ARV formulations and capacitate HCW on their use
- Scale up of peer-to-peer support through the CATS model, young mentor mothers, young mentor dads to enhance uptake, linkage and continuity in care including screening and management of common mental health disorders.
- Scale up DSD models at community and facility level targeting different subpopulations such as men, adolescents and KPs, tailored to their needs and preferences Community ART initiation.
- Strengthen viral load demand creation activities through identification of clients due for VL through cohorting and use of appointment registers, enhancing the DSD model
- Mobilize resources to set up HIV DR testing and procurement of Analyzers and accessories.
- Capacity building of HCW for HIV DR monitoring (pre-treatment, PrEP users and 3rd line ART)
- Expedite the decentralization of third-line ART at central and provincial levels
- Scale up peer-to-peer mental health screening and counselling and mental health screening in health facilities by conducting WHO Mental Health Gap 2.0 training for health workers

3.3.3 Services Integration

Situational Analysis at MTR: Data on the integration of HIV services with other services has been very limited. This paucity of data is a reflection of the silos of programme services, where HIV services are not fully integrated in routine points of services. However, globally there is now a significant focus toward integrating services to prevent, identify and treat HIV diseases, comorbidities and coinfections. This underpins the principle of integrating HIV services as part of the essential and routine health services. The global focus to promote HIV service integration with those for TB, viral hepatitis, syphilis and other sexually transmitted infections, cervical cancer, non-communicable diseases, mental health and as part of Antenatal Care, Post Natal Care, Sexual and Reproductive Health, Harm reduction and adapted for aging populations.

Gaps:

- Data is minimally available for HIV/TB integration services and very scare on the other essential services.
- There is limited integration of services across the continuum of care on comorbidities of HIV

Strategies:

The Strategies defined in Services Integration in ZNASP IV continue to be relevant and must be reinforced. Redesigning care pathway to enhance person-centredness and holistic approach to care. Strengthen data systems to track clients across the different service delivery areas and care points. In addition to the indicators defined in ZNASP IV , the Addendum is recommending Services Integration programme objectives must include :

- *90% of PLHIV receiving preventive treatment for TB by 2026.*
- *90% of PLHIV and at risk are linked to other integrated services seamless by 2026.*

- Strengthen sustainable resource mobilization efforts to support integrated service delivery

- Strengthen the management of AHD, ageing with HIV, opportunistic infections and other comorbidities including cryptococcal meningitis through training and mentorship
- Capacitate primary level of care staff in the prevention, screening and management of mental health issues among PLHIV including children and adolescents
- Strengthen and integrate data systems to track clients horizontally
- Empower PLHIV and communities through literacy sessions, dialogues, digital and social media platforms to increase demand for comprehensive services for including ADH, NCDs, mental health and nutrition
- Resource mobilization for the dissemination and phased implementation of the viral hepatitis strategy starting with priority population groups such as pregnant women, STI clients and drug users
- Strengthen and scale up the implementation of quality improvement initiatives

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3.3.4 Social Enablers

Situational Analysis at MTR: The call globally at MTR is to evolve care pathways to strengthen therapeutic alliances between the people in care and the health and community systems and to expand self-care to ensure that services address the people's needs over the course of their lives including those of children and young people. Stigma, discrimination, human rights and gender inequality are barriers that are slowing the HIV response, leaving key and priority populations behind. This addendum adds focus to these barriers and further advocates for recognising, empowering, resourcing, and integrating community-led HIV responses for a sustainable HIV response. There is need to further integrate effective responses to Sexual and Gender Based Violence, Intimate Partner Violence (IPV) and violence of KPs into HIV programs and services.

3.3.4.1 Laws and Policies

Situational analysis at MTR: There is a global focus towards addressing HIV inequalities through repelling laws and policies that inhibit key and priority populations from accessing key HIV and related services. PLHIV, KPs and people at risk of HIV must enjoy human rights, equality and dignity free of stigma and discrimination. ZNASP IV is up to date with Zimbabwe's laws towards the access to services, where there are still limitations due to policy limitations such as the age of consent which limit the services that young people can access. However, Zimbabwe has successfully repelled the law that criminalises wilful transmission of HIV. More needs to be done towards policies that limiting access to services particularly for AGYP.

Strategies defined in ZNASP IV for improving implementation of existing protective laws and policies and advocating for reviews of laws and policies impacting negatively on access to HIV and TB service continue to be relevant and current to both local and global needs.

3.3.4.2 Stigma

Situational Analysis at MTR: Stigma continues to be a contributing factor towards inequalities in ending HIV/AIDS. The recent stigma index study (NAC, 2021) shows the Stigma experienced by PLHIV in Zimbabwe was as high as 69.7%. For young and old people 35% reported stigma experience in health care settings. The stigma experience amongst KPs

varied from 65% in MSM, 77% in sex workers and 97% in transgender cases. Data on those reached with Stigma reduction messages continues to be minimal.

Table 7: Summary of Stigma statistics by year from 2018-2021

Indicator	Baseline 2018	Target 2020	Reported 2020	Target 2021	Reported 2021	Target 2022	Reported 2022
Percentage of reported stigma by key populations in health care settings	no data		no data	100%	10%		no data
Number of health workers reached with stigma reduction interventions	no data	1,000	no data	1,500	no data	2000	no data
Number of vulnerable and key populations reached with stigma reduction interventions	no data	10,000	no data	11,000	*no data*	12000	no data

Strategies defined in ZNASP IV to strengthen monitoring and evaluation of stigma reduction programmes and to develop appropriate targeted comprehensive stigma reduction programmes in health care settings continue to be relevant and in line with the global calls.

3.3.4.3 Meaningful Involvement of PLHIV

Situational Analysis: There is a global focus towards a people centered, community led responses and strengthening social contracting mechanisms in HIV prevention and care continuum. PLHIV indicators targeting their meaningful involvement have not been met in the MTR.

Table 8: Summary of Indicators on Meaningful involvement of PLHIV

Indicator	Disagg	Baseline 2018	Target 2020	Reported 2020	Target 2021	Reported 2021
Number of PLHIV in support groups 15-24	Female	8000	21,373	18683	20,812	11312
	Male	6000	12,184	9888	12,008	6976
	Total	14000	33,557	28571	32,820	18288
Number of PLHIV in support groups 25-49	Female	25000	30,000	15538	180,855	7499
	Male	11000	26,000	6847	113,759	2861
	Total	36000	56,000	22385	294,613	10360
Number of adolescents living with HIV receiving support from CATS - Adherence monitoring	Female	32000	37,000	21743	42,000	51864
	Male	30000	35,000	17059	40,000	35590
	Total	62000	72,000	38802	82,000	87454

Strategies:
Involvement of PLHIV in all aspects of HIV Prevention, Treatment and Care continuum must be enhanced through empowerment and increased resourcing.

3.3.4.4 Gender including Male Involvement

Situational analysis at MTR: There is now a rallying call for gender inclusivity that places emphasis on GBV, IPV and violence against KPs as these enhance inequalities in the fight against HIV. Gender responsive programming that challenges harmful gender norms and stereotypes and support community-led advocacy to strengthen laws and, policies protective of survivors to violence. Communities must be empowered to monitor, document and report cases of violence, ensuring referral and protective services and justice are readily available. At MTR though the majority of indicators tracking gender and male involvement were met there is need to expand these services to incorporate the wider focus and reach.

Table 9: Summary of GBV indicators being tracked

Indicator	Baseline 2018	Target 2020	Reported 2020	Target 2020	Reported 2020
Number of people who completed the SASA package offered by the SASA Champions	18080	20,000	39053	22,000	38986
Number of people who experienced GBV and accessed services	4232	7,000	3625	10,000	17176
Number of programmes that have conducted gender analysis	no data	13	13	13	13
Number of programmes with gender responsive indicators and reporting on them	no data	13	13	13	13

3.3.4.5 Community Systems Strengthening

Situational Analysis at MTR: CSS is premised on the understanding that strong community participation in the response to HIV, tuberculosis (TB) and malaria is essential to controlling these epidemics. The MTR documented that CSS complemented contributions to ZNASP IV through decongesting Health facilities over-burdened by HIV and offering vital services to communities . The objective of CSS as espoused in ZNASP IV is to ensure that at least 30% of HIV services are community led by 2025 (MoHCC, ZNASP IV, 2020). The MTR concluded this is in line with global AIDS Strategies and frameworks which emphasize implementation

and scale-up of evidence- informed, rights-based, community-led combination prevention packages that are designed to address the diverse needs, circumstances and preferences of the populations who need effective prevention the most that can yield the greatest programmatic impact (UNAIDS, 2021).
Despite low knowledge of ZNASP IV CSS Indicators at MTR CSS remains a core Strategy within ZNASP IV and widely supported by stakeholders.
The country surpassed (62 against a target of 40) the target for the number of districts with community led initiatives. Similarly, the programme surpassed the target for the number of districts with ward-based community-based monitoring system. The figure below shows this progress.

