Report to Department for International Development, Harare, Zimbabwe

Impact Assessment of the Expanded Support Programme
Zimbabwe

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The contents of this report are the sole responsibility of its authors and do not necessarily reflect the views of Health Partners International or the ESP funders.

Abbreviations and Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
AIR	Annual Independent Review
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behaviour change communication
CEA	Cost effectiveness analysis
CHBC	Community and home based care
DACs	District AIDS Coordinators
DFID	Department for International Development
EC	European Commission
EGPAF	Elizabeth Glaser Paediatric AIDS Foundation
ESP	Expanded Support Programme
FA	Fund Administrator
FGD	Focus group discussion
GF	Global Fund
GNU	Government of National Unity
GPA	Global Political Agreement
HCT	HIV Counselling & Testing
HIV	Human Immunodeficiency Virus
HRRS	Human Resource Retention Scheme
IOM	International Organisation for Migration
IP	Implementing Partner
JSI	John Snow Incorporated
MC	Male Circumcision
MCAZ	Medicines Control Authority of Zimbabwe
M&E	Monitoring and Evaluation
MIPA	Meaningful Involvement of People living with HIV
MOHCW	Ministry of Health & Child Welfare
MOT	Modes of Transmission
MOU	Memorandum of Understanding
MSM	Men who have sex with men
NAC	National AIDS Council
NATPharm	National Pharmaceutical Company of Zimbabwe
NBSZ	National Blood Service of Zimbabwe
NGO	Non-Governmental Organisation
OECD-DAC	Organisation for Economic Cooperation & Development – Development Assistance Committee
OI	Opportunistic Infections
PITC	Provider Initiating Testing and Counselling
PLHIV	People Living with HIV
PMD	Provincial Medical Director
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PSI	Population Services International
PSZ	Population Services Zimbabwe
QOL	Quality of Life
TWG	Technical Working Group
UA	Universal Access
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Fund for Children
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling & Testing
WG	Working Group
WHO	World Health Organization
ZAN	Zimbabwe AIDS Network
ZIMRA	Zimbabwe Revenue Authority
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZNNP+	Zimbabwe National Network of People Living with HIV

SECTION 2 – EXECUTIVE SUMMARY

Background

The national response to the HIV epidemic is guided by the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP 2006-2010) which is supported by the Government of Zimbabwe and a number of development partners. The new strategic plan (ZNASP 2011-2015) has been drafted and will soon be finalised. The National AIDS Council (NAC) steers the implementation of the ZNASP with assistance from the Expanded Support Programme (ESP) and other donor support, including from the Global Fund (GF) and the US Government (USG).

The Expanded Support Programme (ESP) aims to support scale up of the national HIV and AIDS response in Zimbabwe through a Common Fund supported by five bilateral donors – Canada, Ireland, Norway, Sweden and the UK. The programme began in 2007 and has focused support on three of the four ZNASP priorities:

- HIV prevention – mainly implemented by UNFPA, NGOs and NAC;
- Treatment and care – UNICEF, WHO, Crown Agents as the main implementers; and
- Management and coordination – UNAIDS is the main partner.

The aim of the Impact Assessment is to provide a thorough examination of the overall influence and impact of the ESP, including an analysis of its appropriateness against national strategies, successes and failures, effectiveness and cost-effectiveness of its components, modes of delivery and quality of services. The Impact Assessment is also intended to provide policy makers with recommendations for strategic planning for the fifth year of the ESP, together with credible scenarios for the future, so that decision making is evidence-based and realistic.

Approach

This assignment focuses on evaluation of the outcomes of the support and seeks to link support provided to results obtained along the results chain, from activities through outputs and outcomes to impact, as defined in the logframe, and taking into consideration the interaction between components and the context of implementation. The analysis of findings is framed according to the OECD-DAC indicators of **relevance, effectiveness, efficiency, impact and sustainability**, at both the overall programmatic level as well as for each component. An assessment of the fund administration and procurement was also undertaken. The team used the revised logframe as a guiding reference, with an assessment of achievement of output indicators to measure *effectiveness*, and of purpose and goal level indicators to measure overall success and *impact*.

A wide range of reference documents and reports were reviewed and the team held extensive discussions with key stakeholders at national, provincial, district and community levels. There were site visits to six districts and available data were gathered from the District AIDS Coordinators (DACs) and health facilities. The team also triangulated data from different sources where possible.

A number of limitations affected the assessment. First, the interval between the award of the contract and the start of the assignment was very short, which had implications for consultant availability. With the benefit of hindsight, the terms of reference could have benefited from review, clearer focus and more explicit priority-setting. A related and substantial obstacle, and

one that impeded the *efficiency* of the assessment, concerned the availability of relevant information and documentation. This presented a problem and consumed a considerable amount of time throughout the course of the entire assignment.

Overall findings & analysis

Generally, the team had a very positive impression and found that the ESP has provided an excellent model for maintaining and enhancing the national response to HIV and AIDS in a highly challenging environment. It has clearly contributed significantly to the response in the 16 districts as well as at national and purpose levels. In terms of contribution to the overall goal of the national programme, it is extremely challenging to attribute change directly to the ESP relative to that of other contributions, in part because no indicators were included in the logical framework to capture this. Therefore, plausible attribution was estimated on the basis of positive results obtained in the different ESP intervention areas together with an assessment of the overall culmination of these efforts.

Relevance: Score 2

The ESP is fully aligned with the ZNASP and national priorities and has been highly relevant in terms of its support to the national response. The focus on 16 districts was appropriate and valid at the time (both of the ESP design and implementation). However, responding to emerging trends and needs in the immediate and longer term will require the flexibility to focus both within and beyond the 16 districts. Emphasis on balancing the focus on HIV with broader health systems development is critical for the future relevance of the ESP.

Channelling resources through the UN agencies has been a necessary mechanism given the socio-economic and political instability in Zimbabwe. This is likely to remain a relevant mechanism for the foreseeable future. The choice of interventions within the ESP has been relevant to the needs of the country, particularly the focus on ART provision and behaviour change for HIV prevention. Both these areas are likely to remain highly relevant in the near future. However, it will be important for the ESP funders to make adjustments to ensure alignment to the national priorities identified in the new ZNASP 2011-2015 and the Modes of Transmission study.

Effectiveness: Score 2

The ESP has been generally effective in meeting targets and producing results. The fund administration and procurement functions were also implemented effectively, albeit with some delays. Overall, the flexibility of the ESP has proved to be a major strength, enabling resources to be directed to nationally identified priorities, thereby contributing to the achievement of national targets. Population growth and increasing numbers of people in need of ART indicate the need for enhanced prevention and treatment interventions over the coming years.

The decentralisation of resources to peripheral levels has contributed to increasing equitable access. However, it is widely recognised that those living in rural as opposed to urban areas remain disadvantaged in terms of accessing services requiring further spread of services. There has been little documentation in the ESP of reaching particularly vulnerable groups.

The programme has had unintended effects, positive and negative. A clear, positive effect is reflected in the human capacity that has been developed, particularly noticeable during the field visits where the competence and dedication of health staff and care givers was impressive. On the negative side, the need to channel resources through the UN agencies, and therefore streamline procedures, has resulted in some loss of local ownership, limited possibilities to be fully responsive to local level needs, and most likely, missed opportunities for local capacity building.

Cost effectiveness/ Efficiency: Score 2

The ESP is one of a number of HIV programmes in Zimbabwe. Its support includes a range of activities at the national level and also a set of activities directed at 16 focus districts. Within these districts, the ESP is not the only programme and as a result it is difficult to attribute change in the epidemic to specific programmes.

According the UNGASS 2010 figures, from 2007 to 2009, the ESP contributed 34% of the total funding for HIV and AIDS programming in Zimbabwe. During that time period, estimated HIV prevalence dropped from 17.7% in 2006 to 13.6% in 2010. Assuming a directly proportional contribution, it could be argued that the ESP has contributed one third of the observed achievements in HIV prevalence reduction. However, it is beyond the scope of this assessment to gauge the impact of other forms of support to the HIV response in Zimbabwe in order to make an informed judgement on the relative contribution of the ESP.

UNFPA has estimated the impact of the behaviour change programmes funded by the ESP and the EC on HIV infections averted in the 26 districts covered. They estimate that between 39,405 and 42,484 infections have been averted, with a cost per infection averted of between $275 and $297 giving a cost saving of up to $306.9 million in terms of the life-time cost of treatment. In terms of cost benefit, this represents a superior return on investment and would appear to offer good value for money as well. In order to estimate the contribution of the ESP component it was assumed that its impact on HIV infections averted was directly proportional to its share of total expenditures. The cost per person reached in the BCC programme was USD 1.7 per person in the general population, with the cost per person accessing treatment for two different cost scenarios varying from USD 57 to USD 182 in 2009. Overall, the ESP's cost per infection averted is substantially lower than other estimations for Southern Africa, which range from USD 1,588 in the year 2007 to USD 900 by the year 2011, again suggesting excellent value for money.

The cost effectiveness analysis (CEA) was limited by several factors, including the time available to gather adequate data for the alternative programmes such as Global Fund that could be used for comparison, and the lack of a real counterfactual or control area. The year 2007 was used as the baseline for the analysis and the calculation of incidence rates and infections averted were for the period 2007-2010.

Impact: Score 2

The ESP has clearly had a significant impact on increasing access by communities to prevention, treatment and care services. The most obvious result of increased access is that with respect to HIV, people's lives dramatically changed for the better in recent years. Less obvious, but important nonetheless, is impact on the lives of those who have *not* become

infected because of preventive interventions and more widespread treatment resulting in lower levels of infectivity. According to the prevalence and incidence data, this constitutes a substantial number of infections averted, as noted above. Similarly, prolonged life and well-being of people living with HIV is also likely to have generated significant psychosocial and economic benefits for children, partners and extended family members. This kind of impact is difficult to capture but is significant nonetheless.

While individual components of the ESP seem to have worked well, the limited degree of synergy across the ESP components has reduced their overall potential impact. NAC and MOHCW will need to strengthen the links between the various components of the national programme and the health system, not only to ensure greater efficiency but also to result in greater impact.

Sustainability: Score 3

Although huge progress has been made, the response to HIV in Zimbabwe still needs to be scaled up in order to reach all those in need. This will require a large investment over a long period of time in order to achieve universal access. Sustaining the national response is highly challenging, both in terms of funding but also with respect to adequate numbers of qualified health staff to deal with the increasing numbers of people in need of treatment. A number of potential synergies exist that, if exploited, could improve the return on investment.

Impressive progress has been made and there is now a strong basis for a sustained and effective response, which can be built upon in future support. There is a need for continued funding support to the Human Resource Retention Scheme in order to maintain capacity for service delivery and to facilitate better integration of HIV-related services within the health system. This funding may need to come from external donors until the AIDS levy increases sufficiently to cover these costs.

Scoring

A six-point scale was used to rate the programme according to four of the five criteria, namely, relevance, effectiveness, efficiency and impact. The scale ranged from 1 (very good) to 6 (very poor). The “sustainability” criterion was rated according to a similar but four-point scale. Scoring was conducted across each output area (O-1 to O-4) according to each of the 5 criteria. These scores were amalgamated for each criterion according to the weighting (Wt) in the revised logframe. This gives a total score for all outputs against the 5 criteria.

Scores across 4 Output areas:

Criteria	O-1	Wt	O-2	Wt	O-3	Wt	O-4	Wt	Total O-1-4
Relevance	1	45%	3	10%	1	35%	2	10%	1.3 (1)
Effectiveness	2	45%	3	10%	2	35%	2	10%	2.1 (2)
Efficiency	2	45%	4	10%	2	35%	2	10%	2.2 (2)
Impact	1	45%	3	10%	2	35%	2	10%	1.65 (2)
Sustainability	3	45%	4	10%	2	35%	3	10%	2.75 (3)

However, as the areas of fund administration and procurement are highly important in terms of overall programme impact, these areas were also scored according to the same criteria. A weighting was then given to fund administration and procurement against the combination score of the 4 output areas.

Scores of Output areas with Procurement and Fund Administration:

Criteria	Total C-1-4	WT	Proc	WT	FA	Wt	Score
Relevance	1.3 (1)	50%	2	25%	2	25%	1.65 (2)
Effectiveness	1.75 (2)	50%	2	25%	2	25%	1.875 (2)
Efficiency	2.3 (2)	50%	2	25%	2	25%	2.15 (2)
Impact	1.75 (2)	50%	2	25%	2	25%	1.875 (2)
Sustainability	2.75 (3)	50%	3	25%	3	25%	2.875 (3)

Final Scores

An overall rating of 1-3 concludes that a programme was successful, while 4-6 indicates that it was unsuccessful. The ESP achieved an overall score of 2. The 5 criteria themselves were not weighted but this could be revised if required and the final score will be recalculated automatically in the table below.

(1) Criterion	(2) Rating for criterion	(3) Weighting for criterion	(4) = (2) x (3) Weighted criterion (automatic)
Relevance	2	2	4
Effectiveness	2	2	4
Impact	2	2	4
Efficiency	2	2	4
Sustainability	3	2	6
Average of the weighted criteria 1 - 5			**2**
If effectiveness, impact or sustainability are accorded a numerical rating of "4" or poorer, the overall rating will be downgraded to "4" even if the average is better than "4". Under exceptional circumstances, should the sustainability be less important (weighting "1", see assessment grid), the overall rating will not be downgraded.			No, the overall rating is not downgraded.
Overall rating of the project/programme:			**2**

Lessons learned

There is no clearly agreed framework for conducting impact assessments on large, complex programmes consisting of multiple components and involving numerous implementing partners. In sector programmes with multiple funders and programmes contributing to the same overall goal, in the absence of clearly-stated, specific outcomes, plausibly linked to particular actions and actors, attribution of change is notoriously difficult. While the revised logframe was used as the reference framework, lack of timely availability of a substantial proportion of requisite data proved to be a major obstacle and a significant constraint for the assessment. Moreover, implementing partners do not report consistently against their own output indicators, making assessment of effectiveness and efficiency challenging.

The decentralisation of interventions and spreading of resources to peripheral levels has clearly resulted in increased access to services. However, for the future, quality assurance and monitoring and evaluation need to be resourced appropriately, both to sustain programme gains but also to assure adequate levels of programme management and accountability. The current modes of delivery have been necessary because of the unstable political and economic environment in Zimbabwe over the past few years. While they have proved to be effective and relatively efficient in generating short-term value, they have not been able to satisfactorily build the local capacity necessary for long term success.

An unforeseen positive impact noted above is that in some communities, members of the community and health workers have banded together to use their own meagre resources to sustain service delivery activities. This sort of unanticipated opportunity to organise demonstrates an impressive level of commitment to compensate for weaknesses in the system and participate in the development of their communities.

Recommendations

1. As the programme is deemed largely successful, the current focus on BCC and treatment should be maintained this year, with a subsequent phasing-in of these areas of support to a new programme within the context of the ZNASP 2011-2015.

2. The ESP should maintain its flexibility to ensure future alignment and response to emerging needs in the context of a changing epidemic. There should be a planning process throughout 2011 to decide on future support to the national response, as well as to develop an exit strategy from the current ESP.

3. The Modes of Transmission study provides a comprehensive summary of the main ways to reduce HIV transmission in Zimbabwe and should be used as a reference for all future programming decisions on prevention, in collaboration with partners to ensure that each intervention area is covered systematically and adequately.

4. The ESP stakeholders should advocate for the participation of new donors and increased funds. At the same time, in view of the apparently improving economy, the ESP group should also lobby for increased government commitment of resources, including from the AIDS Levy.

5. The focus on 16 districts needs to be reviewed for a future programme: there is a need to target resources more specifically to areas identified as hot spots and to the populations at greatest risk.

6. The ESP WG should review the indicators in the logframe to ensure their relevance and appropriateness. The treatment indicator regarding health professionals trained should now be revised to reflect an outcome of the training, and treatment targets should be amended in view of the changed initiation guidelines. CBHC indicators should be adjusted to reflect the changed needs in communities. The indicators for the coordination and management, M&E output area should be adapted to reflect quality issues in planning and reporting from PACs and DACs. For the future, it will be important to design a programme where the outcomes are clearly attributable to the supporting agencies and appropriate indicators are defined.

7. For the remainder of the current programme and in a future programme, Implementing Partners (IPs) should report specifically against logframe indicators relevant to their area of work and this requirement should be incorporated within specific MoUs.

8. The process of appraising IPs' plans should be reviewed to maximise synergy across components.

9. A process of data quality auditing should be incorporated into the M&E system to ensure that data from lower levels is appropriate and accurate.

10. The ESP should continue to support decentralisation but put in place measures to monitor the quality of implementation.

11. The government should be encouraged to develop and implement policies that support the task shifting[1] that is occurring by necessity and was observed in the field, for example, nurses providing ART.

12. In a future programme the ESP could consider a research component to investigate a number of areas, for example, an assessment of the effectiveness and efficiency of task shifting processes and an assessment of the impact of user fees.

13. The ESP should facilitate systematic local capacity building for longer-term sustainability (e.g. for procurement).

14. The ESP should capitalise on the investments and achievements (e.g. Human Resource Retention Scheme [HRRS], task shifting) to continue health systems strengthening.

Specific recommendations for each component are also provided in the main document.

Next steps

1. This report should be widely disseminated to all key stakeholders so that the future of the programme can be debated and agreed in a transparent and collaborative manner.
2. The ESP working group should finalise the 2011 programme according to the short term recommendations if accepted.
3. This should include a process of more intensive documentation of key lessons learned for specific areas.
4. The ESP WG should begin planning for future support to HIV-related activities beyond 2011 bearing in mind the recommendations on moving towards a system of harmonisation with, and strengthening of, the health sector.
5. Following the decision on how to support future health and HIV interventions, the ESP WG should develop a clear exit strategy within the next 3-6 months for those areas that will not receive future support and ensure that other partners will carry forward appropriate experiences.

[1] WHO describes task shifting as a process of delegation in which tasks are moved, as appropriate, from more to less specialized health workers in order to make optimal use of available resources. http://www.who.int/mediacentre/events/meetings/task_shifting/en/

SECTION 3 – MAIN REPORT

3.1 BACKGROUND & INTRODUCTION

The most recent data indicates that over 1 million people are living with HIV in Zimbabwe (2009[2]). Available evidence demonstrates that HIV prevalence has been declining since the late 1990s, from a high of almost 30%[3] to the most recent estimate of 13.6%. This change is attributed to the impact of high mortality and behaviour change.[4]

The national response to the HIV epidemic is guided by the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP 2006-2010) which is supported by the Government of Zimbabwe and a number of development partners. The new strategic plan (ZNASP 2011-2015) has been drafted and will soon be finalised. The National AIDS Council (NAC) steers the implementation of the ZNASP with assistance from the Expanded Support Programme (ESP) and other donor support, including from the Global Fund (GF) and the US Government (USG). A 2008 Mid-Term Review (MTR) of the ZNASP recommended scaling up interventions in order to enhance the likelihood in reaching the agreed targets.