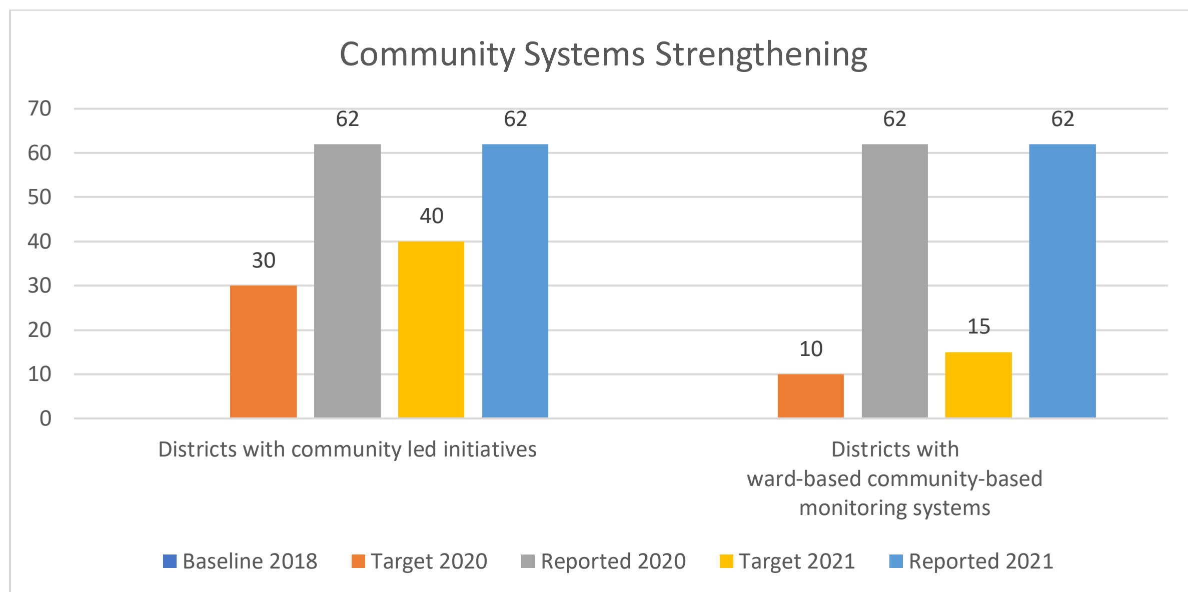


Figure 14: Progress towards achieving CSS targets.

However, there has been a push back on other indicators e.g. involvement of PLHIV in support groups, male involvement, inclusion of informal and private sectors whilst others are not being collected at all e.g. 'annual rate of retention of nurses at primary health care facilities'.
As such the MTR is recommending the continuation and intensification of CSS strategies in ZNASP IV whilst strengthening CSS indicators, coordination, data collection, analysis and sharing, standardization of CML tools, strengthening of community research and advocacy, increasing community social contracting and skilling of communities and their cadres to remain central in leading the response.

Gaps

- Limited awareness of ZNASP IV at community level
- Limited domestic funding for CSS
- Absence of a CSS Capacity Building Plan
- Absence of CSS Guidelines to guide communities.
- Absence of a community advocacy and research agenda
- Limited standardization of Community Led Monitoring (tools and data flow) – Beyond GF and PEPFAR
- Inadequate CSS indicators

Strategies

The strategies outlined in ZNASP IV remain adequate and relevant. At least 30% of HIV services are community led by 2025 is still critical but the target be increased to at least 50%. The following indicators are being suggested to complement the existing Indicators

- 80 per cent of HIV prevention services for populations at high risk of HIV infection, including for women within those populations be delivered by women led and KP led networks.
- # Number of community organizations that received a predefined package of training
- Percentage of health service delivery sites with a community-led monitoring mechanism in place.
- Percentage of civil society organizations contracted by public entities for provision of community-based services to key populations.
- 60 per cent of programmes to support the achievement of societal enablers be delivered by community led organisations.
- Less than 10% of People Living with HIV and Key Populations experience stigma and discrimination.
- Less than 10% of People Living with HIV, women and girls and Key Populations experience gender-based inequalities and gender-based violence.
- Less than10% of communities have punitive laws and communities.

3.3.4.6 Procurement

With Zimbabwe reaching the 95-95-95 targets, it is imperative that a well-functioning procurement and supply chain management (PSM) of health and non-health products is in place to sustain the gains in ART coverage and viral load suppression. Reductions in commodity prices and increased efficiency in HIV programming have contributed to the three 95's success. PSM pandemic preparedness and agility saved the country from the negative consequences seen in other functions of the national response. The country never experienced stock outs of health products. While prices and freight charges went up during the pandemic and the recent war in Ukraine, the country's PSM utilised centrally coordinated health products quantification, pooled procurement, long term partnership agreements with suppliers, and centralised warehousing and distribution to generate savings. Threats to sustainability in procurement include:

- staff turnover due to brain drain.
- delayed quantification.
- budget overruns; and
- a harsh macroeconomic environment.

The following strategies are proposed for 2024-2026:

- Improving forecasting and quantification, efficiency, purchasing and distributing drugs and commodities to all health facilities involving all stakeholders in the processes.
- Increase employee incentives/Offer retention allowance to critical staff.
- Invest in storage, refresher trainings, and PSM staff at the lower levels.
- Begin quantification very early.
- Lobby for budget approvals early to enable early quantification.
- Finalise arrangements to procure active ingredients through Natpharm and provide private players to buy from there.

- Engage RBZ to be flexible with forex allocation.

3.3.4.7 Lab Services

Efficient laboratory systems are critical enablers to sustain the 95% viral load suppression target. This entails that the lab has sufficient supplies, well-functioning equipment, suitable infrastructure, and productive staff members. Lack of universal real time reporting of laboratory information is affecting quantification for procurement. Threats to sustainability in laboratory include:

- Operational costs high even for new machines
- Limited storage capacity for laboratory reagents and supplies at facility level.
- Lack of knowledge of the appropriate conditions for the storage and distribution of reagents and supplies.
- staff turnover due to brain drain.
- delayed quantification.
- budget overruns; and
- aging machinery/equipment associated with high operational costs.

The following strategies are proposed for 2024-2026:

- Improving forecasting and quantification, efficiency, purchasing and distribution
- Increase employee incentives/Offer retention allowance to critical staff.
- Invest in storage, refresher trainings, and lab staff at the lower levels.
- Begin quantification very early.
- Continue investing in new machines to improve cost effectiveness.
- Invest in local technician capacity building to cut on labour costs.
- Invest in infrastructure.
- More frequent trainings required to deal with high staff turnover.

3.3.4.8 Strategic Information

Situational analysis at MTR: ZNASP IV recommends sub-district targeting, and more granular data collection at community level. At review, though targeting has been done at district level reference to the national targets as defined in ZNASP M and E Performance Framework remained weak. Furthermore annual reviews of ZNASP framework has been minimal. Currently the global focus towards effective HIV prevention programming advocates for the establishment of real-time prevention programme monitoring systems with regular reporting. By establishing the community led monitoring systems in DHIS2 for both reporting and client tracking Zimbabwe has setup structures to address this need. There is now a much greater emphasis on data-driven decision making, increasing granular data tracking where reporting averages has been noted to miss on those being left behind. Using more granular data can reduce inequalities by identify and addressing the characteristics that lead to inequalities in testing, treatment and care access and outcome. There is increase advocacy towards data, science, research and innovation across all areas of ZNASP to inform, guide, and reduce HIV related inequalities and accelerate the development and use of HIV services and programmes.

Table 10: Summary of strategic information indicators

Indicator	Baseline 2018	Target 2020	Reported 2020	Target 2021	Reported 2021	Target 2022	Reported 2022
Percentage of districts with district specific targets		1	0	1	0	100%	100.0%
Percentage of district specific targets reported on		1	0	1	0	100%	100.0%
Percentage of health facilities with functional patient level electronic reporting systems	39%	1		1		70%	100.0%
Number of districts with functional community based electronic systems		15		30	62	6	62
Number of Research and Surveillance projects conducted		4		4		4	
Number of national ZNASP progress review meetings held with stakeholders and partners		2	0	2	0	2	0

Strategies defined by ZNASP IV remain current and in line with global calls for granular reporting and tracking to end inequalities. However, there is need to develop appropriate data exchange platforms to allow for richer data exchange and deeper data analysis across the different service points and programmes. The following indicators were proposed to be removed

- Percentage of private sector health facilities dispensing ART based on the national guidelines. **Reason:** Numerator and denominator cannot be ascertained
- Number of people affected/ infected with HIV who successfully sort legal redress. **Reason:** This indicator is vague and difficult to track.

Noting that the current CSS Indicators did not reflect or capture CSS initiatives and the need to adapt Global Indicators to capture all CSS initiatives, it was proposed to add the following indicators:

Type of indicator	Indicator description	Disaggregation Category
Output	Number of community organizations that received a predefined package of training	Type of organization (community-based, community-led). Type of community-led organization (KVP-led(TB),KP-led (HIV), women-led (all diseases).
Output	Percentage of health service mechanism in place.	Type of CLM mechanism (HIV, TB, malaria,TB/HIV, TB/HIV/malaria).
Output	Percentage of civil society organizations contracted by public entities for provision of community-based services to key populations.	Source of financing (domestic, external).Disease (HIV, TB, malaria). Type of key populations
Outcome	Less than 10% of People Living with HIV and Key Populations experience stigma and discrimination Less than 10% of People Living with HIV, women and girls and Key Populations experience gender based inequalities and gender based violence	Type of KP by sex, age and geographic coverage Type of KP by sex, age and geographic coverage Types of inequalities experienced Type of GBV

	Less than10% of communities have punitive laws and policies	Types of punitive laws Communities experiencing punitive laws Geographic coverage

3.3.4.9 Human Resources for Health

Situational Analysis at MTR; The MTR documented anecdotal reports from Stakeholders of critical health staff shortages, especially nurses. There were reports of high attrition especially among nurses emigrating to developing countries such as the UK and United States. Nurses are critical to access and availability of health services including HIV and without them there is a potential the country could report low health outcomes by 2026. The issue of staff shortages has been documented since 2016 as the table below acknowledges (Source: GoZ (2017) Global Fund Funding Request Application) however from 2019, it appears this has been further exacerbated by the prevailing economic challenges, though no data is available as of 2022.

Table 11: Vacancy rates for key cadres, June 2022 (HSB)

Cadre	Vacancy rate
Registered general nurse	18%
District medical officer	22%
Laboratory scientist	46%
Pharmacist	31%
Pharmacy technician	22%
Health promotion officer	13%
Government medical officer	28%
Primary care nurse	3%

The inequalities report (2022) also reported high staff turnover rendering trainings offered to staff on stigma and discrimination against clients ineffective as there are frequently new staff members at healthcare facilities. Despite staff trainings budgeted for in every NSP, complaints against staff attitudes by KPs and vulnerable populations consulted suggests that the trainings need more frequency or delivering at a lower education level. The 2021 report showed knowledge gaps ranging 50%. Most key and vulnerable participants indicated poor healthcare staff attitudes which suggests lack of training for staff on special services provision to survivors of violence, marginalised groups and LGBQTI+ community.

The gaps and strategies identified in ZNASP IV remain critical and relevant, since adequate, motivated and skilled human resources remain key to delivery of quality HIV and STIs interventions. In addition there is need to collect data on the retention of health service providers as it provides a proxy for access and availability of health services. The adoption of the CLM indicator linked to health facilities will be critical to add - % of health service delivery sites with a community-led monitoring mechanism in place.

Gaps

- High staff shortage resulting from the freezing of employment by government and inequitable distribution.
- 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 level and at service delivery points creating sustainability risk in the HIV and STI response in the event of pull out by partners.

Strategies

1. Develop skills of healthcare workers in both public and private sector based on comprehensive needs assessment
2. Develop skills of community care cadres to provide integrated HIV services
3. Improve staff motivation and retention through advocating for additional staff recruitment and developing innovative staff motivation and retention schemes
4. Develop and implement a transition plan for donor seconded or supported staff

3.3.4.10 Coordination

NAC coordinates the multi-sectoral national response to HIV and AIDS since its setup through an act of parliament in 1999. NAC has cascaded coordination to provincial and district levels. In terms of its role in resource mobilization, NAC administers the National AIDS Trust Fund (NATF) collected through the AIDS Levy (3% collected from every workers taxable income (PAYE) and corporate tax). NAC has taken lead in international resource mobilization with its program coordination attracting significant funding from donors which has sustained the national response in light of limited domestic funding. In addition to that, GoZ's thrust to invest in multipurpose medical equipment and infrastructure has led to the country's preparedness for COVID 19 and future pandemics. GoZ's stewardship of laboratory and procurement centralized quantification has yielded benefits of bulk procurement yielding low prices; quality forecasts which yielded efficiencies in matching demand to stock holding, delivery lead times. Covid 19 showed that this system is robust to pandemics because the country did not experience major stockouts or increased product and shipment costs and the prices were already locked into long term contracts. GoZ is also working towards local manufacturing with cotrimoxazole being manufactured locally on one hand, whilst on the other, plans are underway to service a machine used to prepare domestically manufactured medicines for WHO accreditation.

There is need to strengthen the coordination of activities involving other government ministries such as education and law enforcement. While agreements and MOUs would be in place, the other government stakeholders do not seem to prioritise budgeting and implementation of agreed activities or monitoring implementation by their staff.

To reduce inequalities with a particular focus on key and vulnerable populations, the KP program is coordinated through the Key Populations Forum for KP-led organisations and implementers. A KP Technical Working Group reviews technical issues with regard to planning, implementation and monitoring of the programme and advises on strategic and programmatic issues. A KP Technical Support Committee (TSC) was set up in 2019 cochaired by the Ministry of Health and Child Care and NAC.

The first "10" requires that less than 10% of countries have punitive legal and policy environments that deny or limit access to services. NAC needs to take leadership in coordinating advocacy for the removal of barriers to an enabling legal and policy environment which is important in reducing inequalities. With 70% of new infections attributed to KPs and their partners globally, NAC also needs to coordinate resource mobilization for KP earmarked funding to facilitate their universal health coverage. There is need to strengthen capacity and processes to support NAC to craft appropriate policies and laws in that recognize all key populations and their funding priority.

3.3.4.11 Financing of the ZNASP IV

1. Greater emphasis on programmatic and financial sustainability, to ensure the progress we achieve can withstand shocks and reversals, and that the momentum can be sustained

2. Continue to incentivize domestic financing of interventions that address HIV prevention efforts for KP and human rights-related barriers to services. We will expand efforts to encourage and catalyse domestic financing

Table 12: Summary of Expenditure on the Response

Fiscal Year	**2024**	**2025**	**2026**
NSP Resource Needs	$572,988,587.94	$553,937,396.05	$579,437,310.29
Government revenue	$61,642,162.52	$63,861,280.37	$66,160,286.46
United States Government (USG)	$207,360,183.33	$207,360,183.33	$207,360,183.33
Global Fund	$150,000,000.00	$150,000,000.00	$150,000,000.00
Swedish International Development Cooperation Agency	$2,943,954.25	$2,331,845.00	$2,331,845.00
Health Resilience Fund in Zimbabwe	$1,327,869.98	$1,327,869.98	$1,327,869.98
Total External Sources	$361,632,007.56	$361,019,898.31	$361,019,898.31
Total Domestic & External Resources	$423,274,170.08	$424,881,178.68	$427,180,184.77
Financial gap	26.13%	23.30%	26.28%
% Domestic Resources	11%	12%	11%
% External Resources	63%	65%	62%

Table 12 shows forecasted funding and expenditures for ZNASP 2024-2026. Resources required will range between $554 million to $579 million and averaging $569 million over the period 2024 to 2026. Domestic public funds will average $64 million which is approximately 11% of total annual resource requirements. ZNASP IV aimed to increase domestic resources from 20% at baseline in 2018 but macroeconomic challenges in the country, the COVID 19 pandemic and the war in Europe have all combined to constrain economic growth and fiscal space. ZNASP IV also aimed to reduce the financial gap from 40% in 2018 to 20% in 2025. The projections show that the financial gap is expected to range between 23.3% and 26.3% and average 25% over the period 2024 to 2026. A more detailed breakdown of the costed M&E plan and its methodology are presented in appendix 2.

To close the financial gap, ZNASP IV had proposed to:

- increase efficiency of the HIV response through more effective targeting and innovative modes of service delivery.
- strengthening public private partnerships
- 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

The DSD model has worked in increasing efficiency and also proved an effective model to achieve programmatic sustainability during COVID 19 lock-downs which shows better preparedness for future pandemics. Implementation of social contracting has also proved the country's willingness to engage non state actors to provide for services in areas of low government comparative advantage. In addition, the country leveraged on C19RM HIV

mitigation grant to invest in multi-purpose infrastructure and equipment which enhanced the preparedness for future pandemics. This ensures shows the country's transition planning since the non-state actors have previously been funded by developmental partners. However, consultations with private sector have shown that there has not been much meaningful private sector engagement to lobby for its involvement in the national response's financing beyond the AIDS levy. These findings suggests that public health resources from current streams are going to be inadequate without additional innovative solutions. Greater emphasis on programmatic and financial sustainability will ensure that the national response withstands shocks and that the momentum in gains made so far can be sustained.

Proposed strategies:

- Develop community led financing guidelines.
- Develop a sustainability HIV funding plan.
- Improve resource tracking and transparency.
- Lobby for an increase in government funding through AIDS levy, statutory and dormant funds.
- Engage bilateral and multilateral partners for debt SWAPS for transition planning.
- Integrating HIV financing within private health insurance.
- In 2021, key populations and their partners were responsible for 70% of new infections. There is need to mobilize an earmarked fund for KP and vulnerable populations to reduce inequalities in the national response23. This will facilitate universal health coverage by KPs and a reduction in inequalities in access and outcomes.

[23] https://www.unfpa.org/sites/default/files/board-documents/main-document/Report%20on%20the%20implementation%20of%20the%20decisions%20and%20recommendations%20of%20the%20Programme%20Coordinating%20Board%20of%20the%20UNAIDS%20%28DP-FPA2023-1%29.pdf

4. Conclusion

The HIV estimates suggest that HIV prevalence among the population aged 15-49 declined by 18.3% from 15.2% in 2015 to 11.6% in 2021 and is projected to decline further to less than 9.6% by 2025. The number of PLHIV on ART and ART coverage has improved. ***New infections and death are increasing especially among young people.***

The country currently faces a triple threat of HIV, STIs and Teenage pregnancy hence the need to ***redesign the response to reflect the emerging picture***. The number of new infections per 1000 uninfected people (HIV incidence) has remained steady in ZIMPHIA in 2016 and 2020 (0.42% in 2016, 0.45% in 2020 (ZIMPHIA)). HIV incidence rate is females is almost double (2016) to triple that in males in 2020.

The country has made substantial progress towards HIV epidemic control and the goal of ending AIDS by 2030. Progress on the 95-95-95 targets is impressive with 97% of people living with HIV knowing their status, 95% of those who know their status on treatment and 94% of those on treatment virally suppressed. Despite this progress, there are **some population groups that are being left behind including children, adolescents and young people as well as key populations.** The country has also made great strides towards the commitment of zero new HIV infections, zero AIDS related deaths and zero stigma and discrimination. However, more needs to be done as the number of new HIV infections and AIDS related deaths are still unacceptably high whilst HIV related stigma and discrimination is still prevalent. Progress is also hampered by inadequate response to address emerging priories for PLHIV such as ageing with HIV, NCDs and mental health, advanced HIV disease, and quality of care.