A key goal of ZNASP 2011-15 relates to universal access to care and treatment. Zimbabwe has been scaling up access, reaching 326,241 people (including 32,000 children) by the end of December 2010 (as given in the Universal Access 2010 Report), representing 56.1% of adults and children needing treatment. The number of children orphaned and made vulnerable by the impact of HIV and AIDS in Zimbabwe remains high at around one million.

Efforts to prevent the spread of HIV in Zimbabwe have been led by NAC, MOHCW, non-governmental, religious and academic organisations. Prevention programmes have expanded significantly since 2000, but are critically under-funded in comparison to other countries in the region. Heterosexual contact is the principal mode of HIV transmission and extensive efforts have been made towards educating young people, with resulting high levels of knowledge about HIV prevention and evidence of a substantial decline in non-regular or casual sexual partners[5],[6]. Zimbabwe has developed a National Behaviour Change Strategy (NBCS) covering the period 2006-2010. This provides guidance to stakeholders on their contributions to behaviour change promotion and emphasises key prevention strategies such as condom use, reducing multiple concurrent partners and promoting 'faithfulness'. The second most common mode of transmission is perinatal, contracted during pregnancy, at birth or during breastfeeding. The NBCS includes plans to reduce the incidence of HIV infection especially among young people aged 15-24, and to scale up other prevention strategies, such as PMTCT. The country has committed itself towards virtual elimination of paediatric HIV by 2015; there are plans to review the PMTCT programme on achievements during 2006-2010 and a new operational plan 2011-2015 will be developed to address virtual elimination by 2015.

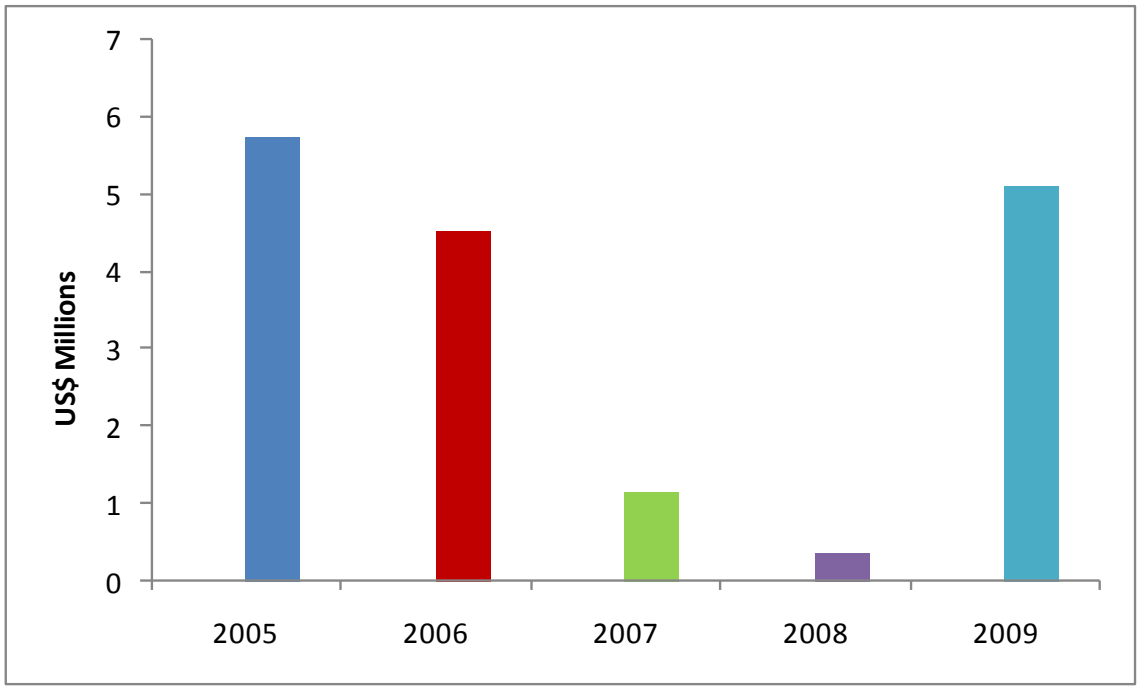
[2] HIV Estimates 2009, MOHCW
[3] UNAIDS Epidemiological Country Profile, Zimbabwe 2008
[4] Gregson S et al: *HIV Decline in Zimbabwe due to declines in risky sex? Evidence from a comprehensive epidemiological review,* April 2010, International Journal of Epidemiology
[5] Ibid, pp 9-10
[6] Halperin D et al: *A Surprising Prevention Success: Why did the HIV Epidemic decline in Zimbabwe?* February 2011, PLoS Medicine, Volume 8, issue 2

Access to voluntary- and Provider Initiated- counselling and testing (VCT and PITC) has improved significantly in recent years with the number of facilities providing these services expanding from 395 in 2005 to 649 by 2007 and 1,218 in 2010 according to the 2010 Universal Access report. There are now only 18 stand-alone VCT sites remaining in the country with the rest integrated within the health delivery system. However, high levels of perceived stigma and discrimination create barriers to testing for many people.

Increased condom use has been identified as a major contributing factor to the recent decline in HIV prevalence[7], with the number of condoms distributed by the government, NGOs and social marketing campaigns expanding significantly in the past decade or so. The number of condoms sold through the private sector has also increased dramatically, and most condoms are now purchased rather than acquired for free, suggesting that condom use has become more accepted in Zimbabwean society.

The national response to HIV is funded through domestic and international sources of finance. Zimbabwe signed the Abuja declaration of 1998, committing that a minimum of 15% of total government budget be spent on health care for the nation. The budget allocation for 2011 to MOHCW was 8.6% of the total budget falling far below the Abuja target of 15%. However, the Government has the National AIDS Trust Fund (or AIDS Levy) which collects 3% of all taxable individual and corporate income to fund HIV programmes. Income from the Levy has been limited in recent years and was particularly hard hit during the most severe period of economic crisis and hyperinflation (2007, 2008) as shown in the graph below.

National AIDS Trust Fund 2005-2009



Source: ZNASP MTR final Report 2011

Nonetheless, this source of income has potential to increase significantly as the economy stabilises and grows.

[7] Gregson S et al: *HIV Decline in Zimbabwe due to declines in risky sex? Evidence from a comprehensive epidemiological review,* April 2010, International Journal of Epidemiology, pp10-11

The Government of National Unity (GNU), created under the Global Political Agreement (GPA), has been instrumental in spearheading the democratic transformation of Zimbabwe. So far, the GNU has made reasonable progress in restoring political and social stability, ending widespread repression and stabilising the economy since February 2009. The decision to hold elections in 2011 – even in the absence of a new constitution – has raised concerns among the international community of the possibility of further instability and unrest. In light of recent statements by President Mugabe that the GPA, which expired in February 2011, should not be extended, political stability is a very real concern.[8]

One of the most significant decisions implemented by the GPA has been the dollarisation of the economy. This has led to an increase in the availability of basic goods and services and to the re-opening of public health and education facilities. However, Zimbabwe's economic situation remains precarious: the GDP real growth rate for 2009 was estimated at -1.3% and at 3.7% for 2010.

Expanded Programme of Support

The ESP began in 2007 at the height of the country's political and economic instability. The programme provided a mechanism through which five international donors – Canada, Ireland, Norway, Sweden and the UK – pooled funding for HIV. Several UN agencies (UNICEF, UNFPA, UNAIDS, WHO) together with Crown Agents function as *Implementing Partners,* facilitating the delivery of goods and services, both in the 16 ESP-supported districts as well as at national level. This mechanism has allowed donors to support the response to HIV at a time when channelling funds through government was not possible.

The ESP has focused support on three of the four ZNASP priorities:

- HIV prevention – mainly implemented by UNFPA, NGOs and NAC;
- treatment and care – UNICEF, WHO, Crown Agents as the main implementers; and
- management and coordination – UNAIDS is the main partner.

Most areas of Zimbabwe's national response are supported to some extent. For example, USAID and DfID fund the Elizabeth Glaser Paediatric AIDS Foundation (EGPAF) programme for PMTCT. Nonetheless, the third Annual Independent Review (AIR) concluded that available funding is inadequate if ZNASP targets are to be met. In particular, stakeholders identify treatment as the most critical gap.

Under the USG, the Zimbabwe PEPFAR programme currently supports the national ART programme. On-going activities include secondment of key MOHCW ART programme and logistics staff, training and mentorship of health workers, site readiness assessments for decentralization of ART, laboratory strengthening and procurement of laboratory consumables, monitoring of HIV drug resistance and outcomes, and integral support for the national drug procurement, logistics, and supply chain management system. The USG, through USAID and CDC, supports forecasting, procurement, storage, quality assurance, and distribution of a

[8] International Crisis Group – Zimbabwe Crisis Watch Database. Consulted on10th November 2010, http://www.crisisgroup.org/en/publication-type/crisiswatch/crisiswatch-database.aspx?CountryIDs={B104FADF-4411-45C7-BBED-5D96FD3CEFFD}#results

number of HIV related commodities (condoms, ARVs, rapid test kits, MC kits) for MOHCW. USAID and CDC Implementing Partners are PSI and JSI.

The USG provides funding and technical assistance to 15 local partners to provide a range of HIV prevention and care services including HIV counselling and testing and palliative care. Support to the national PMTCT programme works through three local NGOs that together provide support to national PMTCT sites in 32 out of the 65 districts in the country. PEPFAR Zimbabwe is working to strengthen national coordination with the Global Fund to ensure that coordinated gap-filling efforts promote continuity of national strategic plans in key areas of USG comparative advantage.

The Global Fund remains the largest single source of support for HIV/AIDS programming in Zimbabwe with over USD 605 million in grant applications and approximately USD 180 million in disbursements. The Global Fund provides the largest share of resources for the national health worker retention scheme started in 2009. These incentive payments for health workers have been fundamental to restoring basic service provision in public health facilities and an increasing share of Global Fund resources have been directed towards making these payments. The Global Fund Round 8 proposal was designed in relation to existing funding sources and assumed continued ESP funding for 16 districts for prevention, treatment and care activities as a contribution to national efforts. A number of GF-R8 program activities have had budgets cut as reprogramming to support the retention scheme has been a priority for government.

Table 1: Key Donor Areas of Support 2010

Donor	Number of Adult ART	Number of paediatric ART	CHBC	BCC	Coordination management and M&E
ESP	72,000 (see note on paediatric ART)	The 72,000 Includes some of the estimated 16,000 children <14 years on adult formulations	16 districts implementing partner ZAN 400 clients per district	16 districts	Logical framework developed and Global fund user friendly performance framework to be adopted NAC income support - USD 900,000
Global Fund	156,000	4,000	48 rural districts, 18,094 clients	All districts minus 26 ESP/EC districts	Capacity building of DACs on national M&E systems ART cohort analysis of ART patient survival rate. Date verification of PR and SR, NAC Income support USD 17.4 million
USG	59,000	30,000 (but some of these are also on adult formulations)			
Clinton Foundation	2,300				

Source: NAC 2010 annual report

3.2 OBJECTIVE OF THE ASSIGNMENT

The Terms of Reference (TORs) defined the areas of assessment for the ESP in terms of its contribution to the overall goals of the national HIV/AIDS programme, namely, 1) the reduction of HIV transmission, 2) mitigation of the effects of HIV/AIDS on individuals and communities in Zimbabwe, and 3) management and coordination/monitoring and evaluation of the national response. The aim is to ensure that this Impact Assessment complements the Annual Independent Reviews (AIRs), that were conducted on an annual basis since the start of the programme, to provide a thorough examination of the overall influence and impact of the ESP including an analysis of the:

- successes and failures of the ESP in light of internal and external environmental factors;
- impact of ESP interventions on HIV and AIDS in Zimbabwe;
- effectiveness of ESP and its components, modes of delivery and quality of services;
- cost effectiveness of ESP, in particular with regards to the choice of interventions and implementing partners;
- coverage and equity;
- by-products – unintended or intended consequences – of the programme; and
- appropriateness of the programme against the national strategies and guides.

This Impact Assessment is also intended to provide policy makers with recommendations for strategic planning for the fifth year of the ESP together with credible scenarios for the future, so that decision making is evidence-based and realistic. The full TORs for the assessment are provided in Annex 1 and the consultants' biodata in Annex 2.

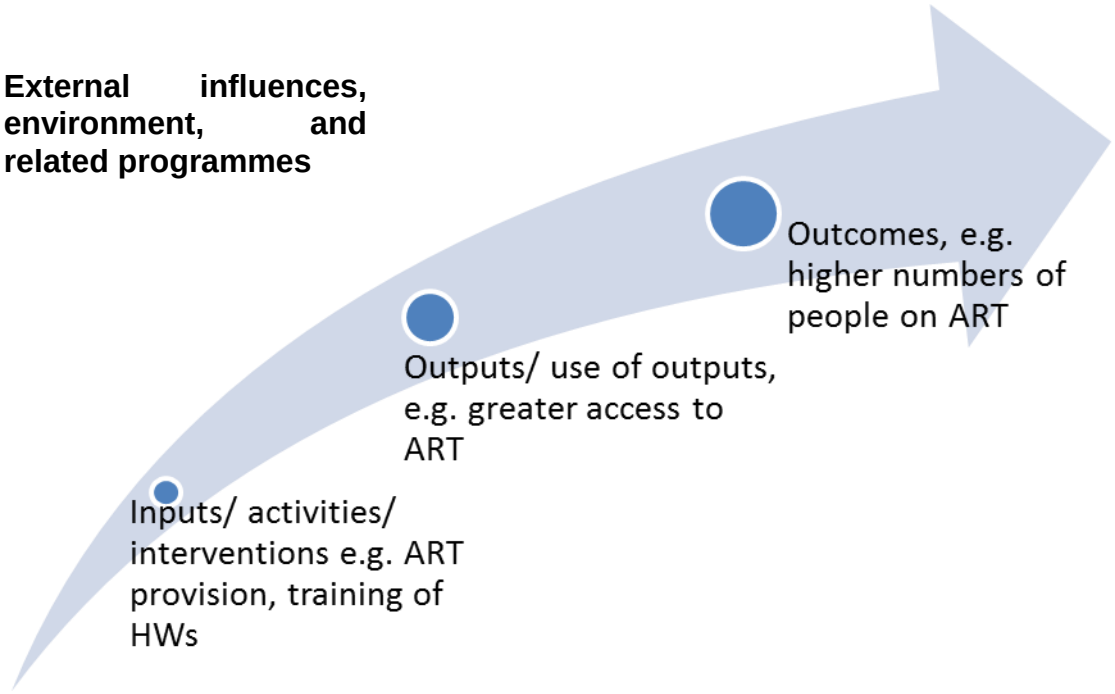
3.3 APPROACH & METHODOLOGY

The ESP, predominantly implemented through UN agencies working in partnership with national authorities and NGOs, provides assistance to the national response to HIV at various levels and in a number of ways:

- tackling prevention through the promotion of behaviour change (16 districts),
- expanding access to treatment, care and support, as well as
- strengthening coordination, management, and monitoring & evaluation.

The ESP has been reviewed several times but mostly focusing upon process. This assignment focuses on evaluation of the outcomes of the support and seeks to link support provided to results obtained along the results chain, from activities to outputs to outcomes to impact, as defined in the logframe, and taking into consideration the context of implementation, illustrated in the model below. The impact assessment therefore required a comprehensive, multi-pronged approach that considered national, district and sub-district levels, examining each intervention, as well as assessing links between components and measuring overarching results.

Figure 1: Theory of Change model:



The following table presents the theory of change for the overall programme with a selection of examples of inputs and indicators from the logframe:

Table 2: Theory of change for ESP

Level	Type of change	Indicators (some examples)
Impact	Reduced transmission and impact of HIV and AIDS	HIV prevalence in adults, children, young people, in focus districts,
		Annual AIDS-related deaths, adults, children
Outcomes	Scale up of the national HIV and AIDS response	% people in need on ARTs
		% on ART 12 months after initiation
		# received HCT and know result
		% young people reporting consistent condom use with non-reg. partners last 12 mths
Outputs	OP1: Increased access to comprehensive HIV treatment	Number of PLHIV in need of treatment receiving ARVs
	OP2: Increased access to community home-based care services	% PLHIV accessing CHBC in last 12 months in 16 districts
	OP3: Increased adoption of safer sexual behaviour and reduced risk behaviour	# people reached through community HIV prevention programmes in 26 districts
	OP4: Effective coordination, management, M&E systems in place	ZNASP 2011-2015 developed, agreed and funded
Inputs	OP1: Supply of ARVs, Training of health workers, support to facilities to initiate ART	# ARVs procured, # health workers trained, # facilities initiating ART
	OP2: Training of care givers, distribution of CHBC kits, in 16 districts	# care givers trained, # kits distributed
	OP3: Conducting BC programme in communities, training of BC facilitators	# people completing BC course, # replacement BCFs trained and community leaders retrained in 26 districts
	OP4: Training of DACs, salary support to NAC staff	# districts implementing annual plans based on Integrated District Planning Process, rate of NAC staff attrition

The assessment sought evidence of changes - positive or negative, intended or not - in the lives of populations affected by HIV, Conceptually the team considered drivers of change and whether and how they create an enabling environment; the alignment of organisational and

systems capabilities necessary to support development and delivery of key interventions at requisite scale; and, the organisational and individual competencies necessary to adapt and implement evidence-based best practices. The approach took account of the political economy that defines the context of ESP implementation, as well as stakeholder—including putative beneficiary—engagement in ensuring the relevance of ESP operations.

The analysis of findings is framed according to the OECD-DAC indicators[9], both at overall programmatic level, as well as for each individual component, together with fund administration and procurement. It should be noted that there are areas of overlap between these criteria.

Relevance

- A thorough analysis of the overall strategic direction of the programme and the extent to which the objectives of the ESP match the needs of the target groups, the policies of Zimbabwe and partner institutions, according to evidence on trends in prevalence and incidence, evidence on the key drivers of the epidemic, and global development goals;
- Analysis of how well the ESP aligns to national priorities and local realities, and how the ESP feeds into and complements planning processes at various levels.
- Assessment of how the support is reflected in the monitoring systems and the impact on M&E systems, mechanisms and practices.
- A general assessment of the appropriateness of the programme strategies against the national strategies and guidelines, and an analysis of the choice of interventions compared to other areas in the ZNASP.