There are gaps emanating from centralized testing capacity which is increasing cost of outreach programmes. *Stock out of rapid test kits further constrain effectiveness while there has been reports of loss of referred clients due to HIV testing performed outside of medical entry point (ANC, infectious disease in-patient settings).* ***The country still experiences extremely limited paediatric case detection outside of EID despite medical protocols. There is low uptake of HTS by couples and families resulting in missed opportunities to offer HTS***. In addition, there is poor follow up and linkage for clients who test positive because of limited community-based testing activities. ***Young people also face difficulties in accessing testing facilities due to health worker attitudes and stigma***. TB screening at HIV clinics is not routinely being done and psychosocial support is hindered by a lack of well-established and coordinated support groups. Private Sectors are not effectively coordinated and their efforts are neither being tracked nor acknowledged.

A routine programme monitoring system has been institutionalised and data currently flows through the DHIS 2 from lower levels. ***The current structure and reporting do not support effective data quality assurance while the system currently tracks GF supported programmes only.*** The capacity of staff is currently not structured to address identified gaps. Support and supervision have limited scope for coaching and mentoring. The MoHCC M&E TWG is not linked to the NAC TWG. Data quality and reliability remains a huge challenge along with multiple data management system which are contrasting each other in terms of numbers.

The country has a sound, however theoretical Pharmaceutical Management Information System (PMIS) that still suffers from lack of updated information which is critical for the smooth functioning of the pharmaceutical supply chain and management. The need for strengthening of all pharmaceutical and laboratory hub systems for improved procurement and logistics management cannot be overemphasised. This will minimise stockouts of pharmaceutical and laboratory commodities and other non-health products. ***The Response should also leverage private sector distribution chains and networks for improved distribution of pharmaceutical and laboratory commodities.***

The current investment which is focused on key populations other than the most at-risk populations such as adolescent girls and young women (AGYW) will likely not yield any significant results for the HIV response. Overreliance on one single source of external funding also remains a threat for future sustainability of the HIV Response. The COVID 19 pandemic, the war in Ukraine and a harsh macroeconomic environment threatened value for money in ZNASP IV spending. Budget execution was below threshold in 2021 indicating low efficiency in implementation. The Ukraine war resulted in an increase of fuel prices of up to 36% while local inflation and unstable currency led to price increases beyond budgeted unit costs on salaries, accommodation and allowances which threatened attainment of economy in ZNASP IV implementation. Procuring units countered these challenges using long term contracts and bulk buying which restored ***economy, efficiency, and sustainability***. Domestic public funding of ZNASP IV, however, remains depressed which shows that the country does not have a sustainable plan in place for transitional planning, financial and programmatic sustainability.

5. Strategic/Policy Recommendations

1. Develop and implement an HIV prevention package that is based on data driven assessment of HIV prevention needs of different subpopulations and geographic areas.
2. Future programming should emphasise the adoption of precision prevention approaches; community led services; removal of social and legal barriers; integration of HIV prevention with essential services; rapid introduction of new HIV prevention technologies; establishing real time prevention programme monitoring systems and strengthening accountability of all stakeholders.
3. Scale up PrEP and the new biomedical HIV prevention methods such as the long acting Cabotegravir injection and the Dapivirine vaginal ring as part of combination HIV prevention.
4. Develop and implement a triple elimination strategy for the mother to child transmission of HIV, syphilis and hepatitis.
5. There is an urgent need to establish a functional ***(data-driven & problem solving)*** multi-stakeholder working group (meet monthly / quarterly) to coordinate a ***people-centred approach*** to the national condom programming in Zimbabwe.
6. It is crucial that NAC carries ***operational research*** to unpack and underscore the declining trends of HIV prevalence among the general population and the emerging increased prevalence among the AGYW population and inform evidence-based programming.
7. There is need to strengthen the implementation of strategies that aim to reduce HIV related mortality and improve the quality of lives of PLHIV including management of advanced HIV disease, management of HIV among ageing clients, prevention and management of comorbidities including NCDs and common mental health disorders.
8. There is need for ***more investment on viral load*** to urgently ensure 100% of VL coverage of all those who are on treatment.
9. Introduction of ***differentiated Service Delivery (DSD) model*** will fast track the treatment programme and improve quality of services including community-based self-testing facilities to reduce stigma and discrimination.
10. There is need to ***Improve linkage to care*** for all people that test positive including ***developing a Unique Identifier system*** to improve targeting and lost opportunities.
11. There is need to carry out ***ART client census*** to validate the active ART cases for proper forecasting and budgeting in the country.
12. NAC need to set up ***strong coordinating mechanisms and structures*** between NAC and other Ministries/Departments with accompanying MoUs which sets out clear parameters for collaboration, and ***revisit TORs of the National AIDS Council to ensure its oversight role is strengthened.***
13. NAC and its Partners must develop a mechanism for ***joint planning, monitoring, and reporting*** of funds to improve accountability and value for money.
14. NAC should develop a ***sustainability plan for HIV financing*** with meaningful involvement of the private sector and communities and buy in from Ministry of Finance at the strategic level to facilitate transitional planning.
15. Stakeholders need to reprioritise prevention to ***sustain gains*** in the national response.
16. NAC should redesign the national HIV response to a model that puts people living with HIV and communities at risk at the centre and expand focus beyond the current 95-95-

95 targets to a more comprehensive package that includes the removal of societal and legal impediments to service delivery, linking or integrating the provision of HIV services with the other services needed by people living with HIV and communities at risk to stay healthy and build sustainable livelihoods. This will include targets on the six 95% targets on combination prevention, SRH, eMTCT, viral suppression, diagnoses and linkage to ART: ***the three 10% targets on punitive laws and policies, stigma and discrimination as well as gender inequality and violence***.

17. The national response should embrace, expedite the introduction and scale up new technology and emerging interventions for HIV prevention and treatment such as blood based HIVST platforms, biomedical prevention methods like PrEP ring and injectable as well as long-acting ART.
18. Strengthen data system for real time monitoring of the national response and quality data to inform improvement, decision, and policy formulation.

6. Annex 1 ZNASP IV Addendum Results Framework

ZNASP IV Addendum Results Framework															
Framework	Indicator	Category	Level	Source of Data	Frequency	Disaggregation	Baseline (2018)	2020	2021	2022	2023	2024	2025	2026	Assumptions
Impact	Reduced total HIV New Infections as a percentage of 2010 levels	Impact	Impact	HIV estimates	Annual	Total	39,000	45.10%	51.50%	57.90%	62.80%	66.20%	67.70%	70%	Based on an 80% reduction from a reference year of 2010 (62920 new infections). Targets are based on 2018 estimates
			Impact	HIV estimates	Annual	Female	22,000	45.90%	52.30%	58.60%	63.20%	66.40%	68.20%	70%	Based on an 80% reduction from a reference year of 2010 (62920 new infections). Targets are based on 2018 estimates
			Impact	HIV estimates	Annual	Male	17,000	44.10%	50.60%	57.10%	62.40%	65.90%	67.10%	70%	Based on an 80% reduction from a reference year of 2010 (62920 new infections). Targets are based on 2018 estimates
	Reduced HIV New Infections in children 0 to 14 years as a percentage of 2010 levels	Impact	Impact	HIV estimates	Annual	Children	5,000	0.00%	8.00%	20.00%	30.00%	40%	45%	50%	Based on an 80% reduction from a reference year of 2010 (62920 new infections). Targets are based on 2018 estimates
	Reduced HIV New Infections in adolescents (10 to 19) as a percentage of 2010 levels	Impact	Impact	HIV estimates	Annual	Total	5500	43.60%	50.90%	58.20%	61.80%	65.50%	67.30%	70%	Based on an 80% reduction from a reference year of 2010 (62920 new infections). Targets are based on 2018 estimates
	Reduced HIV New Infections 15 to 24 years as a percentage to 2010 levels	Impact	Impact	HIV estimates	Annual	Total	13500	43.70%	50.40%	57.00%	62.20%	65.20%	66.70%	70%	Based on an 80% reduction from a reference year of 2010 (62920 new infections). Targets are based on 2018 estimates
			Impact	HIV estimates	Annual	Female	9,200	44.60%	51.10%	57.60%	63.00%	66.30%	67.40%	70%	
			Impact	HIV estimates	Annual	Male	4,300	41.90%	48.80%	55.80%	60.50%	65%	67%	70%	
	Reduced New HIV infections per 1000 population reduced from 2.85 in 2018 to 0.55 by 2026	Impact	HIV estimates	Annual			2.85	2.48	1.23	1.07	0.94	0.75	0.57	0.55	
	Reduced AIDS deaths per 100,000 population	Impact	Impact	HIV estimates	Annual		141.5	4.20%	7.80%	20.10%	29.30%	35.50%	38.60%	40%	

	Reduce Annual total AIDS deaths	Impact	Impact	HIV estimates	Annual	Total	21,800	15.60%	25.20%	35.30%	42.70%	47.70%	50.50%	52%	
			Impact	HIV estimates	Annual	Female	11,200	11.60%	22.30%	33.00%	40.20%	45.50%	48.20%	50%	
			Impact	HIV estimates	Annual	Male	10,600	19.80%	28.30%	37.70%	45.30%	50.00%	52.80%	53%	
	Reduced annual AIDS deaths among children 0 to 14 years	Impact	Impact	HIV estimates	Annual	Total	3300	12.10%	39.40%	51.50%	53%	55%%	57.60%	58%	Targets have been surpassed.
	Reduced AIDS deaths for adults (15+ years) from 18500 in 2018 to 8400 by 2026	Impact	Impact	HIV estimates	Annual	Total	18500	22.70%	31.90%	41.10%	47.60%	52.40%	54.60%	55%	
	Reduced Under 5 AIDS related mortality	Impact	Impact	Special Studies	Annual						53.40%		61.40%	62%	
Primary Prevention															
HTS	Increased proportion of men and women, living with HIV who know their HIV status		Outcome	HIV estimates	Annual	Total 15+years	90%	91%	92%	93%	94%	95%	95%	95%	UNAIDS Baseline 2018
						Female	90%		92%	93%	94%	95%	95%	95%	UNAIDS Baseline 2019
						Male	90%		92%	93%	94%	95%	95%	95%	UNAIDS Baseline 2020
	Increased proportion of children (0 to 14 years), living with HIV who know their status		Outcome	HIV estimates	Annual	Total	68%	70%	80%	90%	95%	95%	95%	95%	UNAIDS Baseline 2021
	Increased proportion of people 15 to 24 living with HIV who know their HIV status		Outcome	HIV estimates	Annual	Total	No data	90%	93%	93%	94%	95%	95%	95%	
			Outcome	HIV estimates	Annual	Female	no data	90%	93%	93%	94%	95%	95%	95%	
			Outcome	HIV estimates	Annual	Male	No data	90%	93%	93%	94%	95%	95%	95%	
	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	Annual	Women	61%	60%	65%	70%	80%	90%	95%	95%	
						Men:	47%	60%	65%	70%	80%	90%	95%	95%	
	Number of men and women who were tested and received their results increased		Output	Programme	Annual	Total	3,011,027	2,580,149	1,769,084	1,805,214	1,793,079	1,777,957	1,814,657	1,814,000	2020 is derived from Global Fund Performance framework 2018 to 2020. 2021 to 2025 are based on projected number of professional use RDTS
						Female	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 Males from 2021 are being increased by 1% for annually from 37% to 42% 2025

						Male	1,051,834	954,655	672,252	704,033	717,232	728,962	762,156	356404	
	Quantity of blood units screened for HIV increased		Output	Programme	Annual		82257	98000	103000	108000	113500	119200	125300	130000	
	Percentage of HIV positive results among the total HIV tests performed during the reporting period maintained		Output	Programme	Annual		6%		5%	5%	5%	5.50%	5.40%	5%	
Pre-exposure Prophylaxis	People at substantial risk of HIV infection reached wth PrEP increased	Pre-exposure prophylaxis	Outcome	Programme Data	Annual		Not available	65%	70%	75%	80%	85%	90%	95%	
	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	6528	10536	50990	79502	79,092	85,875	89,894	66,680	
						Sero-discordant couples (SDCs)		4400	6417	6609	10,149	10,149	10,149	10,149	
						FSW	1570	2475	5940	6213	6,960	6,960	6,960	6,960	Based on 90% of HIV negative FSWs
						MSM	749	1326	1474	1637	4,931	4,931	4,931	4,931	
						PWID	124		20	44	430	430	430	430	
						AGYW (15-19)	No data	1,034	13,442	20,863	12,037	13,494	14,357	12,037	
						AGYW (20-24)	No data	658	16,450	36,190	25,106	28,145	29,945	25,106	
						Transgender			150	206	579	579	579	579	Target is 90% of the eligible should have access to PrEP
						Pregnant and Lactat			6543	7557	18,900	21,187	22,543	6,488	

						ing 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**		**No data**	**58%**	60%	62%	64%	66%	68%	70%	**All of these must be given PEP**
	Percentage of Health Staff reached with PEP within 72 hours of exposure		**Output**	**Programme Data**	**Annual**			**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**This is estimated at about 0.05 of the total Human Resources for Health (nurses and doctors)**
	Percentage of Sexual and gender-based violence victims reached with PEP within 72 hours of exposure increased		**Output**	**Programme Data**	**Annual**		**2356**	**7700**	60%	62%	64%	66%	68%	70%	
	Percentage of People engaged in high risk unprotected sex reached with PEP within 72 hours of exposure		**Output**	**Programme Data**	**Annual**		**No data**	**3000**	60%	62%	64%	66%	68%	70%	**This is estimated at targeting all projected annual new infections in the age group of 15-24 years. To be finalised with programmes**
	Percentage of Sexually abused clients received PEP (HIV, STI, ECP) within 72 hrs	**Post-exposure prophylaxis**	**Outcome**	**Programme Data**	**Annual**		**25%**	**100%**	**-**	62%	64%	66%	68%	70%	
VMMC	**Increased proportion of men 15 to 49 who are circumcised from 43% in 2018 to 85% by 2026**	**VMMC**	**Outcome**	**Programme Data**	**Annual**		**43%**	**50%**	**60%**	**65%**	**70%**	**75%**	**80%**	85%	
	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**	**299,302**	**330,178**	**331,000**	**370,369**	**4,095,122**	**463,448**	**175,211**	125,898	
Key Pops	**Increased proportion of KP reached with the package of HIV combination prevention services**	**Key Populations and Vulnerable Groups**	**Outcome**	**Programme Data**	**Annual**	**FSW**	**no data**	**75%**	**80%**	**85%**	**85%**	**90%**	**90%**	95%	
						MSM	**no data**	**65%**	**75%**	**85%**	**90%**	**90%**	**90%**	**95%**	
						Transgender	**no data**	**40%**	**65%**	**75%**	**85%**	**90%**	**90%**		
	Key populations living with HIV who know their status increased		**Outcome**	**Programme Data**	**Annual**	**FSW**	**93.60%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	95%	

						MSM	50%	65%	70%	75%	80%	85%	90%	95%	
						Transgender	no data	65%	70%	75%	80%	85%	90%		
	Increased proportion of Key populations who received ART	Key Populations and Vulnerable Groups	Outcome	Programme Data	Annual	FSW	71.90%	75%	80%	85%	90%	95%	95%	95%	
						MSM	77%	80%	90%	95%	95%	95%	95%	95%	
						Transgender	no data	50%	90%	95%	95%	95%	95%	95%	
	FSW reached with the defined package of HIV combination prevention services increased		Output	Programme Data	Annual	Population size estimates 45 000	19800	33750	36000	38250	40500	42750	42750	43000	
	MSM reached with the defined package of HIV combination prevention services increased		Output	Programme Data	Annual	Population size estimates	no data	8000	10000	12000	13000	14000	15000	16000	The assumption is based on population size estimates done in Harare and Bulawayo (IBBS-2019)
	Transgender reached with the defined package of HIV combination prevention services increased		Output	Programme Data	Annual		no population size estimate								
Prisons	PLHIV in prisons know their status increased		Outcome	Programme Data	Annual		28%	100%	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
	Increased proportion of PLHIV in prisons are on ART		Outcome	Programme Data	Annual	No data		65%	70%	75%	80%	85%	90%	95%	
	All Prisons implementing an effective TB screening		Outcome	Programme Data	Annual		no data	100%	100%	100%	100%	100%	100%	100%	
	All Prisoners with active TB infection initiated on appropriate TB treatment		Outcome	Programme Data	Annual		0.40%	100%	100%	100%	100%	100%	100%	100%	This is to say that of all cases of TB they must be put on treatment
	PLHIV in prisons know their status		Output	Programme Data	Annual		5572	5572	5572	5572	5572	5572	5572	5572	This is to say that of all cases of TB they must be put on treatment

	PLHIV in prisons are on ART		Output	Programme Data	Annual			5572	5572	5572	5572	5572	5572	5572	This follows the test and treat principle
	Prisoners screened for TB		Output	Programme Data	Annual			19000	19000	19000	19000	19000	19000	19000	Assumes you screen every prisoner
	Prisoners with active TB infection initiated on appropriate TB treatment		Output	Programme Data	Annual	uses a prevalence of 0.4%	22	80	80	80	80	80	80	80%	This is to say that of all cases of TB they must be put on treatment. This is based on TB prevalence of 0.4%
Vulnerable groups	Vulnerable groups reached with the defined package of HIV combination prevention services increased	Key Populations and Vulnerable Groups	Outcome				no data	10%	20%	30%	40%	50%	50%	60%	Vulnerable groups farm workers, artesanal miners, people with disabilities, mobile and cross border populations, and fishermen)
	Vulnerable populations reached with a defined packaged of combination prevention service increased	Condom Programming	Outcome	ZIMPHIA 2016	Annual	Total	25900	36000	41000	46000	51000	56000	60000	65000	Artesanal miners data is available, PWD should be available, ILO should have data
Condom Programming	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	55%	65%	70%	75%	80%	85%	90%	95%	
						Female	44.20%	65%	70%	75%	80%	85%	90%	95%	
						Male	65.70%	65%	70%	75%	80%	85%	90%	95%	
	Increased proportion of men and women(15-49) who reported using a condom during the last sexual intercourse with a none marital, non cohabitating partner					Female	66.70%	70%					90%	95%	
						Male	85.30%	86%					90%	95%	
	Increased condom use in paid sex among men and women 15 - 49 years	Key Populations and Vulnerable Groups	Outcome	ZDHS	5 years	Total	90%						95%	95%	
						Female	90%						95%	95%	
						Male	90%						95%	95%	
	Key populations reporting the use of a condom with a regular or steady partner increased	Condom Programming	Outcome	ZDHS	5 years		no data						95%	95%	
	Key populations reporting the use of a condom with their most recent partner increased		Outcome	ZDHS	5 years		96%						95%	95%	