Effectiveness of the ESP and its components

- Assessment of the extent to which the objectives of the ESP have been achieved and determination of the reasons why objectives are, or are not, being achieved; examination of what unintended positive and negative direct results have occurred through the inputs of the ESP;
- Assessment of promotion and inclusion of evidence-based approaches and interventions, combined with the distribution of resources among the different programmatic areas; analysis of the effectiveness of the different approaches used by the implementing partners and the extent to which the target population has been reached, with a particular focus on the most vulnerable groups; examination of the external environment factors that have contributed either to the success or failure of certain components of the ESP.

Cost effectiveness and efficiency analysis

- Analysis of the degree to which the resources invested in the ESP are appropriate compared to the outputs and results achieved; examination of what resources the ESP is using for the various forms of modes of delivery; assessment of value for money obtained with the costs incurred; assessment of extent to which the objectives and outputs/activities of the programme are coordinated with, or complementary to, those of other implementing agencies;

[9] http://www.oecd.org/document/22/0,2340,en_2649_34435_2086550_1_1_1_1,00.html

Impact of ESP support on HIV and AIDS in Zimbabwe

- Assessment of the evidence of what (positive and negative) changes can be observed in the wider sectoral and regional environment and which of these changes can be plausibly attributed to the ESP at various levels (population, sector, institutions); assessment of evidence of changes in the policies and programmes aimed at mitigating the impact of HIV and ultimately at how those changes affect the lives of populations affected by HIV;

Sustainability of ESP contributions

- Assessment of the probability that any positive results of the ESP will continue beyond the end of assistance, what period is appropriate and realistic for the continuation of the results, and which critical minimum requirements for success in this period are appropriate; analysis of what approaches, instruments, methods or concepts are likely to have continued usage, be institutionalised or further developed by the target groups, partner institutions or other actors and how the results for the target groups, partner institutions and partner country will continue beyond the end of assistance;

Development of recommendations to the ESP Working Group on the ESP for year 5 (2011), short term and long term

- The secondary objective of the impact assessment is to recommend future orientation and strategies for the ESP, which will be based on the conclusions reached during field visits and the appreciation of the development of the macro-economic and socio-political context of Zimbabwe; these will aim to provide the ESP WG with a decision making tool as they look into the future of their support to the ZNASP.

The team used the revised logframe as a guiding reference, with an assessment of achievement of output indicators to measure effectiveness, and of purpose and goal level indicators to measure overall success and impact. Annex 3 contains the revised logframe for 2010-2011. The annual independent reviews (AIRs) of the ESP provide information on progress throughout 2007-2009. While this assessment is not a programme review, the progress on achievement of indicators up to the time of assessment (where available) is included in order to obtain a full picture of the overall success of the programme as the ESP was not reviewed in 2010. This contributes to the analysis of the impact; however, it is not intended to serve as an intensive review of the activities undertaken in 2010, nor is it intended to ignore the achievements of the programme in the earlier years of implementation.

A wide range of reference documents and reports were reviewed (the full list is provided in Annex 4). The team held extensive discussions with key stakeholders at national, provincial, district and community level. There were site visits to 6 districts: Mutasa, Hwedza, Gutu, Kezi-Matobo (all ESP), Mhondoro Ngezi (control), and Gweru (GF), and available data were gathered from the District AIDS Coordinators (DACs) and health facilities. A summary of the field visits is provided in Annex 5. The team also triangulated data from different sources wherever possible. The full list of people met can be found in Annex 6.

The initial findings of the team were presented to the ESP Working Group on Tuesday 8th March 2011. The list of participants is provided in Annex 7. This provided the opportunity for feedback

and discussion of the key observations: in addition, several participants provided written comments which have been incorporated into the report. A draft report was submitted on 21st March 2011, and feedback was received and incorporated into this report.

It should be noted that data from 2010 as required for the logframe indicators were not all available during the assessment or were provided late in the process resulting in some delay in the finalisation of the report.

Scoring system

A six-point scale was used to rate the programme according to four criteria, namely "relevance", "effectiveness", "overarching development results" (impact) and "efficiency". The scale is as follows:

1. **Very good**, significantly better than expected
2. **Good**, fully in line with expectations, no significant defects
3. **Satisfactory**, falling short of expectations but with positive results dominant
4. **Unsatisfactory**, significantly below expectations, and negative results dominate despite identifiable positive result;
5. **Clearly inadequate**: despite several positive partial results, the negative results clearly dominate
6. The project/programme is **useless**, or the situation has deteriorated on balance.

The "sustainability" criterion is rated according to the following four-point scale:

1. **Very good** - the overall success of the programme (positive to date) will continue unchanged or even increase with a high degree of probability.
2. **Good** - with a high degree of probability, the overall success of the programme (positive to date) will only minimally decrease but will overall remain significantly positive (normal situation – to be expected).
3. **Satisfactory** - the overall success of the programme (positive to date) will decrease significantly but remain positive with a high degree of probability.
4. **Inadequate** - the overall success of the programme is inadequate at the time of evaluation and there is a high degree of probability that it will not improve.

An overall rating of 1-3 concludes that a programme was successful, while 4-6 indicates that it was unsuccessful. However, programmes can only be rated as "successful" if the direct results (effectiveness), indirect results (impact) and sustainability are rated *at least* "satisfactory" (3).

The scoring of this impact assessment was complicated by the fact that the different components had been given relative weighting in the logframe. Therefore, each component was scored individually and the relative weighting was taken into consideration in the overall score. The 5 criteria themselves were not weighted but this could be revised if required. Another point to note is that the scoring is partly based on the achievement of targets and indicators set by the programme and if these are either overly or insufficiently ambitious, the scoring may not reflect real impact adequately.

Limitations of the Impact assessment

A number of limitations affected the assessment. First, the interval between the award of the contract and the start of the assignment was very short (and had implications for consultant availability). With the benefit of hindsight, the terms of reference could have benefited from review, clearer focus and priority-setting. Furthermore, only one member of the team that actually conducted the assignment was included in the original proposal. Changes to the team resulted from a request by ESP funders and lack of availability of another key member. The absence of these individuals (and their respective strengths in terms of history and familiarity with the ESP) deprived the team of valuable insight and background, requiring the team to familiarise itself with a complex programme in a relatively short space of time.

A related and substantial obstacle, and one that impeded the *efficiency* of the assessment, concerned the availability of relevant information and documentation. This presented a problem and consumed a considerable amount of time throughout the course of the entire assignment. It is standard practice at the beginning of assignments, for all relevant documentation to be compiled and presented to the team upon arrival (and ideally before). In this instance, before arriving in country, the team received the ESP annual reports, Fund Administrator Reports and the reports of the Annual Independent Reviews. The rationale given to the team for limiting the initial provision of information in this way was that it would allow the team to absorb key documents, at which point individual consultants would be better able to identify their particular needs for further information. Consideration for the consultants' workload was appreciated, and this approach may well have been effective well with a team that was familiar with the programme. However, in this instance the approach was counter-productive and led to information being 'drip-fed' to consultants, a process that continued throughout the assignment up to and including the drafting of the report. It would have been more useful for the team to be provided with a complete list of available documentation from which they could have selected according to their needs. This lack of clarity regarding key sources of data is also reflected in the logical framework, which refers to generic 'reports' rather than to specific, clearly identified sources if information.

3.4 FINDINGS BY COMPONENT

3.4.1 Increased access to comprehensive HIV treatment

Relevance – score 1

The national ART programme was initiated in Zimbabwe in April 2004. Commitment to increasing provision of ART has been a key feature of the Zimbabwe National Strategic Plans on HIV for the periods 2006-10 and 2011-15. Delivery of ART is informed by both the Plan for Nationwide Provision of Antiretroviral Therapy 2008-12 and the ART Scale up Implementation Plan for the same period. The number of people estimated to be infected with HIV means that ART must continue to be a key element of the national response to the epidemic for the foreseeable future. In short, increasing access to ART remains at least as relevant in 2011 as it was in 2006 when the ESP was designed.

The ZNASP for 2006-10 set a target of at least 75% of adults with advanced HIV infection received ART together with *all* children with advanced HIV infection. While substantial progress has been made in particularly difficult circumstances towards achieving universal access to ART for both adults and children, nearly half of all eligible adults and two thirds of children are still not receiving treatment. Future ART targets need to take into consideration the outcomes of the current evaluation of Universal Access which will culminate in the UN High Level Meeting in New York later this year.

According to UNICEF[10], by June 2010, approximately 10% of those receiving ART were children below the age of 15 and less than 10% of those below 18 months were receiving ART, highlighting a significant gap in early infant diagnosis and training. Specific barriers to accessing ART by children include insufficient numbers of trained staff at facility level, the sheer volume workload resulting from the increasing numbers of people on ART, together with irregular availability of drugs in appropriate formulations[11].

Table 3: Children receiving ART 2007-10[12]

YEAR	Target (as per 2009 estimates) Children in need of ART	National target based on previous performance and what the system can handle	Children Receiving ART
2007	76,700	n/a	8.237
2008	74,119	15,000	13,254
2009	71,797	20,000	22,521[13]
2010	89,337	25,000	28,903

[10] UNICEF 2010, A situational analysis of the situation of women's and children's rights in Zimbabwe 2005-2010: A call for reducing disparities and increasing equity

[11] In a response to the draft of this report WHO responded that paediatric formulations became available (with assistance from CHAI in 2006, since when there have been no challenges with formulations. Nonetheless, the issue was mentioned by staff in several treatment facilities.

[12] Sources: MOHCW ESP Reports 2007-10; WHO Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector. Progress reports2008- 2010

[13] Feb 2010

Obstacles to universal access include the policy that only physicians can initiate ART in Zimbabwe. While MOHCW has adopted the WHO guidelines on Integrated Management of Adult Illnesses (IMAI), enabling ART initiation at first level by nurses, the policy and regulatory framework has not kept pace with these changes.

Equity

The assessment identified a number of issues relating to equity. First, as mentioned above is the need to scale up access to treatment by children. Other equity issues include gender, marginalisation and discrimination, and poverty. These are addressed in turn below and should inform future decisions about allocation of resources.

Women account for 62% of all adult infections[14]a reflection of socio-economic and biological vulnerability. Women also tend to become infected at younger ages than men. This highlights the need for data to be consistently disaggregated by both gender and age.

With particular reference to men in relation to treatment, the picture that emerges from interviews and observations is complex. On the one hand, men are variously described as feckless, selfish and unsuited to caring responsibilities. On the other hand, several of the nurses and carers encountered in the field were men. The need to increase male involvement was frequently raised in the team's discussions at national and district levels and related to all components of the programme: counselling and testing, treatment, behaviour change and community home based care.

> *Challenges? Yes, male involvement. We're in rural areas and the men go to town centres for work. Also men here are breadwinners not volunteers, although we have 12 male caregivers and they are all still involved. (NGO worker)*
> *However men are a very big problem. They only come for treatment when they get ill and if they are not ill, they don't come. Some even steal their wives' drugs. (NGO worker)*

With funding from the ESP, the International Organisation of Migration conducted a study of vulnerable populations and the factors that contributed to inequitable access to services[15]. The study considered bus and truck drivers, sex workers, construction workers, cross- border traders, game rangers, irregular migrants, illegal and small scale miners, internal traders, people living in informal settlements, seasonal workers and officials from immigration and the Zimbabwe Revenue Authority (ZIMRA). The researchers highlighted the challenges posed to members of migrant and mobile populations by the requirement of the ART delivery system that allowed patients to access ART at a single centre or satellite site. The purpose of this policy is to ensure compliance and to support data monitoring. However, it was found that this makes it difficult for those whose circumstances require them to be away from home to access services in other locations. The study concluded that patients should be able to access ART anywhere (nationally and regionally) provided they carry appropriate documentation that includes their ART history.

[14]http://www.unaids.org/en/regionscountries/countries/zimbabwe/
[15] IOM, 2009, Assessment Study on Mobile and Migrant Populations' Access to HIV Prevention and Treatment and Care Services in Zimbabwe

Sex work and homosexuality are both illegal in Zimbabwe. While there is no formal policy of denying members of these groups access to services, and dedicated services are available to sex workers in some locations, prejudice and discrimination are likely to act as strong barriers to access.

Another issue affecting access to services concerns user fees[16]. Over the course of the last twenty years, the Government of Zimbabwe has gone from being able to provide universal basic health services for the entire population, to the current situation in which user fees are charged for many services. In contrast to some countries where user fees are charged to supplement health workers' salaries, in Zimbabwe fee income contributes to non-wage recurrent costs.

> *We need to continue supplying ARVs for free because people here are very poor and won't be able to buy them or to reach services. If ESP stopped, the shortage would be critical. (Health worker)*
> *The drugs are free, but the diagnosis isn't. (Health worker)*
> *It pains me to see patients having to pay for services. (Health worker)*

While official policy has attempted to protect pregnant women, the elderly and children under five, the economic crisis has led to reduced government funding for frontline health services. In turn this has left many services with no alternative but to introduce user fees in order to cover the shortfall. The Zimbabwe Association of Doctors for Human Rights identified health financing and user fees as the most important barriers inhibiting peoples' access to health care[17]. Removing user fees could cost in the region of USD 20 million per annum[18]. If charges are removed (for some or all services/groups) there is likely to be significantly increased demand, especially for outpatient services, and this would need to be anticipated.

A further issue relating to equity of access concerns transport costs. The 2008 review of the ART programme conducted by MOCHW identified these as potentially an even more substantial barrier to access than user fees. Transport costs were raised by many patients in the course of the team's visits to districts hospitals, highlighting a further benefit of outreach services.

Recommendations:

- **Attention should be focused on treatment, both as an end in itself, as well as in terms of *treatment as prevention.***
- **There is a need to identify strategies for rationalising user fees together with more equitable ways of increasing Hospital Service Funds.**
- **The treatment needs of most at risk populations have already been identified and now need to be addressed as a matter of urgency.**
- **The policy and regulatory framework should be reviewed to take into consideration the enhanced capacity of nurses to initiate ART.**

[16] Comprehensive national data on the nature of fees charged is not easily accessible but information was gathered by the team in three districts and can be found in the reports of the visits to districts in the appendices to this report.
[17] Zimbabwe Association of Doctors for Human Rights Annual Report 2009 Page 10.
[18] http://www.unicef.org/esaro/5440_investment_in_health.html

Effectiveness – score 2

Assessing progress against targets and associated indicators has proved challenging and involved numerous documents, some of which provide conflicting estimates of the same data. The following table should therefore be read as *indicative* rather than final. This highlights the need for more effective and reliable consolidation (and disaggregation) of data recording, analysis and presentation.

Table 4: Estimated need and provision of ART (National & 16 ESP Districts 2007-2010)[19]

	2007	2008	2009	2010
Total estimated need for ART: Adults/Children	**A341,382 C 34,719**	**A 338,947 C 34,337**	**A343,460 C 35,189**	**A500,000 C 71,000**
National target for ART provision	**250,000**	**A170,000 C 15,000**	**A210,000 C20,000**	**260,000 C25,000**
ART provided: Total Male/Female Adults Children	**97 692**	**147, 804 M 49,701 F 85,625 C 13,254**	**A197,068 C 21,521**	**A303,062 C 28,903[20]**
ESP contribution 16 districts + national programme	**2,568[21]**	**16,582 32,000 48,582**	**33 546 30,000 63,546**	**52,615 19,385 72,000**
ESP contribution to national ART provision[22]		**28.5%**	**34.2%**	**22%**

The majority of districts have been able to reach the initial target of initiating more than 1,000 patients on ART (with the exceptions of Guruve, Mbire and Hwedza). Strategies contributing to this success have included provincial teams that support initiation and follow up of patients and mentor site level staff, accelerated site capacity building and accreditation and decentralisation of services (including strengthening outreach services). Underperforming districts are to be prioritised for support visits and monitoring during 2011.

Since April 2007, 4,326 patients on ART have died (mortality rate: 7.48%) and a further 3,701 have been lost to follow up (6.40%) within the ESP supported districts. A total of 14,590 adults and 5,266 children were still waiting treatment at the end of 2010. NAC cohort analysis studies report retention at 12 and 24 months after ART initiation of 75% and 64% respectively[23].

[19] The data in this table are extracted from several sources and contain some inconsistencies: Final UNAIDS annual reports 2008, 2009 & 2010; Estimates Report (2010); UNGASS Zimbabwe Country Report: Reporting Period: January 2008 to December 2009; MoHSW 2010 Annual ESP Report; ZNASP II 2011-15; Overview of the National OI/ART Programme. Ministry of Health and Child Welfare, January 28, 2010, Harare

[20] The ZNASP 2011-15 gives a figure of 33,424 children on ART *by June 2010*, representing 37% coverage based on the new WHO guidelines.

[21] No breakdown available for adults/children or by sex. A total of 4705 patients were already initiated on ART.

[22] Proportions of ART patients covered by other donors: GF 35%; USG 18%; NATF 24%; Clinton HIV/AIDS Initiative 1%.

[23] ART Data Verification & Cohort Analysis in 22 districts, Global Fund Round 5 Zimbabwe (1-6 November, 2009)

Table 5 (below) demonstrates the effectiveness of the ESP in terms of delivering against the milestones identified for 2010. The targeted number of people in need who have received ART (both in the 16 districts as well as nationally) has been reached, together with all but one of the training targets.

Visits to both initiating and follow-up sites in several districts identified no specific ARV stockouts. Nonetheless, paediatric formulations of cotrimoxazole together with some adult OI drugs were not consistently available (e.g. fluconazole and ketoconazole). The other issue of availability related specifically to the relatively small number (approximately <3%) of patients on second-line regimens. Some pharmacy staff reported that these are not included in standard pharmacy provision, requiring patients to purchase their own supplies, sometimes at considerable cost. However, WHO confirmed that once 2nd line treatment is sanctioned by a physician, drugs should be available and provided from the national store. This is according to National ART Guidelines 2007 version.

The targeted number of initiating sites in ESP districts was missed by one (32/33), while the number of follow-up sites exceeded the target by 18 (65/83). Effectiveness has been improved by the contribution of new cadres of (ESP supported) Primary Counsellors and Primary Care Nurses who are able to undertake a number of tasks previously conducted by nurses.

Availability of CD4 machines has also helped to improve the effectiveness of service delivery in terms of diagnosis, initiation and monitoring of ART. However, in Mutasa district, there is a single machine which requires the laboratory technician from Bonda Hospital to travel on a weekly basis the considerable distance to Hauna Hospital (where the machine is located) in order to conduct his own batch of tests. Lack of air conditioning, frequent power cuts and the sheer volume of tests mean that the machine is in frequent danger of over-heating. In Hwedza district, a set of small CD4 machines had been provided (together with training in their use) by a donor and were being used effectively in rural health centres. In districts with only one CD4 machine, priority is given to pregnant women, children and new initiating patients, with the result that CD4 counts for 6 and 12 monthly monitoring purposes are likely to be sacrificed.

There is a paucity of educational materials for both adults and children who are initiating ART. Several staff expressed the view that such material could play an important role in assisting those about to initiate ART to internalise the considerable amount of information they were given. There was also a lack of toys and other materials specifically for children.

Table 5: Progress against logframe milestones

Output 1: Increased access to comprehensive HIV treatment			
Indicator	**Baseline 2007[24]**	**Baseline 2009**	**Milestone 2010**
Number of PLHIV in need of	**104,000**	**28,000 (ESP)** + **30,000 (National)**	**72,000**

[23] Cohort Analysis of ART patients 24 Months after ART Initiation, NAC, Jan 2010
[24] Source: MOHCW Review of the National HIV and AIDS Treatment and Care Programme 2004-2007. Zimbabwe. May 2008

Output 1: Increased access to comprehensive HIV treatment			
Indicator	**Baseline 2007[24]**	**Baseline 2009**	**Milestone 2010**
treatment receiving ARVs	**target 250,000 (= 30% adult coverage 10% paediatric coverage[25])**		
Number of health professionals in 16 districts trained in comprehensive HIV management (C&T, PITC, PMTCT, ART/OI)	**4000** total trained by end 2007[26] Adt//Ped OI/ART: n/a PITC: n/a Rapid testing**:** n/a Child counselling: n/a MER/EID: n/a	(Target) Achieved **480** **170** **480** **208** **340** **163** **480** **206** n/a n/a	**(Target) Achieved** Adult OI/ART: **(240)** **240** Paed OI/ART: **(120**) **114** PITC: **(100)** **129** Rapid testing**:** **(100)** **114** Child counselling **(100)** **128** MER/EID: **(200)** **266**
Number of health facilities in 16 districts (a) initiating ART and (b) providing ART follow-up services	Initiating**:** **86** Follow-up**:** **64** **(51/62 Districts)**	**28** (National 117) **6** (National 183)	Initiating**:** **33** **32** National 125 128 Follow-up**:** **65** **83** National 220 387[27]
Percentage of health facilities in ESP districts reporting no stock outs of ARVs	**n/a**	**98.6%**	**Comprehensive information not available** **100%**

Recommendation:

- **Consistent, regularly updated, nationally comparable data (including cohort studies) should all be available from a single, clearly identified source and should be disaggregated by both sex and age.**

Efficiency – score 2

Several factors have contributed to the efficiency of the treatment component of the ESP. For example, the decision to de-link drugs from donor and district has facilitated the process of drugs being distributed to where they are most needed.

Other examples include task-shifting in which some nurses have been able to initiate OI/ART treatment in simple cases, decentralisation, for example through outreach (assisted by a NAC allowance) and capacity building of rural health centres to deliver a more comprehensive set of services. Outreach brings services closer to community members and reduces the need for visits (and associated costs) to hospitals. Some patients argued that three (rather than the current two) monthly refilling of OI/ART prescriptions would reduce their costs.

Efficiency has been improved by the contribution of new cadres of (ESP supported) Primary Counsellors and Primary Care Nurses who are able to undertake a number of tasks previously conducted by nurses.

[25] No figure provided for number of children receiving ART
[26] No breakdown data available by subject.
[27] Includes both static and outreach. Source: MOCHW/World Health Organisation/Crown Agency. ESP Report on HIV/AIDS Treatment and Care Component. 1January to 31 December 2010.

In response to the deteriorating economic and political environment, outward migration, in particular of skilled health workers reached a peak in 2008. When cholera broke out in Zimbabwe in 2008, the impact of this exodus of health workers became clear. With an initial commitment of USD1m from DFID, Crown Agents designed a model, with suitable controls, to deliver retention payments to staff in areas affected by the cholera epidemic. Eligible workers received a monthly allowance (funded by donors[28]) linked to existing salary scales, with basic salaries paid by government. The payment was made directly to workers' accounts which reduced overheads and transaction costs. This first phase established the credibility of the mechanism and increased morale with more staff reporting for duty and an increase in staff attendance of 20-30% was reported[29]. Successful implementation of the initial phase led to more donors becoming involved and pooling funds, thereby keeping administration costs as low as possible. In August 2009 DFID provided a further £1.335m (via the ESP) and a number of other donors (UNICEF, UNFPA, EC, Australia and Denmark) have also contributed to the Health Worker Retention Scheme. In October 2009 the scheme was adopted by the Global Fund.

It is estimated that more than 30,000 health sector workers of all cadres have been paid a total of USD 25 million through this project to date, and health delivery systems have been maintained to support the people of Zimbabwe. In May 2009 the scheme was revised to cover only skilled health workers and has helped to increase their number from less than 10,000 in April 2009 to 19,000 by December 2010. Visits conducted to local health facilities during the impact assessment confirmed the importance of the payments (despite the sometimes irregular and delayed nature of their payments) and these are likely to be playing a role in the improved levels of staff retention.

Impact – score 1

> *The difference made by ART is huge. In the villages the father used to go and get treatment and the others were left behind. Outreach services are really making a difference in terms of helping mothers and children to also attend local services for treatment. (NGO worker)*
>
> *Before I was always sick, absent from school (I'm a teacher). But since I started medication I am always present (except today of course) and I am very fit and do all the games with the children, including netball! Now I can look after my child… (ART patient)*
>
> *So many people are now going for treatment and there are far fewer bed-bound clients. When ART was introduced many defaulted. In 2009 we had 596 clients of whom 120 were not on drugs. Now we have 729 clients and only 11 are not on drugs. (Health worker)*
>
> *More people are living positively. If they get ill they are more likely to seek treatment. Medicine is good. They see I am gaining weight. I'm now strong enough. I'm HIV + and I talk openly about it. I am on ART (4 years) but my wife is negative so we use condoms. (ART patient)*

[28] In US dollars, an important incentive in itself given the level of hyper-inflation at the time.
[29] http://www.publications.parliament.uk/pa/cm200910/cmselect/cmintdev/252/25208.htm

The UNAIDS 2010 Global Report states that in Zimbabwe 172,000 life years have been gained from ART between 1996 and 2009. Clearly, for many people the impact of increased availability of ART has been the stark and literal difference of life over death. Asking patients about the difference made to their lives by receiving ART was often met with a degree of incredulity, as if the answer was so obvious that to state it was unnecessary.

When pressed, informants talked with pride about their restored ability to care for themselves and their children and to contribute to the household income. Significantly, several health workers encountered during the course of the field visits volunteered that they too are benefitting personally from ART, delivering a double-impact: upon their lives as individuals and their ability to continue to contribute to the delivery of health services.

> *We treat them as nurses but we feel their pain as people living with HIV. My husband died. I was sick, coughing and coughing and eventually unconscious. I was treated for TB, but there was no improvement and then they tested me for HIV. Now I feel I can do anything. I am on second line drugs and they are working very well. (Nurse living with HIV)*
>
> *I wasn't sick but my friend said to me 'you're getting very thin'. I was tested in 2003 and told 'you need to start ARVs'. My weight went from 54 to 68 kilos and I am so happy to be on ARVs. I was so hurt to find I was HIV when I was 23. I did nothing wrong. (Nurse living with HIV)*

The impact of ART is dramatic, extending beyond the health and well-being of individuals to affect their families, households and communities. Development and application of more nuanced and sophisticated measures of quality of life could contribute to increasing understanding of the impact of ART, thereby supporting arguments for continuing towards universal access.

It is too early to see the effects of increased access to ART in terms of consequent, decreased demand upon health services. HIV continues to place a heavy burden upon hospitals (including occupancy of beds), albeit with less mortality. Assuming that progress continues, it is likely that in the longer-term, with more efficient and earlier initiation of ART, together with more regular and effective monitoring (depending of course upon availability of staff and equipment), systemic benefits will become more apparent.

The impact of ART has changed experience and perception of HIV at community level. This was consistently identified (unprompted) by interviewees in response to questions about the difference made to communities by the availability of ART. Increasing availability of treatment (together with PMTCT) has proved to be an incentive for testing with the result that HIV testing is gradually being 'normalised'. HIV is increasingly understood to be a potentially manageable condition, rather than a fatal one. Not only are people who are living with HIV (at least where treatment is available) no longer easily identified by their wasted appearance, many of those on ART now look healthy and are well enough to contribute to their households and communities. In every community and facility visited, people referred to reduced HIV-related stigma which they attributed to ART and increasing openness among those affected.

Efforts are now underway for Treatment 2.0, which is a new approach to simplify the way HIV treatment is currently provided and to scale up access to life-saving medicines. Using a

combination of efforts, this new approach could bring down treatment costs, make treatment regimens simpler and smarter, reduce the burden on health systems, and improve the quality of life for people living with HIV and their families. Modelling suggests that, compared with current treatment approaches, Treatment 2.0 could avert an additional 10 million deaths by 2025. Treatment 2.0 is a radically simplified treatment platform and holds promise to simplify treatment and provide all people needing it with a better pill less likely to lead to resistance, simpler diagnostics and monitoring, easier HIV testing, and more community empowerment.

Sustainability – score 3

Two issues that need to be considered in terms of sustainability concern the need to continue strengthening the health system and funding for ARVs, particularly in light of the growing treatment gap that resulted from the changing WHO guidance on thresholds for initiating ART from <200 to <350 CD4. With the time and resources available, it was not possible to investigate the cost implications of changing specific drug regimens (in line with WHO guidelines).

A key contributing factor to the sustainability of ART in Zimbabwe is the fact that it makes use of, and strengthens existing service delivery mechanisms, instead of creating parallel structures. However, the country's socio-economic difficulties have taken a significant toll upon the health system. Strengthening decentralised services depends upon availability of suitable staff. While the Human Resources Retention Scheme has contributed to reducing attrition rates among some health service personnel, nonetheless out-migration continues in response to the continuing economic challenges in Zimbabwe, together with the frustration and dissatisfaction with the delays and amounts of retention (which, though welcome, do not necessarily increase disposable income and cannot complete with salaries in neighbouring countries). Also, retention allowance do not compensate for challenging working environments and increasing workloads. It is worth considering additional non-financial retention incentives such as subsidised housing, transport or education allowances.[30] The sustainability of health system capacity to continue and expand delivery of ART and related services will depend, at least in part, upon identification of appropriate, longer term solutions to these structural and systemic obstacles.

In terms of the costs of ARVs, for the foreseeable future, this will continue to be dependent upon external support. It is likely that the proportion of these costs borne by Government may grow as the economy improves and revenue increases from the AIDS levy. Nonetheless, donor support will continue to be necessary for the foreseeable future, and if re- application to the Global Fund proves unsuccessful, an alternative strategy for continuing procurement and provision of ARVs needs to be developed as a matter of urgency.

Recommendation:

- **Treatment needs to continue to receive priority (in roughly the same proportion to care and prevention as in the current ESP) in any future funding scheme.**
- **Commitment to retaining key health staff needs to be sustained, for example through improving the efficiency of the payments under the HRRS, as well as considering the addition of sustainable non-financial incentives.**

[30] USAID, Zimbabwe Health System Assessment 2010

3.4.2 Increased access to community home-based care services (CHBC)

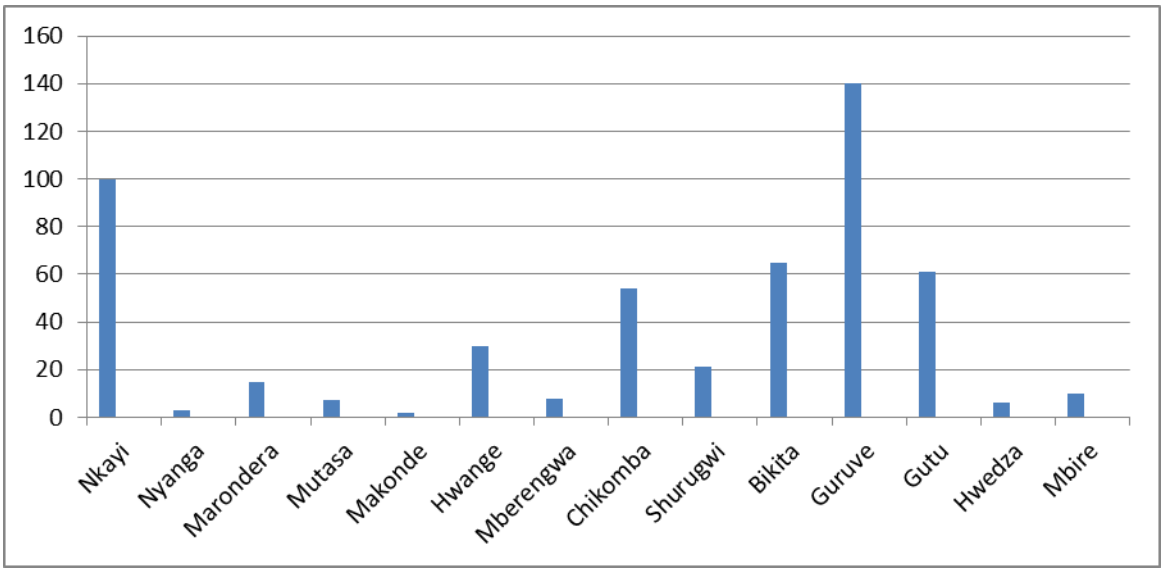
Relevance – score 3

"CHBC is not about the bed-ridden anymore…it has moved beyond the kit", Key informant, Harare

Community and home based care (CHBC) and support services delivered over the course of the past 5 years have included: palliative care, psycho-social support, spiritual guidance and preventive services. National guidelines and training were developed in order to harmonise the nature and quality of care. The caregiver policy guides the management of CHBC care givers. CHBC services are provided in all 16 ESP districts, with all districts having approximately 30% coverage. Whether by design or default, this constrains the reach of services to those in need. As a result of the increasing numbers of people on treatment, enhanced understanding of HIV and greater willingness to be tested, there are now fewer bed-ridden clients than when the ESP began.

The following graph[31] demonstrates this reduction in numbers of bedridden clients, with several districts reporting as few as four clients. All four districts consulted still have approximately 60 secondary care givers.

Figure 2: Number of Bed-Ridden Clients by District[32]



There has also been a reduction in the numbers of clients requiring high levels of assistance in Global Fund supported districts, where HOSPAZ is the implementer, reported as 6%, 10% and 4% from quarter two to four respectively[33]. It is worthwhile to note that substantial progress has been made towards achieving universal access to ART for both adults and children, as discussed under treatment above. In 2007, 24.8% of clients who needed treatment were enrolled, increasing to 57.1% in 2009. A decline was registered in 2010 (37%) due to the

[31] The graph contains data on 14 of the 16 ESP districts: for reasons that are not clear, Matobo and Chirumhanzu districts are excluded.
[32] ESP Clients reached as at December 2010
[33] NAC 2010 Annual Report

revised WHO guidelines, but an increase was registered in absolute terms from 20,003 to 33,424 clients.

However, the NAC 2010 annual report actually reports an increase of bedridden clients throughout the year[34] despite increasing numbers of people accessing ART. NAC attributes this trend to distortions in reporting or the result of withdrawal of nutritional support to CHBC clients but it could also be a result of low CHBC coverage as while all districts are covered, not all wards are covered. For example in Shurugwi, only 9 wards out of 36 are accessing CHBC services. The different scenarios being presented may call for further interrogation of the programme to establish the correct situation. ZNASP II also draws attention to the fact that while ART coverage has increased significantly, CHBC has not been sufficiently reoriented to reflect this. It is noted that the programme has been revised to focus more on treatment support in line with the new guidelines and the revised training manual but the observations in the field indicate that some aspects of the programme are not relevant to the needs of communities. According to a headman who is living with HIV and was once bed-ridden but is now well:

"When I was bed-ridden, my child was receiving school support through BEAM. Now I am strong again, but what about my child....he was taken off BEAM. What do you expect me to do? Be bed-ridden again for my child to be supported?..." (Headman Hwedza District).

CHBC does not necessarily focus exclusively on HIV and includes caring for those with cancer, diabetes and other conditions. As the health of PLHIV improves so too does the nature of the support they require. There is now increasing need for support groups that can provide psychosocial support, treatment literacy and adherence. Support groups for PLWHV have been established in the 16 districts where the implementing partners at district level are working closely with ZNNP+ MIPA representatives. To this end, NAC should increase collaboration with ZNNP+ which has established over 500 support groups countrywide and can build on this capacity in all districts. Strengthening the capacity of ZNNP+ to establish and work with support groups would also make a meaningful contribution to the MIPA principles. While NAC has MIPA officers, more needs to be done in order to create and sustain meaningful involvement of PLHIV.

In light of the changing needs surrounding CBHC it would be prudent to re-craft this component in order to ensure continued relevance to community needs. It is likely that any redesign will need to include a significant focus on initiating and sustaining income generating projects. In terms of broader impact mitigation, it is clear that orphaned and other vulnerable children also need support with nutrition and education.

Effectiveness – score 3

Several of the indicators for the CHBC programme (as presented in the logical framework) proved difficult to measure since few are systematically recorded and reported. Significant human capital was developed in 2010 with the number of trained secondary caregivers reaching 963, just exceeding the target of 960. The number of PLHIV in the 16 districts accessing CHBC over the past 12 months was 6,521 (target: 6,400). Thirty one participants from MOHCW, local authorities and NGOs were trained in the use of the revised CHBC training package. The total number of kits distributed across the 16 districts was reported as 1,133 (target: 6,000 in

[34] NAC 2010 Annual Report

logframe but UNICEF advised it should be changed to 3,840) although it is noted that this number may not be the final one.

Several issues that constrained effectiveness were noted during the impact assessment: delayed receipt of incentives, bicycles that are unsuitable for the terrain and which cannot be repaired locally, failure to deliver kits to some of the partners, staff turnover, and inadequate reporting.

In Gutu, Batanai, the CHBC partner, covers 4 wards and has 30 registered secondary care givers per ward. Of the 30 care givers in each ward, 15 are supported by ESP while the others do not receive material support. Nonetheless, secondary care givers continue to provide services to their clients (without remuneration or incentives). High turnover of caregivers and volunteers linked to burnout and stress are also reported[35].