	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 Programming	Outcome	ZDHS MICS ZIMPHIA	5 years	Total	25%						90%	95%	
						Female	25%						90%	95%	
						Male	25%						90%	95%	
	Increased proprotion of young men and women aged 15-24 who can access condoms	Condom Programming	Outcome	ZDHS	5 years	Female	48.20%						90%	95%	
						Male	86.40%						95%	95%	
	Increased Male/female condoms distributed		Output	Programme Data	Annual	Male	134,000,000	116 m	116 m	122 m	128 m	134.4m	141.1m	141,100,000	The assumption is each male condom will have its lubricant
						Female	5,000,000	4.8m	5m	5.2m	5.46 m	5.733m	6m	6m	
STI	Men and women (15-49years) who had an STI in the last 12 months (by age and gender) reduced	Condom Programming	Outcome	Programme Data	Annual	Female	2.60%	2%	1.50 %	1.20 %	1%	<1%	<1%		
						Male	2.20%	2%	1.50 %	1.20 %	1%	<1%	<1%		
	Reduced new STI cases reported		Output				174,818	174, 500	173, 500	173, 400	173, 300	173, 200	173, 100	173,000	
	Percentage of STI cases treated		Output					87%	88%	89%	90%	91%	93%	100%	
EMTCT	Reduced infants born to HIV-positive mothers infected by HIV	EMTCT	Outcome	HIV estimates	Annual		7.80%	8.70 %	8.90 %	8.90 %	8.40 %	8.00 %	6.50 %	<5%	
	Increased proportion of pregnant women attending at least one ANC visit	EMTCT	Outcome	Programme Data	Annual		93.50%	91%	90%	92%	93%	94%	95%	95%	
	Pregnant women with known HIV status	EMTCT	Outcome	Programme Data	Annual		98.70%	96%	97%	97.50%	97.50%	98%	98.50%	99%	
	Pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months increased	EMTCT	Outcome	Programme Data	Annual		22%	25%	26%	27%	28%	29%	30%	30%	
	Percentage of HIV positive pregnant and lactating women who receive anti-retroviral therapy to reduce the risk of MTCT increased	EMTCT	Outcome	Programme Data	Annual		93%	87%	87%	88%	90%	92%	94%	95%	
	Increased proportion of Infants born to HIV positive mothers receiving ARV prophylaxis for prevention of MTCT		Outcome	Programme Data	Annual		72%	75%	77%	80%	83%	85%	87%	90%	
	Infants born to HIV-positive women received a Virological	EMTCT	Outcome	Programme Data	Annual		63%	56%	76%	77%	83%	85%	90%	90%	

	(DNA PCR) test for HIV within 2 months of birth increased														
	Pregnant women tested for syphillis increased	EMTCT	Outcome	Programme Data	Annual		91%	56%	85%	88%	90%	93%	95%	95%	
	Pregnant women, syphillis positive, treated for syphillis increased	EMTCT	Outcome	Programme Data	Annual		80%	81%	96%	95%	95%	95%	95%	95%	
AGYP	People with comprehensive correct knowledge of HIV&AIDS increased	Behavioural Change Communication	Outcome	ZDHS	5 years	Female	54.60%					95%	95%	95%	
						Male	55.70%					95%	95%	95%	
	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	5%						<1%	<1%	
						Male	6%						<1%	<1%	
	Adolescents and young people reached with comprehensive HIV prevention packages	Youth	Outcome	Programme Data	Annual	Female							90%	95%	
						Male							90%	95%	
	Girls and boys in school reached through HIV and AIDS life-skills education	Youth	Output	Programme Data		Female	1,000,000	1,010,000	1,020,000	1,030,000	1,040,000	1,050,000	1,060,000	1,070,000	
						Male	990,000	1,000,000	1,010,000	1,020,000	1,030,000	1,040,000	1,050,000	1,060,000	
						Total	1990000	2010000	2030000	2050000	2070000	2090000	2110000	2120000	
	Youth out-of-school reached with HIV&AIDS education	Youth	Output	Programme Data	Annual	Female	118000	123000	128000	133000	138000	143000	148000	150000	
						Male	115000	120000	125000	130000	135000	140000	145000	150000	
						Total	233000	243000	253000	263000	273000	283000	293000	295000	
	Youth in tertiary institutions reached with HIV&AIDS education	Youth	Output	Programme Data	Annual	Female	35000	40000	45000	50000	55000	60000	65000	70000	
						Male	5000	6000	7000	8000	9000	10000	11000	120000	
						Total	40000	46000	52000	58000	64000	70000	76000	82000	

	Increased proportion of PLHIV who are receiving ART	**Treatment**	**Outcome**	**Programme Data**	**Annual**	**Total Adults**	**85%**	**91%**	**92%**	**93%**	**94%**	**94.50%**	**95%**	95%	
Treatment						**Female**	**88%**	**93%**	**93%**	**93%**	**94%**	**94.50%**	**95%**	97%	
						Male	**82%**	**91%**	**92%**	**93%**	**94%**	**94.50%**	**95%**	95%	
						Children	**67%**	**69.80%**	**72.60%**	**75.40%**	**78.20%**	**81%**	**83.80%**	83.80%	
						Female 15-24	**88%**	**93%**	**93%**	**93%**	**94%**	**94.50%**	**95%**	95%	
						Male 15-24	**90%**	**91%**	**92%**	**93%**	**94%**	**94.50%**	**95%**	95%	
	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**	**90%**	**91%**	**92%**	**93%**	**93%**	**94%**	**95%**	95%	
						Female	**90%**	**91%**	**92%**	**93%**	**93%**	**94%**	**95%**	95%	
						Male	**90%**	**91%**	**92%**	**93%**	**93%**	**94%**	**95%**	95%	
						Children	**92%**	**92%**	**92%**	**93%**	**93%**	**94%**	**95%**	95%	
	PLHIV enrolled: outreach, facility, CARG(Community ART Refill Groups) , FARG(Family ART Refill Group) - Differentiated Service Delivery (DSD) Model	**Treatment**	**Outcome**	**Programme Data**	**Annual**	**Total Adults**	**35%**	**55%**	**60%**	**65%**	**70%**	**75%**	**80%**	52%	
	PLHIV on ART who are tested for viral load increased	**Treatment**	**Outcome**	**Programme Data**	**Annual**	**Female**		**50%**	**60%**	**70%**	**80%**	**85%**	**90%**	95%	
						Male		**50%**	**60%**	**70%**	**80%**	**85%**	**90%**	95%	
						Total Adults	**44.00%**	**70%**	**75%**	**80%**	**85%**	**90%**	**95%**	95%	**Baseline 2018: There were 502 000 viral load tests done in 2018. With 1,2 million people on ART**
						Female 15-24	**no data**	**80%**	**92%**	**93%**	**94%**	**95%**	**95%**	95%	
						Male 15-24	**no data**	**80%**	**92%**	**93%**	**94%**	**95%**	**95%**	95%	
	Increased proportion of PLHIV on ART who have a suppressed viral load	**Treatment**	**Outcome**	**Programme Data**	**Annual**	**Total**	**85.30%**	**90%**	**92%**	**93%**	**94%**	**95%**	**95%**	95%	

						Female	86.10%	90%	92%	93%	94%	95%	95%	95%	
						Male	75.10%	80%	92%	93%	94%	95%	95%	95%	
						Female 15-24	no data	80%	92%	93%	94%	95%	95%	95%	
						Male 15-24	no data	80%	92%	93%	94%	95%	95%	95%	
						Total Adults	no data	80%	92%	93%	94%	95%	95%	95%	
	PLHIV on ART		Output	Programme Data	Annual	Total Population	1,146,532	1,220,757	1,241,360	1,262,033	1,282,279	1,295,565	1,308,194		
						Female Adults+15	668,322	712,061	718,324	724,682	738,841	749,151	758,930		
						Male Adults+15	419,038	454,196	470,063	486,697	495,751	502,330	508,483		
						Children 0-14	59,172	54,500	52,973	50,654	47,687	44,084	40,781		
						Female 15-24	76,215	77,145	73,742	71,052	69,730	68,744	67,903		
						Male 15-24	34,041	42,781	41,916	41,489	41,306	41,297	41,145		
	Private sector (key definition) health facilities dispensing ART based on the national guidelines	Treatment	Outcome	Programme Data	Annual		no data	50%	65%	75%	85%	95%	100%	100%	
Meaningful Involvement of People Living with HIV/AIDS	PLHIV in support groups 15-24					Female	8000	21373	20812	20575	20494	20596	20501	21000	Based on 30% of the 15-24 living with HIV as the target
			Output			Male	6000	12184	12008	12090	12257	12544	12610	13000	
						Total	14000	33557	32820	32665	32751	33140	33111	34000	
	PLHIV in support groups 25-49					Female	25000	30000	180855	179817	178485	176869	174501	176000	Calculated at 30% of the total people living with HIV as the target.
			Output			Male	11000	26000	113759	112827	111793	110717	109179	111000	