Table 6: Output 2 – CHBC Achievements[36]

Indicator	Baseline 2009	Milestone 2010
Output 2: Increased access to community home-based care services *(weighting 10%)*		
Proportion of PLHIV accessing CHBC in last 12 months in 16 districts	48%	52% Not available
Number of PLHIV accessing comprehensive care in 16 districts	Not known	6,400 (400/district) 6,521
Percentage HBC patients visited at least once a week		80% 5,217 = 80% of 6,521*
Number of PLHIV provided with adherence support		500 2026
Number of secondary care givers trained in 16 districts Refresher courses for caregivers	0	960 (60/district) 963 872
Number of CHBC kits distributed in 16 districts	Not known	3,840** 1133*** (240/implementing partner)
Percentage HBC implementing partners reporting stock outs of at least one of: disposable latex gloves, disinfectant, soap, gauze		<5% 45%
Number of functioning PLHIV support groups in each of 16 districts	Not known	160 (10/district) 137

*Updated number provided by UNICEF

**The target in the logframe was 6,000; UNICEF advised it should be changed to 3,840

***UNICEF advised that this figure should be corrected but no new figure was provided

[35] Zimbabwe National HIV and AIDS Strategic Plan 2011-2015 [ZNASP II]. Revitalizing our commitment to zero infections, zero deaths and zero discrimination. First draft, 21 November 2010

[36] Achievements highlighted in yellow

While secondary care givers were pleased to receive bicycles, these proved to be unsuitable for the terrain, arrangements for repair were unclear and caregivers lack the resources to repair them. In Hwedza, caregivers pushed broken bicycles from their homes to our meeting place so that the team could see for themselves the state that they were in. Clearly, it is essential that bicycles procured are appropriate to the terrain, durable, repairable and come with spare parts.

Similarly, distribution of kits is unsatisfactory. UNICEF emphasised that its responsibility was for *procurement* of kits. They argued that if nationwide distribution were required, UNICEF could use its national distribution systems. However, the distribution of kits is actually for a relatively small number of districts and ZAN's responsibility in relation to kit distribution is unclear. The team was given to understand that ZAN was responsible for collecting and distributing the kits to local partners, many of whom lack vehicles or fuel to be able to collect them. Indeed, the team was also given to understand that ZAN has ten provincial level coordinators, each of whom has a vehicle at their disposal, Whatever the respective responsibilities and failings, the reality is that in many instances kits were not reaching those who needed them, In Hwedza, caregivers (under Seke HBC in Makarara Ward) last received soap, linen savers, betadine and aprons in June 2009. In Mutasa, ARISE noted that around half of their allocated bicycles and kits have been awaiting collection from Harare for over a year. The total of 1,133 kits distributed in 2010 (against a target of 6,000) highlights the inadequacy of the current arrangements.

A further impediment to effectiveness is staff turnover. For example, ZAN has lost three key staff members, (the Finance Officer, the Grants Manager and the CHBC Officer). Staffing challenges are experienced at district levels also as organisations close or downsize in response to lack of funding. This has proved challenging in terms of being able to maintain continuity of implementation.

Reporting is a major challenge[37]. For example, in the second quarter of 2010, 5 of 16 districts submitted their reports. Of the five reports received, only 2 were actually satisfactory, the others were incomplete and did not disaggregate data according to the specified variables. Reported indicators sometimes vary, making alignment of reports challenging and measurement of success against the logframe difficult. The specific format and tools for reporting need to be clarified and agreed amongst all partners so that there is consistency and reliability of data collected and used as the basis of assessing progress in relation to the specific targets and outputs in logframe.

Efficiency – score 4

The CHBC programme experienced delayed disbursements of funds which led in turn to an emphasis on accelerated implementation in order to compensate for lost time. The gaps and challenges identified above adversely affected the efficiency of the programme and are attributable to weak management and coordination of the programme together with limited capacity to provide appropriate support to local partners.

DFID supports the national Protracted Relief Programme (PRP) nationwide and this contains a CHBC component. It is worth considering the feasibility of moving the management of the CHBC component of the ESP to the PRP or at least establishing linkages between the two programmes to ensure provision of comprehensive CHBC services, and transferring the

[37] UNICEF/ZAN/NAC/MOHCW Quarter Two Report – April to June 2010

management of psychosocial support to a more suitable implementing partner with the necessary management and technical capacity required to establish and support income generation projects.

Impact – score 3

From 2007 to end of 2009 the CHBC programme was developing national guidelines and training materials, community level implementation of several activities actually began in 2010. Given this, it is not yet feasible to assess programme impact. The change of the Implementing Partner responsible for CHBC (from the WHO to UNICEF) presented yet another challenge to programme implementation, and perhaps one that could and should have been anticipated.

Data was unavailable for measuring the CHBC indicator at the purpose level of the logframe.

Table 7: Scale up of the National HIV and AIDS Response in Zimbabwe through CHBC

Indicator	Baseline 2009	Milestone 2010
Purpose: Scale up of the national HIV and AIDS response in Zimbabwe		
Percentage of PLHIV reporting improvement in QOL following enrolment in CHBC programme	Not known	60% Not available

Despite these numerous, significant challenges, human capital has been built and training has enabled secondary caregivers to increase their confidence and skills, which have in turn, contributed to improved well-being of individuals and communities.

Sustainability – score 4

In its present form, the sustainability of the CHBC component is unlikely, although it is acknowledged that sustainability is possible to some extent given that the secondary caregivers continued to work before the incentives were disbursed and the support groups are running their own activities with minimal assistance. Support needs of the population are changing and the programme needs to be reconceptualised and refocused in response.

Lessons learned:

The key lesson for CHBC is the need to ensure that planning and implementation are driven by community needs. Regular reviews, with strong community participation, can assist implementers to understand the relevance (or lack thereof) of their activities as well as facilitating timely and appropriate adjustments. A key strength of the ESP, repeated throughout this impact assessment, has been its flexibility. It is regrettable that this was better not exploited by the CHBC component, although it is acknowledged that amendments and requests were made and approved by the ESP WG during the implementation period to address needs that were noted, e.g. development of a volunteer policy, printing of the translated secondary care giver handbook, etc. .

Recommendations:

- Strengthen procurement, logistics and distributions systems for community CHBC materials.

- Reconsider the existing supply chain management system with a view to changing to the Delivery Team Topping-Up system (DTTU) system that is currently working well for ART and family planning commodities.
- Consider the costs and benefits of merging the management and coordination of the ESP and PRP CHBC activities or creating stronger linkages between the programmes
- Strengthen monitoring and evaluation systems for community and home based care, in particular, identify the particular nature of data to be recorded (and at what level) in order to assess progress against the logframe.
- Capitalise on existing community level capacity in CHBC to strengthen integrated HIV/TB case detection, adherence counselling, psychosocial support.
- Further strengthen the capacity of ZNNP+ to establish, coordinate and network with support groups of PLHIV.
- Strengthen community systems through supporting income generation activities by Support Groups.

3.4.3 Increased adoption of safer sexual behaviour and reduced risk behaviour

Relevance – score 1

The BC component of the ESP is guided by the National Behaviour Change Strategy 2006-2010 and contributes to key elements of the National strategy: specifically creation of an enabling environment, adoption of safer sexual behaviours, and reduction of risk behaviours through community mobilization and interpersonal communication. The model is adapted from *Stepping Stones* and is called *Love and Respect.*

The BC programme is highly relevant: it enhances community participation and involvement in HIV issues as these affect the lives of community members. The process assists community members to identify key drivers of the epidemic and agree on how to address them. Examples of drivers identified include multiple concurrency, non-use of condoms (as well as inconsistent and incorrect use), specific cultural and religious beliefs and practices, and the absence of an enabling environment in which to discuss matters relating to HIV and sex.

Involving community and traditional leaders as entry points has been fundamental for 'buy-in'. Traditional leaders, as custodians of culture, play a pivotal role in influencing behaviour change. The Behaviour Change Facilitators (BCFs) were identified from the community and work in their own areas of residence. As role models in the community, the opportunity for continued dialogue in the community is thus guaranteed. Trained community members in turn share information with others at gatherings such as funerals, weddings and church meetings, resulting in extensive reach with information to most members of the community.

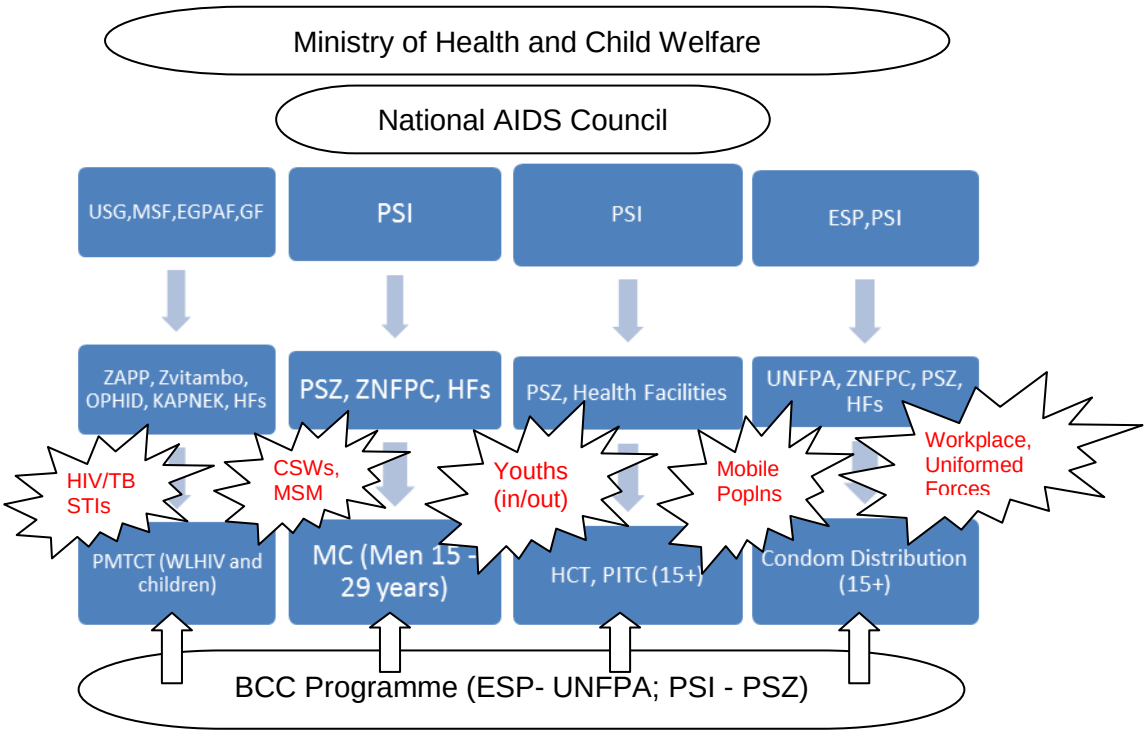
The programme is further strengthened by mixing information dissemination strategies. For example, inter-personal communication is complemented by a radio program 'Love Carefully' and accompanied by support materials and manuals for community leaders and facilitators.

The BC programme has established links with other MOHCW activities such as HTC, condom distribution, HIV treatment and care. In all districts where the BC component functions, increases were reported in relation to demand for HIV testing, treatment, and enrolment for

PMTCT. The programme has also managed to penetrate religious sects that are not usually receptive to health activities.

The ESP BC component is one among a number of prevention strategies and activities supported by donors in the country. The diagram below illustrates the key constituent components of prevention work in Zimbabwe.

Figure 3: HIV Prevention Packages in Zimbabwe



The ESP BC component model complements the work of PSI and other partners, although increased emphasis on TB/HIV screening and case management; and STI management could further strengthen BC. BC reaches its identified target groups. However, more focused work needs to reach sex workers, men who have sex with men, young people (in and out of school), uniformed services, prisoners and mobile populations.

Effectiveness – score 2

Considered in relation to the specific targets in the logframe, the BC component has achieved most of its objectives (see Tables 8 and 9 below). Cumulative person exposures reached between 2007 and 2010 are 9.2 million against a target of 4.7 million. Achievements for 2010 on person exposures were 4.4 million against a target of 2.7 million. This is so because HIV prevention information is shared at almost all gatherings in the community (funerals, weddings, churches), hence more people are reached. However, there is also a possibility of double counting, leading to higher numbers. The programme successfully reaches the 18 to 44 year age group as well as community leaders.

Reporting and monitoring of the programme are efficient and contributed to programme effectiveness. The BCC programme has reached commercial sex workers through two drop in

centres in Harare, Mbare Edith Opperman, and Bulawayo and 15 mobile clinics along main highways (Harare - Nyamapanda; Harare – Chirundu; Harare – Mutare; Bulawayo – Victoria Falls and Bulawayo – Beitbridge). 1,271 clients were reached through clinical services in quarter 4 of 2010 while 2,766 clients were reached since 2009.

Table 8: Output 3 – BCC Cumulative Achievements

Indicator	Targets Cumulative	Achievements Cumulative
Output 3: Increased adoption of safer sexual behaviour and reduced risk behaviour including among most-at-risk populations *(weighting 35%)*		
Number of people reached through community HIV prevention programmes (person exposures) in 26 districts	4.7 million (2007-2010)	9,181,390 (2007-2010)
Number of people completing BC course in 26 districts	234,340 (2009-2010)	284,706 (2009-2010)
Number of BCFs and community leaders refresher trained in 26 districts	3,820 BCFs (2007-2009) 3,820 Leaders (2007-2009)	4,106 BCFs (2009-2010) 5,067 Leaders (2009-2010)
Number of sex workers reached through drop-in and outreach services in 16 districts	-	2,906 (2009-2010)

Table 9: BCC 2010 Achievements against Targets

Indicator	Targets 2010	Achievements 2010
Output 3: Increased adoption of safer sexual behaviour and reduced risk behaviour including among most-at-risk populations *(weighting 35%)*		
Number of people reached through community HIV prevention programmes (person exposures) in 26 districts	2,7 million	4,426,199
Number of people completing BC course in 26 districts	120,000*	134,031
Number of BCFs and community leaders refresher trained in 26 districts	1,441 BCFs 2,162 Leaders	2,031 BCFs 1,497 Leaders
Number of BCFs trained to replace those that left the programme	-	490
Number of sex workers reached through drop-in and outreach services in 16 districts	-	1,772

**as per national target set out in GF performance framework (was 144,000 previously)*

Efficiency/Cost Effectiveness – score 2

Despite initial delays, implementation of activities was accelerated and the achievements discussed above realised.

It is estimated that between 39,405 and 42,484 new infections were averted by the BC programme based on the assumptions made in this analysis (see Annex 8). Cost per infection averted is between USD 275 and USD 297 giving a cost saving of up to USD 306.9 million, compared to life-time cost of treatment. If infections averted are only sustained for 5 years, cost savings would be substantially lower, but would still be USD 47.4 million compared to USD 300 per person per year for comprehensive drug and systems costs for treatment, care and support.

A limitation, lies in the fact that outcomes of cost-effectiveness analysis for HIV prevention programmes depend largely upon assumptions and source data collected for other purposes and that have low statistical power for the particular type of analysis conducted here (in particular HIV prevalence data from ANC surveillance).

Impact – score 2

Based on statistics from PSI, achievements have been made at purpose (national) level: for example, the percentage of young people (15-24) reporting consistent condom use with non-regular partners in last 12 months increased from 42.2% in 2009 to 78.2% in 2010 for females, and from 68% to 78% for males during the same period. In the 2009 interim survey 25% reported consistent use of condoms after completing the 11 week love and respect course. Assessing the proportion of married men and women reporting sex with more than one partner in the preceding 12 months, PSI reported a decline among females from 9% in 2009 to 8.2% in 2010 while the proportion for men increased from 28.4% to 35.3%. This is supporting the 2009 BCC interim survey which noted that 25% of 18-24 year old males reported reducing number of sexual partners after attending the 11 week course. This impact will further be assessed against findings from the forthcoming ZDHS.

According to NAC annual report 2010, adults 15 to 49 receiving HIV counselling and testing and knowing there results was 652,330. This is against a target of 900,000 (see Table 10). Since HTC was reported to be high in the 16 ESP/EC districts, the failure to reach the target may be assumed to be as a result of lower figures from non ESP/EC districts.

A clear increase in knowledge has been accomplished and this is likely to have contributed towards:

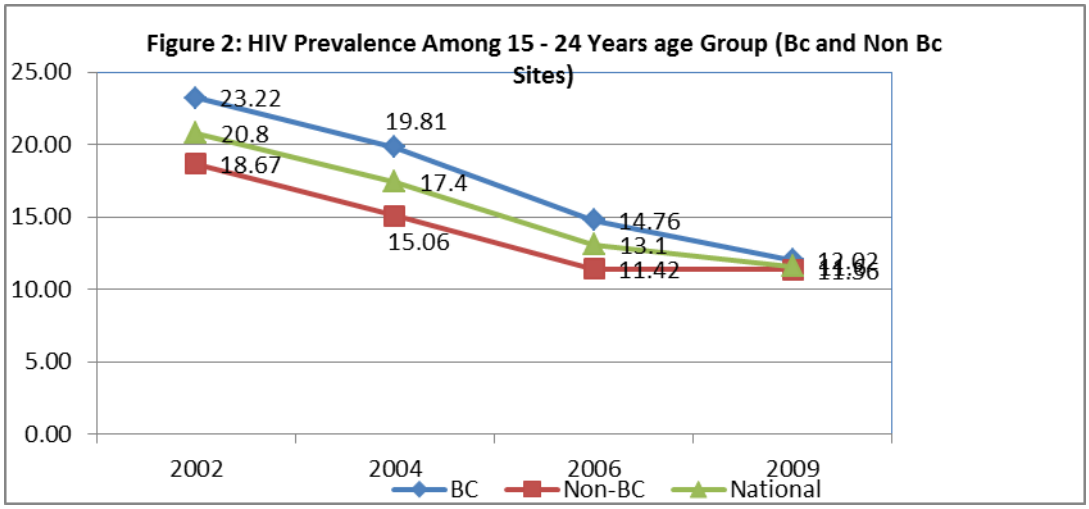
- increased demand for HIV testing (36% in 2007 and 50% 2009),
- increased condom use (20.7% for people not exposed and 25.5% for those exposed to BCC messages)
- increased numbers of clients on treatment (discussed under component 1);
- decreased HIV-related stigma
- reduced reported partner concurrency (15% reported having two or more partners in 2007, compared to 9% in 2009);
- establishment of a more open and enabling environment for discussion of HIV and related issues (see comments in Annex 9).

Information dissemination through the BCC programme has led to increased knowledge on HIV Gathered through FGDs, an unintended but welcome change brought about by the BC component has been reflected in better conflict management and resolution at couple, family and community levels (see Annexes 9 and 10).

Table 10: Scale up of the National HIV/AIDS Response in Zimbabwe through BCC

Indicator	Baseline 2009	Milestone 2010
Purpose: Scale up of the national HIV and AIDS response in Zimbabwe		
Number of adults (15-49) who have received HIV C&T and know their result	579,767	900,000 652,330
Percentage of young people (15-24) reporting consistent condom use with non-regular partners in last 12 months	Female:42.2% Male: 68%	Female: 45% 78.2% Male: 70% 78%
Percentage of sex workers reporting condom use with their most recent client	74%	76% Not available
Percentage of adults (18-44) reporting concurrent sexual relationships in last 12 months	Female: 2.5% Male: 9.6%	Female: 2.4% Male: 9% Not available
Proportion of married men and women reporting sex with more than one partner in last 12 months	Female: 9% Male: 28.4%	Female: 8.3% 8.2% Male: 26.4% 35.3%

After controlling for several factors (including the higher baseline prevalence in the 26 ESP/EC districts), an analysis of HIV prevalence (among 15-24 year olds) indicates 24% lower in the 26 ESP/EC districts (i.e. declined more - 24% steeper, or in fact continued to decline in BC districts while it levelled off in non-BC districts). Even though this finding was not statistically significant for the three years of the programme (p-value =0.13), it is perceived as a good indicator for impact if programme implementation is 5-10 years of transmission. A further analysis of impact and HIV infections averted is indicated in Annex 10. The decline from ANC surveillance data between 2006 and 2009 is shown in the figure below.



HIV-related behaviour change is not an event but a process that unfolds over of time. The longer the duration of a programme, the more the expected gains and benefits will exist for the community. The reason for the convergence of prevalence among the different groups in 2009 is not clear and warrants further investigation.

Sustainability – score 2

The ownership of BC activities demonstrated by local communities bodes well for sustainability. However, the programme still needs external support for continuity and sustainability, and to reach areas and populations as yet not covered.

Lessons learned

Information exchange, sharing of experiences and refresher courses need to continue A headman in Mutasa emphasized this:
"It is the same with attending church services, you have to continuously partake in church activities and follow its teachings. If not, you can easily be led astray".

Recommendations

The achievements of the BC component are considerable but more needs to be done in order for HIV prevalence to continue to decline:

- **Continue funding support** to sustain the achievements made so far;
- **Expand coverage by** continuing work in the existing 26 ESP/EU districts and expanding into remaining non-ESP, non GF districts for national coverage and increased impact;
- **Extend reach to** engage with most at risk populations, in-school programme (primary school, high school, tertiary institutions), workplace, host spots – growth points;
- **Strengthen BC Programme linkages and synergy across** PMTCT, MC STI management and TB-HIV co-infection, HIV treatment literacy and adherence counselling;
- Promote **male involvement;**
- Support communities with **income generating programmes** for livelihood and for economic empowerment;
- Strengthen documentation of **qualitative information** which offers excellent opportunities for learning and better practice.

3.4.4 Effective coordination, management, monitoring & evaluation of the national response

The "three ones" principles has been realised by giving the National AIDS Council (NAC) responsibility for the coordination of the National Response through the decentralised system. The NAC has the mandate to coordinate and maintain the one national M&E system and the National Strategic plan has an M&E framework developed with indicators and targets.

The mandate of NAC includes building the capacity in areas such as institutional, human, technical, logistics and financial areas at the national, provincial, district and community levels to

ensure proper planning, institutional coordination, information management, and facilitation of communication, reporting systems, monitoring and evaluation.

The NAC's role and comparative advantage is in the administration of the National AIDS Trust Fund (NATF). The NATF is made up of a 3% levy of tax with funds used to support NAC administration cost and also provides funds to certain sections of the national response such as procurement of ART. Its volume is dictated by the economic status of the country.

Relevance – score 2

The ESP strategies are in alignment with national strategies to achieve the goals of the national strategic plan by providing technical assistance through implementing partners and management of a common pooled fund to support increased achievements of the national response. The NAC is responsible for the development and implementation of the National AIDS response to reduce the spread of HIV, improve the quality of life of those infected and affected, and mitigate the socio-economic impact of the epidemic in Zimbabwe. NAC is responsible for the development of the national strategic plan and support to development of plans at all levels provincial, district and community levels and monitoring and evaluation of the inputs of national response activities by public and private sectors and their achievements.

Effectiveness – score 2

ESP support has helped to strengthen coordination and monitoring and evaluation. The Provincial and District AIDS Committees have been given adequate capacity through the various training programmes supported by UNAIDS such as financial and project management, the use of the M&E Modules, data management and use to be able to coordinate and monitor the work of implementers under their care.

District HIV and AIDS action plans have been developed in all 16 ESP districts. ESP has supported the development of the new national strategic plan ZNASP 2001 – 2015 with inputs of work-plans from the districts and provinces.

The ESP has worked with the MOHCW and NAC and Global Fund in a coordinated way that has effectively reduced duplication of activities and harmonised modes such as joint contributions for the human resource retention scheme (HRRS) and procurement of commodities for treatment of HIV and AIDs.

ESP funding for the HRRS has helped to stabilise staff in the health service and, in some cases, attract staff back to work. ESP salary support has also ensured that key posts are filled at NAC and helped to reduce staff attrition gradually.

Year	Overall NAC Terminations	DACs
2007	32	14
2008	49	17
2009	25	7
2010	16	1

The introduction of a US dollar salary scale together with retention packages also contributed to the reduction in staff turnover. Recently, most staff attrition has occurred specifically among

trained M&E officers who, with now enhanced technical capacity, have become more attractive to other employers able to offer higher salaries. In addition to resignations there have also been a number of dismissals resulting in a 3% attrition rate and 2% dismissal rate.

NAC Staff	Resignation	Dismissal
M&E officers	4	
OVC coordinator	1	
DAC		1
Accountant	1	
Registry	1	
Drivers	3	3
Security Guards		2
Percentage of NAC	3%	2%

M&E taskforces for the 85 districts and the 10 provinces are functional and meet routinely. Implementing organizations and health facilities submit National Activity Report Forms (NARF) on monthly basis to NAC Districts Offices though some submitted by implementers were incomplete. The district data is all gender disaggregated and the district reports are all coordinated into annual reports at the provinces.

Efficiency – score 2

The mechanism of the ESP Working Group facilitates effective and efficient collaboration among partners. The Working Group is responsible for decision-making in relation to approval and allocation of funds for costed six monthly and annual plans. However, the role of NAC as co-chair of the Working group creates a potential for conflict of interest since NAC is also a fund recipient. This was not perceived to be a problem for the majority of partners.

The quarterly reports of ESP Implementing Partners lack systematic assessment of progress against national targets and report on activities rather than results. Budgets and financial reports lack detailed costs breakdown and do not link expenditure with results. As a result, it was a challenge to assess fully programme efficiency.

The ESP works harmoniously with Government agencies, in particular with NAC, MOHCW and NatPharm, and coordinates and manages NGOs. Implementing partners of ESP work with a variety of partners: for example. UNFPA works with MASO, World Vision on BCC in the ESP and EC districts, and UNICEF also funds, manages and supports ZAN on CHBC programmes in several districts.

Effective management of the ESP is based on its major mode of action of **flexibility.** The ESP has an effective, flexible funding mechanism, which has responded rapidly to emerging needs, for example, financing the national health worker retention scheme and emergency procurement of drugs for treatment of HIV infected patients. The ESP pooled funding mechanism with its single fund administrator provides efficient coordination among donors and implementers and reduces transaction costs. Also, ESP procurement is undertaken by UNICEF in order to exploit economies of scale.

The annual independent review of the ESP has been an effective process for assessing the progress of the programme and its activities and for informing decisions concerning the most effective use of ESP resources. For example, following recommendations the ESP decided on increasing the budget for treatment for as long as this did not entail too much reduction in budgets of other programme components.

In the integrated district planning process (IDPP) plans are consolidated at provincial level before being integrated within the national annual plan. However, implementing partners do not always follow up on the planning activities during IDPP. In some districts, the IDPP template was not perceived to be particularly user-friendly, and some district work plans and budgets were not signed by PACs. Districts have had their capacity upgraded to implement their annual plans and produce reports with support from NAC through the DAC and PAC. In 2010, 72% of the districts had their reports submitted on time to the provinces.

The ESP has supported strengthening of monitoring and evaluation; however, the challenge of effective M&E still persists at all levels especially at the District health facilities. Parallel M&E systems are a challenge between the MOHCW and NAC, as reporting forms in the health facilities are designed by the MOHCW and not well coordinated with the reporting formats of the NAC.

The ESP log-frame has several outcome indicators which can only be measured by long range surveys such as the DHS and behavioural surveillance surveys. More performance based indicators would make targets and achievements more reliable, as used in the indicators of the Global Fund quarterly performance update reports.

Impact – score 2

The impact of the funding on positive change in the HIV/AIDS national response appears to be high because of the joint donor programming with a common fund mechanism and adoption of common goals.

While serious efforts have been made to coordinate with other programmes and maximise the impact of contributions, this assessment has found that even within the programme, ESP implementing partners have not always capitalised on potential links between components or with other programmes to create synergy. This clearly limits the potential impact.

Table 11: Outcomes of support to NAC

Main Objective: Improve coordination between implementers and lead UN agencies, partners, and donors.	
OUTCOMES	**Achievements 2006-2010** {No baseline data, Outcome Indicators or specific targets}
Strengthen the coordination of the National Response to HIV and AIDS	The NAC continues to strengthen its capacity as the coordinating authority for HIV and AIDS activities. NAC supported by NATF, ESP GF to build coordination and management capacity and retain trained personnel

Main Objective: Improve coordination between implementers and lead UN agencies, partners, and donors.	
	NAC staff attrition 2008 (49) 2010 (16)
	The National Partnership Forum facilitates coordination between Government, UN agencies and donors.
Enhance evidence based planning and programming through development of District Action plans	1.ZNASP developed for 2006-2010 2. ZNASP developed for 2011-2015 2010 -All districts in the country have developed integrated plans for HIV and AIDS activities which give an overview of the activities which partners are funding and the gaps in the districts. The Integrated district plans are making coordination more meaningful and resources are being used more effectively in the districts. PACs and DAAC continuously trained by NAC and UNAIDS for plan development and monitoring and evaluation of programmes at district and provincial levels / Improved coordination and management competencies of DAACs.
Enhance gender and MIPA in planning, programming and monitoring of the National Response	2008 - A gender policy was developed and adopted for NAC used in the different thematic areas to ensure *gender* mainstreaming into HIV/AIDS Streamlined gender and MIPA activities in Programmes through training of NAC and ZAN staff in gender mainstreaming
Enhance lessons learning and advocate for the expansion of ESP	ART cohort analysis of ART patient survival done; BCC survey, DHS Increased donors' contribution to the HIV programmes, Global Fund, USG, NATF and advocacy for ESP expansion and renewed funding directions.

Sustainability – score 3

Although HIV prevalence has declined, Zimbabwe still needs to continue reducing incidence and keeping those who are infected alive on treatment in order to also reduce the number of orphans. It is important to work towards securing future funding for ZNASP 2011-2015.

Collaboration and coordination, support for the national HIV response, national ownership of HIV response through partnerships and reliance on evidence-based decision making all combine to make the program more sustainable for the long term.

Making recommendations about future support is complex due to uncertainty about the political situation in Zimbabwe. There is the urgent need to have ongoing and increased support from the ESP and other donors. With improvement in the national economy and stability, if the AIDS levy keeps increasing it will contribute to longer term sustainability of reduction in incidence of HIV and survival from AIDS. Sustainability will be achieved through building local capacity and increasing Zimbabwean ownership of the programme and by the ability to secure future funding

for the ZNASP 2011-2015. This is not yet known but will provide a strong indication of the confidence of donors in the systems that have been developed to lead the national response.

3.4.5 Fund Administration

UNDP functions as Fund Administrator (FA) for ESP common funds. Plans are submitted to the ESP Working Group and upon approval funds are disbursed. The main duties of the FA are to receive funds from donors, administer and disburse to implementing partners through the agreed framework, account for them and provide regular reports on their use.

Relevance – score 2

The Zimbabwean economy went into decline from 2000 onwards, a result of both external and internal factors. Drought, international isolation and general macroeconomic instability, characterized by hyperinflation and an acute shortage of foreign currency, all impacted adversely upon the economy. Foreign currency shortages resulted in a thriving parallel market which led to a rise in the cost of foreign currency with transaction costs spiralling.

Utilisation and productive capacity of industry also fell dramatically to averages of between 10% and 15%. In turn, this led to shrinkage of the tax base and reduced limited revenue flow. Cumulatively, these negative macroeconomic factors had significant impact upon the health sector, with considerable reduction in health expenditure, massive staff exodus and near collapse of the country's health system. Health indicators, once the envy of the continent, underwent reversal. Confidence in the government system of revenue and allocation was at an all-time low.

The introduction of the ESP as non-direct budget support brought with it the possibility of reversing the downward trend of health in Zimbabwe.

Effectiveness – score 2

Compared to other mechanisms of donor support in Zimbabwe, the flexibility of the ESP funding mechanism gives it a particularly strong advantage. Global Fund programmes are known to allow using funds from another line budget in a limited number of circumstances. The ESP Working Group approval process has sometimes resulted in delays to the release of funds to implementing partners. While service providers have responded to such delays by accelerating delivery as best they can once funds are released, in some cases delays have compromised the quality of the service.

Efficiency – score 2

Use of the pooled funding mechanism has lowered the cost of fund management in terms of overheads and reduced transaction costs. While targeting the selected districts addressed equity issues (at least to a degree), in some instances, efficiency was compromised by delays, for example, in relation to drug distribution to remote areas, increased transport and transaction costs. For example, in districts such as Kezi-Matobo, supply of CHBC kits has been erratic. In Gutu, the CHBC provider had to provide their own transport in order to collect and distribute kits.

This however, was not as a result of the fund administrator's inefficiency, but more to do with the delays by the ESP Working Group in approving budgets.

Across the entire programme, the absorptive rate was 92%. The absorptive rate of IPs was, on average, greater than 80% for the year 2009. However, the absorptive rate of UNICEF for procurement (68%) and WHO care and treatment (72%) fell well below this average.

In terms of technical efficiency, direct disbursements to the implementers enabled most critical services to be delivered on time, thus lowering the unit costs of service delivery. In theory at least, partnership with international organisations such as World Vision and ZAN, allowed the ESP to capitalise on their comparative advantage in terms of geographical and community reach. However, in reality, challenges were experienced in terms of efficient distribution of kits to more remote areas.

Impact – score 2

Given the country's political instability, using the UN system for delivery has offered a cost effective option. A capped administration fee has enabled UNDP to deliver value for money. However, the fees charged by the various UN implementing agencies (highlighted by the 2010 Independent Annual Review) give cause for concern. At 0.6%, UNDP provides better value for money than, for example, the Global Fund Local Fund Agent fees of (on average) 5.3% of total expenditure, and 2.2% of grants under management (Global Fund, 2010). Specifically in relation to the WHO, the experience of the ESP has demonstrated that WHO is more strategically positioned to provide technical assistance than, for example, undertake procurement or work with NGOs. While the original MOU indicated that the IPs would charge overheads according to their organisational rules, the 13% charged by WHO was not felt to represent value for money. However, the WHO has since reduced the fees to 7% starting in 2011.

Sustainability – score 3

Zimbabwe's application to Global Fund Round 10 was designed on the assumption that ESP funding would continue, together with funds from other sources. Failure to secure Round 10 support has critical implications for sustaining service delivery. The Global Fund Round 10 proposal identified funding gaps for 2011-2013 of USD117 million, USD128 million and USD139 million respectively. The table below also shows the failure by the fiscus to meet the budget bids submitted by the MOHCW for selected line items in 2011, buttressing the need for ESP to continue funding HIV and AIDS.

Reduction in 2011 Budget Bids for selected line items

Programme/unit under Medical Care	% reduction
National Blood Transfusion Services	67%
TB Drugs	80%
ART Drugs	66%
Nutrition	98%

Source: Ministry of Health and Child Welfare Budget Bids 2011

Pooling funds, for example through Sector Wide Approaches (SWAPs), have worked well in countries such as Zambia and Mozambique. Zimbabwe's experience with ESP has shown that this kind of mechanism can be sustainable. However, use of a parallel mechanism (in the case

of ESP through the UN system) was necessitated by specific socio-economic and political circumstances. As the economy improves and political stability emerges, there will need to be a gradual shift towards more direct budget support. Anticipated increased flow of funds from the National AIDS Levy as more and more companies increase production will allow the National AIDS Council to become more financially independent.

3.4.6 Procurement

Relevance – score 2

The current procurement system through the UN system is still relevant given that NatPharm, the local pharmaceutical company, still needs to develop their capacity, When Natpharm becomes more competent and can obtain favourable prices UNICEF should consider a gradual shift of responsibilities. The procurement of some items such as bicycles needs to be left to the local organisations in order to also build the capacity of the local players and ensure local level relevance of procured items.

Effectiveness – score 2

UNICEF has been able to exploit economies of scale by using international procurement systems together with national logistics management and distribution systems (e.g. NatPharm). In this way, UNICEF has exploited partners' comparative advantages and thus delivered value for money. De-linking drugs (from donor and districts) enabled effective delivery to areas in need and hence contributed to promoting equity. However, in some instances, the effectiveness of particular programme components has been compromised by delays in procurement as well as ineffective procurement, for example, of unsuitable vehicles and bicycles, which resulted in more maintenance costs for vehicles and non-use of some bicycles. Nonetheless, the overall assessment of the procurement system concludes that it is cost effective when compared to the currently weak national procurement systems.

Efficiency – score 2

The use of NatPharm's distribution system enabled UNICEF to deliver goods with an acceptable level of efficiency. Exploitation of economies of scale was possible by purchasing goods at the lowest prices. However, some pieces of equipment (e.g. CD4 count machines) have broken down, while optimal use of others is constrained by limited technical capacity. In Gutu District, a shortage of Laboratory technicians also limited the amount of testing that could be done. The chain of delivery for CHBC kits - in which UNICEF procures kits which ZAN is responsible for delivering - increases overheads and transaction costs. There was also apparent confusion about the distinct roles of each agency regarding distribution. Nonetheless, comparison with Global Fund districts reveals a similar pattern of delays in the distribution of Kits and in some cases of ARVs.

Impact – score 2

The impact of the UNICEF procurement system is better felt in terms of lower unit cost prices of delivery for the different programme interventions. The mechanism has undoubtedly resulted in a greater availability of drugs and equipment in the country.

Sustainability – score 3

The current mechanism is not a long term desirable model as it detracts from national ownership. With a view to the longer-term, in-country capacity for procurement should be developed now so that, when the time comes when handover from the UN to national partners is feasible, the transition can be made with minimum disruption.

3.4.7 Human resource retention scheme

In response to the deteriorating economic and political environment, outward migration, including large numbers of skilled health workers, reached a peak in 2008. The legacy of the exodus is still apparent in some health facilities that have high vacancy rates of key cadres. When cholera broke out in Zimbabwe in 2008, the impact of the exodus of health workers became clear.

With funding support from DFID, Crown Agents designed a model, with suitable controls, to deliver retention payments to areas affected by the cholera epidemic. Eligible workers received a monthly allowance (funded by donors[38]) linked to existing salary scales, with basic salaries funded by government. The payment was made directly to workers' accounts which reduced overheads and transaction costs. This first phase established the credibility of the mechanism and increased morale as more staff reported for duty. According to UNICEF, an immediate increase in staff attendance of 20-30% was reported.