						Total	36000	56000	294613	292644	290279	287586	283680	287000	
	Adolescents living with HIV received support from CATS - Adherance monitoring					Female	32000	37000	42000	47000	52000	57000	62000	65000	
			Output			Male	30000	35000	40000	45000	50000	55000	60000	65000	
						Total	62000	72000	82000	92000	102000	112000	122000	130000	
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		95%	100%	100%	100%	100%	100%	100%	100%	
	TB patients who are HIV positive enrolled on ART		Outcome	Programme Data	Annual		85%	90%	95%	95%	95%	95%	100%	100%	
	PLHIV diagnosed of TB put on TB treated.		Outcome	Programme Data	Annual		95%	100%	100%	100%	100%	100%	100%	100%	
	PLHIV newly enrolled in HIV care started on TB preventive therapy (TPT)		Outcome	Programme Data	Annual		2%	50%	70%	75%	80%	85%	90%	95%	
	PLHIV completed TB preventive therapy (TPT)		Outcome	Programme Data	Annual		77%	80%	85%	90%	95%	95%	95%	95%	
	TB patients tested for HIV		Outcome	Programme Data	Annual		90%	100%	100%	100%	100%	100%	100%	100%	
	TB patients enrolled on ART		Outcome	Programme Data	Annual		67%	100%	100%	100%	100%	100%	100%	100%	Assumption is all cases of TB must be screened for HIV
	PLHIV in care screened for TB during their last clinical visit		Output	Programme Data	Annual		37141	670000	800000	940000	1100000	1200000	1300000	140000	This is calculated as 50% to 95% of the PLHIV and are on ART
	TB patients, who are HIV positive, enrolled on ART		Output	Programme Data	Annual		45000	50000	55000	60000	65000	70000	75000	80000	This is an estimated figure of 5000 person increaments
Cervical Cancer	Percentage of women living with HIV (30 to 49 years) screened for cervical cancer	Integration of Services	Outcome	Programme Data	Annual				50%	70%	80%	85%	90%	95%	
	Percentage of women living with HIV (30 to 49 years) treated for cervical cancer		Outcome	Programme Data	Annual				50%	70%	80%	85%	90%	95%	
	Number of women living with HIV (30 to 49 years) screened for cervical cancer		Output	Programme Data	Annual		76000	81000	86000	91000	96000	101000	106000	111000	
	Number of women living with HIV (30 to 49 years) diagnosed for cervical cancer		Output	Programme Data	Annual		3800	4300	4800	5300	5800	6300	6800	7300	Estimated at 500 increments

	Number of women living with HIV (30 to 49 years) treated for cervical cancer		**Output**	**Programme Data**	**Annual**		**no data**	**4300**	**4800**	**5300**	**5800**	**6300**	**6800**	**7300**	**Target is to treat all diagnosed**
Mental Health	**Percentage of PLHIV screened for mental health**	**Integration of Services**	**Outcome**	**Programme Data**	**Annual**		**no data**		**50%**	**70%**	**80%**	**85%**	**90%**	**95%**	
	Percentage of PLHIV diagnosed mental health						**no data**		**50%**	**70%**	**80%**	**85%**	**90%**	**95%**	
	Percentage of PLHIV treated for mental health						**no data**		**50%**	**70%**	**80%**	**85%**	**90%**	**95%**	
	Number of PLHIV screened for mental health		**Output**				**no data**	**500**	**1000**	**1500**	**2000**	**2500**	**3000**	3500	
	Number of PLHIV diagnosed mental health						**no data**	All diagnosed	All diagnosed	All diagnosed	All diagnosed	All diagnosed	All diagnosed	All diagnosed	
	Number of PLHIV treated for mental health						**no data**	All diagnosed	All diagnosed	All diagnosed	All diagnosed	All diagnosed	All diagnosed	All diagnosed	
Hepatitis	**Percentage of PLHIV screened for Hepatitis B**	Integration of Services	**Outcome**	**Programme Data**	**Annual**		**no data**	**10%**	**15%**	**20%**	**25%**	**30%**	**35%**	40%	
	Percentage of PLHIV treated for Hepatitis B						**3%**	**3%**	**3%**	**3%**	**3%**	**3%**	**3%**	**3%**	**This is the positivity rate of HPV B. GAM**
	Number of PLHIV screened for Hepatitis B		**Output**				**1500**	**2000**	**2500**	**3000**	**3500**	**4000**	**4500**	4500	
	Number of PLHIV treated for Hepatitis B						**50**	**67**	**83**	**100**	**117**	**133**	**150**	**150**	**Maintaing the same 3% positivity rate**
	Percentage of PLHIV screened for Hepatitis C						**no data**	**10%**	**15%**	**20%**	**25%**	**30%**	**35%**	**40%**	**Estimated percentage**
	Percentage of PLHIV treated for Hepatitis C							**<1%**	**<1%**	**<1%**	**<1%**	**<1%**	**<1%**	**<1%**	**Based on the positivity rate**
	Number of PLHIV screened for Hepatitis C						**100**	**150**	**200**	**250**	**300**	**350**	**400**	**450**	**Based on the 2018 baseline of 103**
	Percentage of PLHIV treated for Hepatitis C						**0**	**<10**	**<10**	**<10**	**<10**	**<10**	**<10**	<10	
Reproductive Health	**Reduced unmet need for family planning among women living with HIV**	**EMTCT**	**Outcome**	**ZDHS**	**5 years**		**10%**						**6.50 %**	6%	
	Contraception used among women living with HIV						**67%**						**68%**	68%	

	Number of women living with HIV received HIV / SRH services		Output	Programme Data	Annual		no data	375000	455000	537000	620000	706000	752000	760000	This is based on the number of women living with HIV and increased from 50% for 2020, by 10% to 95% 2025
Nutrition	Reduced proportion of PLHIV who are malnourished	Integration of Services	Outcome	Programme Data	Annual		9%	8%	7%	6%	5%	5%	5%	5%	
	PLHIV received nutritional care and support		Output	Programme Data	Annual		117000	104000	91000	78000	65000	65000	65000	65000	
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		no data	2	2	2	2	2	2	2	
	Less than 10% of communities have punitive laws and policies		Outcome	Programme	Annual	Type Community Coverage								<10%	
Stigma	PLHIV reporting internalized stigma in the past 12 months reduced		Outcome	ZDHS	5 years		no data						<10 %	<10%	
	Percentage of PLHIV reporting anticipated stigma in the health facility		Outcome				no data						<10 %	<10%	
	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	40%						<10 %	<10%	
						Males 15-24	45%						<10 %	<10%	
						Females 15-49	28%						<10 %	<10%	
						Males 15-49	31%						<10 %	<10%	
	Reported stigma by key populations in health care settings		Outcome	Programme	Annual		no data						<10 %	<10%	
	Number of Health workers reached with stigma reduction interventions		Output	Programme	Annual		no data	1000	1500	2000	2500	3000	3500	4000	This is an estimated figure
	Number of Vulnerable and key populations reached with stigma reduction interventions		Output	Programme	Annual		no data	10000	11000	12000	13000	14000	15000	16000	This is an estimated figure
	Less than 10% of People Living with HIV and Key Populations		Outcome	Special Studies	3 to 5 years	KP	65%							<10%	

	experience stigma and discrimination					Geography Age group									
	Less than 10% of People Living with HIV, women and girls and Key Populations experience gender based inequalities and gender based violence		Outcome	Special Studies	3 to 5 years	KP Geography Age group								<10%	
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		18.70%						8%	8%	
	SGBV cases reported		Output				no data								
	Programmes conducted gender analysis		Output				no data	13	13	13	13	13	13	13	
	Programmes with gender responsive indicators and repored on them		Output				no data	13	13	13	13	13	13	13	
Community Systems Strengthening	Communities leading the response		Outcome				no data	10%	15%	20%	25%	30%	30%	30%	
	Clients receiving HIV and AIDS services satisfied with quality of service		Output	Programme	Annual	All community based implementing partners must have tools	no data	50%	70%	80%	85%	90%	90%	95%	
	Number of Districts with community led initiatives		Output					30	40	50	60	63	63	63	
	Percentage of civil society Organizations contracted by public entities for provision of community-based services to key populations.		Output	Programme	Annual	Type Disease Funding								100%	

						source									
	Percentage of health service delivery sites with a community-led monitoring mechanism in place.		Output	Programme	Annual	Type of CLM								100%	
	Number of community organizations that received a predefined package of training		Output	Programme	Annual	Org Type								?target	
	Increased rate of retention of nurses at primary health care facilities		Outcome	Programme	Annual		97%	100%	100%	100%	100%	100%	100%	100%	2016 programme data baseline
	Districts with ward based community based monitoring systems and tools in use		Output	Programme	Annual		to get number of implementing partners	10	15	30	40	50	63	63	
Procurement and Supply Chain	Health facilities with a functional electronic Logistics Information Management System		Output	Programme	Annual	This is out of 1600 facilities	5	100	600	1350	1600	1600	1600	1600	
	Health facilities reported a stock out of the recommended first-line HIV drugs						<1%	<1%	<1%	<1%	<1%	<1%	<1%	<1%	
Laboratory Services	Laboratories accredited according to national or international standards	Laboratory Services	Output	Programme	Annual		1	4	4	4	7	7	11	11	
	Lower level laboratories covered with quality assurance services		Output					100	600	1350	1600	1600	1600		
Strategic Information	ZNASP indicators reported according to reporting time frames						Not applicable	100%	100%	100%	100%	100%	100%	100%	
	Districts with district specific targets							100%	100%	100%	100%	100%	100%	100%	
	Percentage of district specific targets reported on							100%	100%	100%	100%	100%	100%	100%	
	Health facilities with functional patient level electronic reporting systems	Monitoring and	Output	Programme	Annual		39%	50%	60%	70%	80%	85%	90%	90%	