Successful implementation of the initial phase led to more donors becoming involved and pooling funds, thereby keeping administration costs as low as possible. It is estimated that more than 30,000 health sector workers have been paid a total of USD 25 million through this project to date, and health delivery systems have been maintained to support the people of Zimbabwe. The scheme has helped to increase the number of health workers from less than 10,000 in December 2008 to more than 26,000 in February 2009[39]. Visits conducted to local health facilities during the impact assessment confirmed the importance of the payments (despite the sometimes irregular and delayed nature of their payments) and these may be playing a role in the high reported levels of staff retention.

Experience from Zambia[40] in human resource retention emphasised the importance of stakeholder participation in the design and development of the sustainable scheme as well as an effective and efficient remuneration system. A balance is also recommended between financial and non-financial incentives together with a suitable performance appraisal system to monitor and enhance productivity of retention scheme participants.

[38] In US dollars, an important incentive in itself given the level of hyper-inflation at the time.
[39] http://www.publications.parliament.uk/pa/cm200910/cmselect/cmintdev/252/25208.htm
[40] Mwale, HF, Smith,S. Human resources retention scheme: qualitative and quantitative experience from Zambia http://www.who.int/workforcealliance/forum/presentations/Hilary_Francis.pdf

Scoring

The scoring system used is based on a methodology employed by German Technical Cooperation (now merged into a new organisation called German International Cooperation). The intention behind borrowing this scoring method is simply to make use of an existing method that is based on the 5 OECD-DAC criteria, and therefore add some degree of objectivity and transparency to the assessment. It should not be interpreted as a stringent scoreboard.

Scoring was conducted across each output area (O-1 to O-4) according to each of the 5 criteria. These scores were amalgamated for each criterion according to the weighting (Wt) in the revised ESP logframe. It should be noted that the logframe weightings were actually 50%, 10%, 35% and 15% respectively across the outputs 1 to 4. However, as these add up to 110%, the team sought clarification from DFID on what weightings to use and was advised to adjust these to 45%, 10%, 35% and 10% respectively. The table below shows the total score for all outputs against the 5 criteria.

Scores across 4 Output areas:

Criteria	O-1	Wt	O-2	Wt	O-3	Wt	O-4	Wt	Total O-1-4
Relevance	1	45%	3	10%	1	35%	2	10%	1.3 (1)
Effectiveness	2	45%	3	10%	2	35%	2	10%	2.1 (2)
Efficiency	2	45%	4	10%	2	35%	2	10%	2.2 (2)
Impact	1	45%	3	10%	2	35%	2	10%	1.65 (2)
Sustainability	3	45%	4	10%	2	35%	3	10%	2.75 (3)

Since the areas of fund administration and procurement are highly important in terms of overall programme impact, these areas were also scored according to the same criteria. A weighting was then given to fund administration and procurement against the combination score of the 4 output areas. This was judged to be 25% each against a combined output score of 50% weighting. If this is felt to be a misrepresentation of relative weighting, the scores can be adjusted accordingly.

Scores of Output areas with Procurement and Fund Administration:

Criteria	Total C-1-4	WT	Proc	WT	FA	Wt	Score
Relevance	1.3 (1)	50%	2	25%	2	25%	1.65 (2)
Effectiveness	1.75 (2)	50%	2	25%	2	25%	1.875 (2)
Efficiency	2.3 (2)	50%	2	25%	2	25%	2.15 (2)
Impact	1.75 (2)	50%	2	25%	2	25%	1.875 (2)
Sustainability	2.75 (3)	50%	3	25%	3	25%	2.875 (3)

Final Scores

An overall rating of 1-3 concludes that a programme was successful, while 4-6 indicates that it was unsuccessful. The ESP achieved an overall score of 2. The 5 criteria themselves were not weighted but this could be revised if required and the final score will be recalculated automatically in the table below.

(1) Criterion	(2) Rating for criterion	(3) Weighting for criterion	(4) = (2) x (3) Weighted criterion (automatic)
Relevance	2	2	4
Effectiveness	2	2	4
Impact	2	2	4
Efficiency	2	2	4
Sustainability	3	2	6

Average of the weighted criteria 1 - 5	**2**
If effectiveness, impact or sustainability are accorded a numerical rating of "4" or poorer, the overall rating will be downgraded to "4" even if the average is better than "4". Under exceptional circumstances, should the sustainability be less important (weighting "1", see assessment grid), the overall rating will not be downgraded.	No, the overall rating is not downgraded.
Overall rating of the project/programme:	**2**

3.5 OVERALL FINDINGS & ANALYSIS

Generally, the team had a very positive impression and found that the ESP has provided an excellent model for maintaining and enhancing the national response to HIV and AIDS in a highly challenging environment. It has clearly contributed significantly to the response in the 16 districts as well as at national level. The purpose, according to some of the indicators defined in the revised logframe for 2010-2011, is well on the way to being achieved. Although some indicators will not be available until the next ZDHS, due to be published in April 2011, there is good evidence in the available studies and surveillance data that the figures are moving in the right direction. The table below summarises known recent progress on the key indicators. It is important to note that there has been an increase in the denominator of the first purpose level indicator, the percentage of adults and children with advanced HIV receiving ARVs. This is a result of the number of people in need of ART having risen because of the changed WHO guidelines on starting treatment earlier. The new denominator is Adults: 503,678, Children 89,490. So the original targets have been well exceeded in terms of numbers but not in percentage of those in need according to the revised guidelines.

Table 12: Progress against higher level logframe indicators[41]

Indicator	Baseline 2007	Baseline 2009	Milestone 2010	Target 2011
Purpose: Scale up of the national HIV and AIDS response in Zimbabwe				
Percentage of adults and children with advanced HIV receiving ARVs:	Target Adults: 250,000[42] Children: n/a	Adults: 64% (204,883) Children: 28% (20,166)	Target Adults: 76% (260,000) Children: 35% (25,000)	Adults: 84% (310,000) Children: 42% (30,000)
Denominator now changed to reflect revised guidelines – number of adults in need = 503,678 in 2010, number of children in need = 89,490	Achieved Adults: 30% Children: 10% 104,000[43]		Achieved Adults: 61.6% 310,360 Children 35.7% 31,904	
Percentage of adults and children on treatment 12 months after initiation of ART	n/a	75%	Target 78%	81%
			Achieved 69%[44] Range 60-77%	

[41] Achievements and points to note are highlighted in yellow
[42] Need estimated at 376,101 (341,382 Adult + 34,719 Children) according to MOHCW. 2009. Zimbabwe National HIV and AIDS Estimates.
[43] Data not disaggregated by age group. However, the 2009 Estimates provides a figures of 34,337 for children in need of ART in 2008;
[44] This is the figure from the NAC of people still on treatment after 2 years from initiation

Indicator	Baseline 2007	Baseline 2009	Milestone 2010	Target 2011
Number of adults (15-49) who have received HIV C&T and know their result		579,767	Target 900,000	1,050,000
			Achieved 623,179 (PITC)[45]	
Percentage of young people (15-24) reporting consistent condom use with non-regular partners in last 12 months		Female:42.2% Male: 68%	Target Female: 45% Male: 70%	Female: 50% Male: 75%
			Achieved	
Percentage of sex workers reporting condom use with their most recent client		74%	Target 76%	78%
			Achieved	
Percentage of adults (18-44) reporting concurrent sexual relationships in last 12 months		Female: 2.5% Male: 9.6%	Target Female: 2.4% Male: 9%	Female: 2.2% Male: 8.3%
			Achieved	
Proportion married men and women reporting sex with more than one partner in last 12 months		Female: 9% Male: 28.4%	Target Female: 8.3% Male: 26.4%	Female: 7.2% Male: 22.8%
			Achieved	
Percentage of PLHIV reporting improvement in QOL following enrolment in CHBC programme		Not known	Target 60%	70%
			Achieved Not available	
Goal: Reduced transmission and impact of HIV and AIDS in Zimbabwe				
HIV prevalence adults (15-49)	17.7%	14.3%	14%	13.8%
HIV prevalence young people (15-24)	Female:7.46% Male:3.37%	Female: 6.9% Male: 3.3%	Female: 6% Male: 3.1%	Female: 6% Male: 3.1%
HIV prevalence young people (18-24) (in 26 BC focus districts)		Female: 14.1% Male: 2.6%		Female:11.3% Male: 2.3%
HIV prevalence children (0-14)	2.14%	3.0%		2.75%
Annual AIDS-related	79,363	56,676		

[45] The figure from Provider-induced HCT

Indicator	Baseline 2007	Baseline 2009	Milestone 2010	Target 2011
deaths (adult)				
Annual AIDS-related deaths (children)	13,016	9,397		

In terms of contribution to the overall goal of the national programme, it is extremely challenging to clearly attribute changes to the ESP specifically compared to other contributions since there were no indicators defined that capture this. Many partners have contributed to the goal of reducing transmission and AIDS related deaths and in the absence of sensitive indicators and clear means of verification of a specific ESP contribution, plausible attribution can only be estimated on the basis of the positive results obtained in the different ESP intervention areas and an assessment of the overall culmination of these efforts. In order to overcome this challenge, the assessment team looked for specific aspects of the ESP that seemed to have contributed very clearly to successful implementation of the national response and for models within the ESP that have been copied by others. Some important lessons are identified for the future in terms of design, M&E and capturing impact.

Relevance: Score 2

The ESP supports the aim of the national response to achieve Universal Access and was fully aligned with the ZNASP 2006-2010 which provided the initial strategic framework. The new ZNASP 2011-2015 has been drafted with full consideration of the experiences gained from the ESP and other programmes, as well as the findings in the MTR of the ZNASP 2006-2010 and the MOT study. Future support from the ESP or an alternative programme would need to ensure full alignment with the strategic direction of the new plan. Of particular importance, is the need to target resources to those most at risk, including those residing and working in the identified 'hot spots' (growth points, farms) and to the most vulnerable groups (sex workers, MSM, drug users, prisoners, migrant workers). This has not been a particular focus of the ESP to date. The current practice of programmes supporting specific districts has its advantages in terms of bringing resources closer to the implementation level but has distinct disadvantages regarding ability to respond to priority needs throughout the country and the risk of potential neglect of entire geographical areas. The ESP overcame these limitations to some extent by ensuring flexibility in its processes, for example, contributing to the national ART supply in addition to the ART supply to the 16 focus districts and supporting the Human Resource Retention Scheme (HRRS). However, a more flexible and needs-based design from the start would be helpful for a new or extended programme.

Continuing to balance a HIV focus with broader health systems development is a critical area for the future relevance of the ESP. Currently there is much talk about integration of HIV-related services into the health system and this is undoubtedly a priority given the chronic nature of the epidemic and the strong associations with other aspects of health, including pregnancy-related issues, tuberculosis, and other STIs. For many donors and international partners there is likely to be a future move towards convergence of support for vertical programmes to a more holistic and comprehensive approach. This reflects an acknowledgement of the substantial links between health and HIV programmes and the recognition that an integrated approach is more likely to result in the development of stronger health systems and synergy across inputs, which will in turn enhance the likelihood of achieving the Millennium Development Goals. The

contribution of the ESP to the HRRS provides important support to health system strengthening, as do the experiences in task shifting to nursing staff at peripheral levels. Addressing the social aspects of the epidemic is largely undertaken outside the formal health system and there remains a strong need to find effective ways to reach vulnerable people through multi-sectoral means.

Gender

There are large social and economic gaps between women and men in Zimbabwe, and these inequalities have played a central role in the spread of HIV. The gendered nature of the HIV epidemic and its impact are well documented. With particular reference to men in Zimbabwe, the picture that emerges from interviews and observations is a complex one. On the one hand, men are variously described as feckless, selfish and unsuited to caring responsibilities. On the other hand, several of the nurses and carers encountered in the field were men. Increased availability of ART has increased women's access, according to one health worker:

> *Difference made by ART is huge. In the villages the father used to go and get treatment and the others were left behind. Outreach services are really making a difference in terms of helping mothers and children also to attend local services for treatment.*

Attitudes towards female sexuality are more constrictive than more lenient ones towards the sexual activity of men, resulting in a situation where men often have multiple sexual partners and women have little authority to instigate condom use. Sexual abuse, rape and coerced sex are all common. While stigma associated with HIV appears to be reducing and this was widely reported as the case during the field visits, the ZNASP 2011-2015 acknowledges that this is still a major problem and it is likely to remain a deterrent for many people in accessing services. These realities need to be taken into consideration in addressing the underlying factors contributing to the continued spread of HIV. The ESP does not appear to have explicitly attempted to address these issues. Clearly addressing gender inequality is a goal worth pursuing in its own right, as well as in terms of its value as a strategy for addressing HIV. The BC component with its focus on community involvement would seem to present an ideal opportunity to address gender (especially given the strong gender focus of the original Stepping Stones methodology from which the programme is adapted).

The relevance of the ESP to the current political and economic environment in Zimbabwe warrants a special mention. During the lifetime of the ESP the country underwent major challenges, including increasing political and economic isolation, an unprecedented rise in inflation peaking in 2008 at 100,000%[46], a severe cholera epidemic, high rates of unemployment, political violence, and a near-total collapse of the health system. Channelling resources through the UN agencies has been a necessary mechanism given the instability in the country over the past few years. As circumstances remain somewhat uncertain, this is likely to remain a relevant mechanism for the foreseeable future; however, the situation will need to be reviewed regularly to allow for alternative modes of delivery to be developed over time and the necessary capacity built in advance to enable that to happen.

The choice of interventions within the ESP has been relevant to the needs of the country with a stronger focus on ART provision and behaviour change for HIV prevention. Both these areas

[46] http://news.bbc.co.uk/2/hi/business/7255588.stm

are likely to remain highly relevant in the near future but there is a risk that treatment needs, particularly with the revised WHO guidelines, will overshadow all other needs. As the Zimbabwean economy improves and the AIDS Levy increases, the government should be able to contribute more to ART provision, leaving external donors more flexibility to respond to other pressing needs. The extent to which this will occur is somewhat uncertain; however, the economy is expected to continue growing for the immediate future.

Emerging issues in prevention include the need to increase access to PMTCT which is known to be highly cost-effective, the need to support the massive scaling up of Male Circumcision services, and the need to target prevention interventions more specifically to the most vulnerable groups, particularly in the 'hot spot' areas identified. The ESP stakeholders will need to work with other partners in the coming years to see where the biggest gaps are in meeting these needs. However, it should also be noted that widespread and effective treatment contributes significantly to prevention efforts by reducing the infectivity of PLHIV. The CHBC component started later than other components and seems to have received less attention; however, it only had a weighting of 10% in the logframe. As the results have been less satisfactory in this area, it would be important for the ESP stakeholders to decide whether or not it makes sense to continue at all or to hand this area over to another more qualified partner. In any case, the design of such a component would need to be revised according to the changing needs of communities as outlined in the CHBC section above.

Effectiveness: Score 2

All four output areas were reasonably effective in meeting targets and producing results. The fund administration and procurement functions were also implemented effectively, albeit with some delays. Overall, the flexibility of the ESP proved to be a major strength, enabling resources to be directed to nationally identified priorities and thereby contributing to the achievement of national targets. The decentralisation of resources to peripheral levels has contributed to increasing equitable access. However, there is little evidence of focused targeting of interventions and resources to those most in need and some examples of uneven distribution of resources were encountered during the field visits.

The Zimbabwe Modes of Transmission study notes that HIV prevalence is expected to continue to slowly decline, then stabilise and perhaps eventually rise with increasing ART coverage. Incidence is predicted to level off if current low levels of risk are maintained. Further reductions in incidence will require additional risk reduction. Population dynamics and increasing numbers of people in need of ART indicate the need for enhanced prevention and treatment interventions over the coming years.

Since treatment is required for life and delivering universal coverage will continue to be challenging, it still makes sense, ethically and financially, to *prevent* as many new infections as possible. Thus, it will be important to be vigilant and maintain a strong and active focus on prevention since successes delivered through prevention so far still need to be sustained and expanded. These were, at least in part, the result of the economic decline and concomitant reduction in multiple concurrent sexual partners. As the economy improves, sexual behaviour patterns may also change and the success of prevention efforts could be undermined.

The MOT study provides a comprehensive summary of the main ways to reduce HIV transmission in Zimbabwe and should be used as a reference for all future programming decisions in collaboration with partners to ensure that each intervention area is covered systematically and adequately. These areas include reducing sexual networks and concurrency, increasing ART, increasing male circumcision, increasing HCT and condom use, and expanding PMTCT.

Pre-exposure prophylaxis is an important emerging issue. CDC trials are currently investigating the safety and efficacy of Tenofovir (alone or in combination with Emtricitabine[47]), taken in a single daily dose by HIV negative individuals considered high risk for infection. In addition to the initial focus on MSM and drug users, this is now being explored for heterosexual individuals and is particularly relevant to sero-discordant couples.

As mentioned in the relevance section, the harmonization of ESP with national priorities, e.g. HRRS and pooled drugs, has proved effective and particularly useful in contributing to the achievement of national targets. These areas of support along with the other components of the ESP contain the key elements of a continuum of care approach from prevention through treatment, care and support. They also offer good opportunities for enhancing further health system strengthening. However, it was noted that there were missed opportunities for synergy between components. This could be strengthened by establishing more in-depth coordination mechanisms where relevant. The current vertical nature of implementation of components by different partners does not facilitate collaboration. Despite the perceived strong communication channels in place within the ESP Working Group, this has not necessarily translated into direct collaboration and synergy in the field. In the current set-up, this could be improved by enhancing the support for district level coordination between components, but if a future programme operates at national level with targeting of resources to areas of particularly high need, then appropriate mechanisms of coordination at those levels would need to be established.

The programme has resulted in some unintended positive and negative effects. One strongly positive effect is the human capacity that has been developed, particularly noticeable during the field visits. The team was highly impressed with the competent and hard-working nurses and caregivers and their commitment to serving local communities, even when this entailed a degree of personal sacrifice. To see this degree of dedication in spite of extreme hardship (some individuals had not been properly paid in months), was remarkable and a tribute to the ordinary people of Zimbabwe.

On the negative side, the need to channel resources through the UN agencies, and therefore have very streamlined procedures, resulted in some loss of local ownership, limited possibilities to be fully responsive to local level needs, and most likely missed opportunities for local capacity building. Some field level partners displayed a certain degree of frustration with the fact that they were unable to take decisions locally and had to deal with provision of irrelevant items of support, including vehicles that were unsuitable for the local terrain, or imported bicycles that could not be repaired locally. For the future, it will be important to be able to have a mix of cost-effective and efficient programme arrangements, along with mechanisms that facilitate the most effective, locally relevant outcomes.