		Evaluation													
	Functional community based electronic systems (ward level)	Monitoring and Evaluation	Output	Programme	Annual		Not applicable	15	30	60	63	63	63	63	
	Research and Surveillance projects conducted		Output	Programme	Quaterly		Not applicable	4	4	4	4	4	4	4	
	Increased proportion of HMIS or other reporting units submitting timely reports according to national guidelines		Output	Programme	Quaterly		98.97%	100 %	100 %	100 %	100 %	100 %	100 %	100%	
Coordination	ZNASP progress review conducted		Output		Biannual		Not applicable	2	2	2	2	2	2	2	
	District ZNASP progress review conducted	Coordination	Output	Programme	quarterly		Not applicable	4	4	4	4	4	4	4	
HIV Financing	Funding gap closed						40%				s		20%	20%	this is 50% of the funding gap which is 100% (in this case 40% of total funding)
	Local funds mobilized to support the national HIV response	HIV Spending	Output	Programme	Annual		30%						40%	40%	

7. Annex 2: Costing to ZNASP IV Addendum

Introduction and Methodology to costing

The costing approach implemented involved attaching unit costs to the M&E targets developed for the ZNASP IV 2024-2026 addendum. Since M&E targets were developed using a combination of modelling and stakeholder consultations, an excel based costing tool developed as a hybrid of One health tool, Resource Needs Model, and activity-based costing was adopted for the costing exercise. Costs were categorised into two major groups namely intervention costs and program support costs. Intervention costs were established using the population-based approach which attaches commodity unit costs to each targeted person, while the package-based approach involves a number of services that are jointly provided, which had to be disaggregated for each person targeted. Program support costs include the enabling environment, program management, research, strategic communication, logistics, program level human resources, training, lab equipment, and community systems strengthening. Due to the multi-stakeholder approach of the national HIV response, program support costs were obtained from historical average costs documented in the National AIDS Spending Assessment report 2018-2020, National AIDS Council financial report of 2021, and the NFM3 budget developed by implementing partners. The NFM3 budget was adjusted for changes mainly in fuel, accommodation and per diems as informed by implementing partners and 2023 government approved fuel and T&S rates.

Unit costs were developed from various sources including UNDP PSM procurement, MOHCC procurement, and NAC Finance. Unit costs were compared to Global Fund reference price database[24] and the USAID Global Health Supply Chain Program database[25]. Additional sources of unit costs included scientific and grey literature as highlighted in the attached Excel costing file. Of particular importance is the National Quantification for Laboratory Commodities report of July 2022 to December 2024 which was used to estimate unit costs of lab tests. All unit costs were adjusted for a global inflation rate of 3.6% since all costs are expressed in US dollar. Unit costs obtained from international sources were adjusted for import costs at 27%.

To establish the financial gap of the national response, historical donations for the period 2021-2023 were used to estimate average external funding per year. Major developmental partners analysed were the Global Fund, PEPFAR, SIDA, and the Health Resilience Fund. Domestic funding mainly through the AIDS Levy were forecasted to grow by 3.6% per year as informed by the 2023 national budget.

[24] https://www.theglobalfund.org/media/5813/ppm_arvreferencepricing_table_en.pdf?u=637384507675200000

[25] https://www.ghsupplychain.org/sites/default/files/2022-08/eCatalog%20July%202022.pdf

Costed Results

Table 13 shows forecasted funding and expenditures for ZNASP 2024-2026. Resources required will range between $554 million to $579 million and averaging $569 million over the period 2024 to 2026. Domestic public funds will average $64 million which is approximately 11% of total annual resource requirements. ZNASP IV aimed to increase domestic resources from 20% at baseline in 2018 but macroeconomic challenges in the country, the COVID 19 pandemic and the war in Europe have all combined to constrain economic growth and fiscal space.

Table 13: Financial Gap Analysis

Fiscal Year	**2024**	**2025**	**2026**
NSP Resource Needs	$572,988,587.94	$553,937,396.05	$579,437,310.29
Government revenue	$61,642,162.52	$63,861,280.37	$66,160,286.46
United States Government (USG)	$207,360,183.33	$207,360,183.33	$207,360,183.33
Global Fund	$150,000,000.00	$150,000,000.00	$150,000,000.00
Swedish International Development Cooperation Agency	$2,943,954.25	$2,331,845.00	$2,331,845.00
Health Resilience Fund in Zimbabwe	$1,327,869.98	$1,327,869.98	$1,327,869.98
Total External Sources	$361,632,007.56	$361,019,898.31	$361,019,898.31
Total Domestic & External Resources	$423,274,170.08	$424,881,178.68	$427,180,184.77
Financial gap	26.13%	23.30%	26.28%
% Domestic Resources	11%	12%	11%
% External Resources	63%	65%	62%

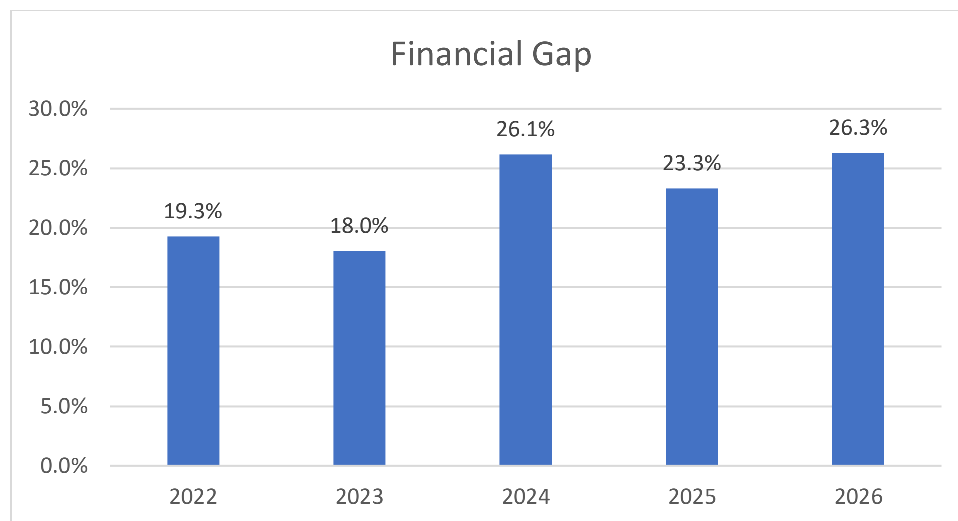


Figure 15: Financial Gap Analysis

External resources from developmental partners are forecasted to contribute an average of $361 million per year representing approximately 64% of resource requirements per year. ZNASP IV aimed to reduce the financial gap from 40% in 2018 to 20% in 2025. Figure 1 shows that the financial gap is expected to range between 23.3% and 26.3% and average 25% over the period 2024 to 2026.

Table 2 shows the costed ZNASP IV 2024-2026 addendum by intervention and program support category. Community Systems Strengthening has been added to emphasize its important role in the 30-60-80 target [26]. Prevention costs are expected to fall from $160 million to 135 million in 2026 due to lower targets in key programs such as VMMC as it approaches saturation. Treatment care and support costs are forecasted to range from $192million in 2023 to $209 million in 2026. Treatment, Care, and support commands an average of 35% of the resource requirements per year, followed by prevention at 25% and program management and support at 22%.

[26] 30% of testing and treatment services to be delivered by community-led organizations; 60% of the programmes to support the achievement of societal enablers to be delivered by community-led organizations; 80% of service delivery for HIV prevention programmes for key populations and women to be delivered by community, key population and women-led organizations. https://www.unaids.org/sites/default/files/media_asset/prevention-2025-roadmap_en.pdf

Table 14: Costed ZNASP IV 2024-2026 Addendum

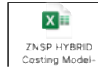
MODULE	2024	2025	2026
Prevention	**$160,375,300**	**$133,002,644**	**$135,095,166**
VMMC	$47,431,053	$18,577,312	$13,829,297
KP	$40,149,070	$43,444,900	$46,819,033
AGYW	$61,153,029	$58,335,409	$61,346,591
Condoms	$11,642,149	$12,645,024	$13,100,245
STIs	$698,184	$738,789	$781,393
Differentiated HTS	$7,125,065	$7,548,096	$7,836,124
PMTCT	$4,581,040	$4,878,649	$5,064,107
Treatment Care and Support	**$191,666,972**	**$200,304,650**	**$209,036,817**
TB/HIV	**$37,823,932**	**$43,850,138**	**$50,487,748**
Service Integration	**$46,213,518**	**$42,346,641**	**$44,336,820**
Program Management & Coordination support	**$124,504,578**	**$121,267,790**	**$126,799,133**
Enabling environment	$9,498,285	$9,251,355	$9,673,333
Program management	$25,718,476	$25,049,864	$26,192,454
Research	$1,280,416	$1,247,129	$1,304,013
Monitoring and evaluation	$8,512,229	$8,290,934	$8,669,105
Strategic communication	$5,177,317	$5,042,720	$5,272,732
Logistics	$6,958,704	$6,777,796	$7,086,950
Program-level HR	$19,617,512	$19,107,509	$19,979,053
Training	$1,204,831	$1,173,509	$1,227,036
Laboratory equipment	$3,995,133	$3,891,270	$4,068,761
CSS	$42,541,675	$41,435,705	$43,325,697
Grand Total	$572,988,588	$553,937,396	$579,437,310

Costing Recommendations

To narrow the financial gap, the following recommendations are proposed:

- Increase efficiency of the HIV response through more effective targeting and innovative modes of service delivery.
- Strengthening public private partnerships,
- Developing community led financing guidelines,
- Developing a sustainability HIV funding plan,
- Integrating HIV/Aids into the insurance system, and
- Increase earmarked funding for HIV given the role that CSS and CLM will play in the wider health system.

Worksheet used for the Addendum costing



[i] VOA. Available from URL: https://www.voanews.com/a/covid-19-pandemic_zimbabwe-reports-major-rise-teen-pregnancies-during-pandemic/6204648.html