[47] PrEP Trials Fact Sheet, CDC, February 2011

Cost effectiveness/ Efficiency: Score 2

The costs of the ESP Programme

The ESP programme is only one of a number of HIV programmes in Zimbabwe. Table 9 shows the total HIVAIDS spending in Zimbabwe over between 2007 and 2009 and the ESPs contribution.

Table 13: **Total HIV/AIDS expenditure in Zimbabwe, in USD (2007-2009)**

Year	**2007**	**2008**	**2009**	**Total 2007-9**
Total	54,697,169	26,484,932	54,147,723	135,329,824
ESP	12,117,680	16,330,026	16,099,142	46104330
ESP %	22%	62%	30%	34%

Sources: NASA report 2009 for 2006 and 2008; UNGASS report 2010 for 2008 and 2009.

Table 14 records the ESP actual expenditure information for the years 2007-2009 for the different HIV and AIDS interventions and the different programme processes.

Table 14: ESP - Actual Expenditures for 2007-2009 in USD

Theme	**Actual Exp. Year I**	**Actual Exp. Yr II**	**Actual Exp. Year III**	**Cumulative Expenditure Total**
Behaviour Change & Prevention	2,574,489	2,135,936	2,522,575	7,233,000
Care & Treatment	401,734	855,239	1,930,982	3,187,955
Human Resources	0	0	4,100,000	4,100,000
Management & Coordination	1,105,024	1,784,037	1,690,719	4,559,029
Procurement	9,614,666	11,554,814	5,854,866	27,024346
Total	**13,695,913**	**16,330,026**	**16,099,142**	**46,104,330**

1 These figures include the CHBC costs
2 These figures include monitoring and evaluation

Behaviour Change and Prevention: These expenditures are concentrated on the 16 ESP districts and are part of a larger project being implemented by UNFPA. This overall project includes funding from the EC and covers 26 districts. More detailed information on these expenditures based on data provided by UNFPA can be found in Table 15. The total figure for the ESP component in Table 11 differs from the figures in Table 10 reflecting the different data sources and illustrates the difficulties faced in interpreting the cost data. The differences probably reflect differences in reporting formats; it was not until Year 2 that the fund administrator and the implementing partners agreed on a common reporting format.

Care and Treatment: This line item includes service delivery capacity building in ART, CHBC and HIV/TB. The treatment and care component enabled ART patients in both the ESP districts and national level to get better services through the training of health workers in testing and

counselling, infrastructure and systems strengthening as well as the effective monitoring and coordination of the programme.

Human Resources: A new line item was introduced in 2009 – Human Resources. This was to cover the human resources retention scheme introduced in 2009 and being implemented through Crown Agents. This is a national scheme and paid for top ups of all health workers and not only for the 16 districts.

Procurement: The Procurement line item includes procurement of ARVs for the ESP districts and also for the national ART programme. For instance in 2009 drugs were procured for 28,000 patients in the 16 ESP districts and another 30,000 patients in the national ART programme. The significant drop in funds spent between 2009 and 2008 does not reflect a real drop in procurement expenditures but the late disbursement of funds in the last quarter of 2009 which made it impossible for UNICEF to procure in the same financial year.

Management and Coordination: This line item includes the fees charged by the Fund Administrator, costs associated with the internal review of the national monitoring and evaluation systems, support to the district integrated planning process and the costs of drafting, printing and disseminating the ZNASP 2011-2015. Support for the management and coordination increased in 2008 as the programme expanded but fell slightly in 2009.

Table 15: Breakdown of Behaviour Change and Prevention Expenditures in USD

Inputs		2007	2008	2009	2010	TOTAL
Training of Leaders.	Activity01	48,237		150,155	33,214	231,607
Ward Action Planning	Activity02	64,546	263,375	91,817	6,891	426,629
Training of BC facilitators	Activity03	48,237	248,673	207,023	127,985	631,919
Community Session on BC	Activity04			87,199	-	87,199
BC facilitators Allowances	Activity05		111,763	195,501	210,464	517,728
Training and Support Visits	Activity06			141,663	102,808	244,472
Support to community Events	Activity07			58,399	281,420	339,819
Human resources	Activity08	356,782	448,522	548,501	511,158	1,864,962
Vehicle Running	Activity09	85,342	121,123	92,680	155,468	454,613
Office Running Costs	Activity10	74,142	185,682	164,812	178,950	603,585
BCSOs Staff Training in BC	Activity11	88,594		25,193	16,583	130,370
BC Material Production	Activity12	36,160	304,279	37,415	85,887	463,742
IPC Targeting SW	Activity13			22,606	321,870	344,476
BC Film Production	Activity14			43,505	70,133	113,638
BC incentive Items	Activity15			84,236	1,138	85,373
Stationery procurement	Activity16			25,794	27,049	52,843
Training Peer Review of BCSOs	Activity17	13,938		50,909	7,901	72,748
STI Control training	Activity21			19,547	-	19,547
IT Equipment for BCSOs		99,664				99,664
Procurement of vehicles BCSOs		258,925				258,925
BC M&E	Activity18	207,289	7,922	69,502	42,417	327,131
Unfpa Local Program Mgt	Activity19	-	120,000	122,646	118,031	360,677
Audit - BC Support Organisations	Activity20	30,392	40,768	43,190	65,877	180,227

Inputs		2007	2008	2009	2010	TOTAL
Indirect cost 7 %	Indirect cost 7 %	98,247	108,618	180,596	165,567	553,029
Total ESP expenses		1,510,495	1,960,726	2,462,890	2,530,812	8,464,922
BC programme specific expenses ESP		1,510,495	1,960,726	2,420,736	2,208,942	8,100,899
Corresponding BC expenses through EC grant		965,581	965,581	965,581	690,968	3,587,711
Total cost of BC programme 2007-10		2,476,076	2,926,307	3,386,317	2,899,910	11,688,610

Source: UNFPA

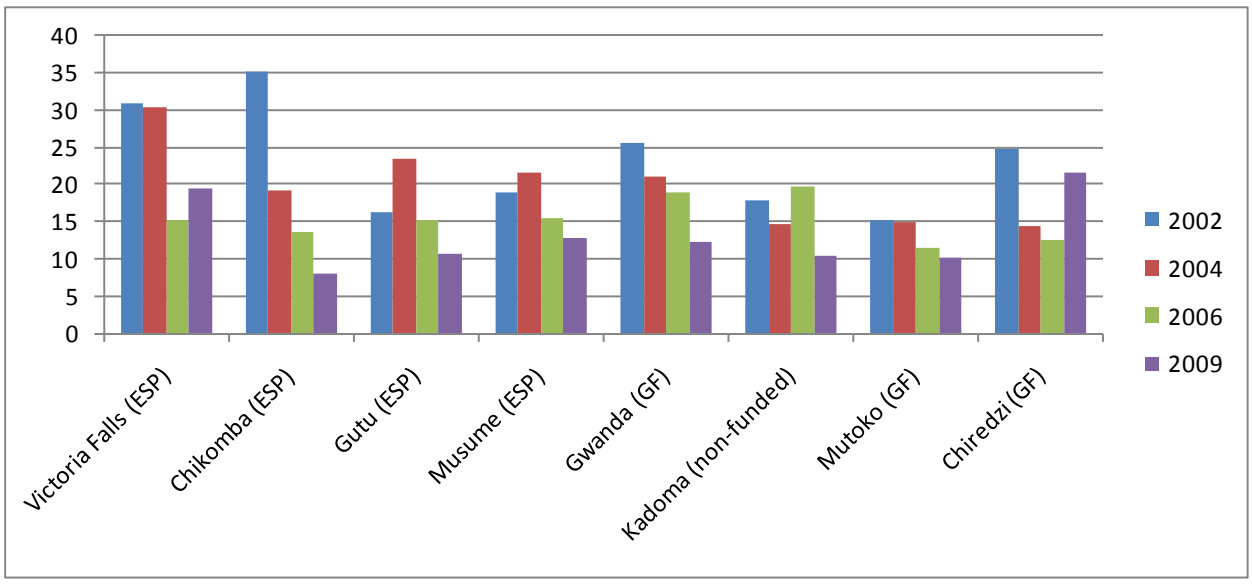
The effectiveness and cost effectiveness of the different approaches used by the ESP supported programme

The ESP programme is only one of a number of HIV programmes in Zimbabwe. Its support includes a range of activities at the national level and also a set of activities directed at 16 focus districts. Even in these districts it is not the only programme working in each of the districts. As a result, it is extremely difficult to attribute changes in the epidemic to any particular programme and a number of assumptions have to be made as outlined below.

Limitations of the CEA

There was limited time to gather enough information for the other alternative programmes such as Global fund that could be used as a comparator Therefore in this evaluation there will be no comparison of options beyond the baseline of 'Doing Nothing'. Where an evaluation is done after an investment has already been made, it is always difficult to develop a counterfactual. The year 2007 was used as the baseline for the analysis and the calculation of incidence rates and infection averted were for the period 2007-2010. Difficulties in interpreting differences are further compounded by the marked differences in prevalence of HIV in different parts of the country (see Fig 4).

Figure 4: HIV Prevalence 15-24 years



Source: Ministry of Health and Child Welfare estimates 2009.

Assumptions

In the analysis that follows we have focused on the direct costs of the programme. For a more comprehensive analysis ideally one would look at the indirect costs as well. However, those data are not available.

We have grouped the activities of the ESP programme into two depending on the focus of their activities

Approach 1: Behaviour change and prevention
Approach 2: Care and Treatment

In assessing the effectiveness and cost effectiveness of these approaches we estimated by year the:

- Cost per case of HIV averted
- Cost per person on treatment

We have also looked at the cost per person reached by the behaviour change and prevention programme and the costs of the different components of the treatment and care programme. We were not able to compare the costs of these approaches against other programmes currently ongoing in Zimbabwe as the data were not available for other programmes. It should also be noted, that, especially for treatment, it is essential that the programmes took place at similar times as the cost of ARV drugs and how they are taken has changed considerably over time.

Approach 1: Behaviour Change & Prevention

Estimating HIV infections averted

UNFPA has estimated the impact of the behaviour change programmes funded by ESP/EC for two different scenarios (see Table 16). In their model, it was assumed that in the absence of any prevention programmes new infections would have moderately increased by 12% a year as compared to 2006. These figures were then compared to the estimated incidence in the ESP/EC districts were based on the National HIV Estimates after adjusting for differences in HIV prevalence in ANC women in the ESP/EC districts and non-ESP/ EC districts[48].

Scenario 1: It was assumed that the ESP/EC programme contributed 50% of the reduction in number of new infections in the 26 focus districts and 20% to the reduction in number of new infections in the rest of the country (ie. non focus districts).

Scenario 2: It was assumed that the number of cases averted from the ESP/EC programme was the difference in the incidence between focus and non-focus districts plus 20% of the reduction in number of new infections in the rest of the country (ie. non focus districts)

[48] A review of ANC data suggested that after controlling for various factors, HIV prevalence among ANC attendees aged 15-24 was 24 % lower (p=0.13). Based on difference in HIV prevalence trends in focus and non-focus districts, it was assumed that incidence was 40 % lower in focus districts (the difference in HIV incidence is expected to be higher than the difference in prevalence. (text extracted from UNFPA spreadsheet)

Table 16: Total infections averted by ESP/EC supported BC programme

	2007	2008	2009	2010	2007-10
Scenario 1: compared to national baseline scenario	4,991	8,925	12,638	15,929	42,484
Scenario 2: compared to non-focus districts	7,787	9,113	10,517	11,988	39,405

Source: UNFPA

In order to estimate the impact of the ESP component only we assumed that its impact on HIV infections averted was directly proportional to its share of total expenditures as recorded by UNFPA (See Table 17).

Table 17: Annual expenditures for the ESP/EC supported programme in USD

	2007	2008	2009	2010
BC programme specific expenses ESP	1,510,495	1,960,726	2,420,736	2,208,942
Corresponding BC expenses through EC grant	965,581	965,581	965,581	690,968
Total cost of BC programme 2007-10	2,476,076	2,926,307	3,386,317	2,899,910
ESPs % share of costs	61.0	67.0	71.5	76.2

Source: UNFPA

Table 18 records the estimated number of infections averted by the ESP component of the programme. For the period 2007-09 the estimated number of cases averted under the two scenarios are 18,060 and 18,375 and for the period 2007-10 27,506 and 30,193 respectively.

Table 18: Total infections averted by the ESP component of the ESP/EC supported BC programme

	2007	2008	2009	2010	2007-10
Scenario 1: compared to national baseline scenario	3,045	5,980	9,035	12,133	30,193
Scenario 2: compared to non-focus districts	4,750	6,106	7,518	9,131	27,506

Cost per case of HIV averted

Table 19 records the estimated costs of behaviour change and prevention components of the ESP programme. In doing this analysis we have treated the costs in two ways.

- Cost 1: Only the line item behaviour change and prevention was included
- Cost 2: The line item behaviour change and prevention plus 20% of the total procurement costs plus 35% of the management and coordination costs

Table 19: Estimated costs of behaviour change and prevention in USD

	2007	2008	2009
Cost 1			
Behaviour Change & Prevention	2,574,489	2,135,936	2,522,575
Cost 2			
Behaviour Change & Prevention	2,574,489	2,135,936	2,522,575
Procurement	1,922,933	2,310,963	1,170,973
Management & Coordination	386,758	624,413	591,752
Total	4,884,181	5,071,312	4,285,300

Table 20: Cost per case of HIV averted in USD for the 2 different cost scenarios and the two scenarios of cases of HIV averted

	2007	2008	2009
Cost 1			
Scenario 1	845	357	279
Scenario 2	542	350	336
Cost 2			
Scenario 1	1604	848	474
Scenario 2	1028	831	570

These figures show that the annual cost per case of HIV averted has fallen over time as would be expected given the initial set up costs.

The differences between the costs per case averted under cost scenario 1 in this table and the UNFPA estimates (see Table 21) reflects the differences between the costs of the ESP programme as detailed in the programme report (Table 10) and as detailed in the UNFPA spreadsheet (see Table 15). The overall analysis of the ESP funding mechanism shows that it has been quite cost effective. Stover and Bollinger (2007) estimated that in Southern Africa, the cost per infection averted would drop from USD1 588 in the year 2007 to USD900 by the year 2011. Overall though, the average cost per HIV infection in Sub-Saharan Africa drops about USD3000 (2007) to USD2000 (2011) and again shows that the ESP programme is indeed highly cost effective at cost per infection averted of between USD279 and USD570.

Table 21: Cost per infection averted from the UNFPA spreadsheet (all costs in USD)

Cost per infection averted	2007	2008	2009	2010	Total
SCENARIO 1: Total infections averted by ESP/EC supported BC programme	4,991	8,925	12,638	15,929	42,484
ALTERNATIVE SCENARIO: Total infections averted by the ESP/EC supported BC programme	7,787	9,113	10,517	11,988	39,405
Cost of the BC programme	2,476,076	2,926,307	3,386,317	2,899,910	11,688,610
Cost per HIV infection averted Scenario 1	496	328	268	182	275

Cost per infection averted	2007	2008	2009	2010	Total
Cost per HIV infection averted Alternative Scenario	318	321	322	242	297
Comparable life-time cost for treating one person / USD	7,500	7,500	7,500	7,500	7,500
Total hypothetical cost for treating persons whose infections were averted Scenario 1	37,432,986	66,939,814	94,787,096	119,466,798	318,626,694
Total hypothetical cost for treating persons whose infections were averted /Alternative scenario	58,401,523	68,348,385	78,877,945	89,906,363	295,534,217
Cost saving Scenario 1	34,956,910	64,013,507	91,400,779	116,566,888	306,938,084
Cost saving Alternative Scenario	55,925,448	65,422,078	75,491,628	87,006,454	283,845,607
Cost saving if infections averted are only sustained for 5 years					47,418,233

Cost per person reached by the behaviour change programme

Under Output 3 in the Indicators Table there is information provided that can be used to generate rough estimates of costs per person reached. Again these figures are based on UNFPA data and cover all 26 districts that are part of the ESP/ EC programme. As a result in estimating the costs per person it is important to use the full costs of the UNFPA/ESP programme (see Table 11). In this analysis we have not attempted to add in any of the shared costs for the whole ESP programme (ie. procurement costs or management and coordination costs)

Outcome 1: Number of people reached through community HIV prevention programmes (person exposures) in 26 districts.

- The baseline figure for 2009 was a cumulative figure for 2007 to 2009 of 5.2 million people reached. The cumulative costs of the ESP/EC programme over this period were USD 8.79 million which works out as a cost of USD 1.7 per person reached.

Indicative Costs of the different elements

Detailed breakdowns of the budget for the Behaviour Change Programme can be extracted from the UNFPA annual plans. Note: these are estimates of the cost of the ESP/ EC programme and cover activities in 26 districts. Table 18 illustrates the budgeted costs for two activities over time.

Table 22: Budgeted cost of different components of the behaviour change programme (USD). The figure in brackets is the number of each activity budgeted for – (e.g., leaders trained or ward action plans)

	2008	2009	2010
Cost per leader trained	110 (120)	110 (60)	70 (60)
Cost per ward action plan	500 (20)	500 (8)	560 (12)

Source: UNFPA Plans. * Global Fund supported activities in old districts

Approach 2: Care & Treatment

Estimating the number of people on treatment

Table 23 records the number of people currently accessing treatment by year.

	31/03/2007	31/12/2007	31/12/2008	31/12/2009	31/12/2010
Number of people currently accessing treatment in ESP districts	5,266	7,273	16,582	33,594	52,615

Cost per person on treatment

Table 24 records the estimated costs of the treatment and care components of the ESP programme.

In doing this analysis we have treated the costs in two ways.

- Cost 1: Only the line item care and treatment was included
- Cost 2: The line item care and treatment plus 60% of the total procurement costs plus 40% of the management and coordination costs

Table 24: Estimated costs of care and treatment in USD

	2007	**2008**	**2009**
Cost 1			
Care & Treatment	401,734	855,239	1,930,982
Cost 2			
Care & Treatment	401,734	855,239	1,930,982
Management & Coordination	442,010	713,615	676,288
Procurement	5,768,800	6,932,888	3,512,920
Total	6,612,543	8,501,742	6,120,189

Table 25 shows the estimated cost per person accessing treatment under the two different cost scenarios. The figures highlight the marked decrease in cost over time reflecting the high initial set up costs associated with equipping clinics, building up supplies, purchasing vehicles, etc. The figure for 2009, however, is probably an underestimate owing to the procurement delays.

Table 25: Cost per person accessing treatment in USD for the 2 different cost scenarios

	2007	2008	2009
Cost 1	55	52	57
Cost 2	909	513	182

Costs of the different elements

Table 26 records the budget for the procurement of goods for the treatment and care components of the ESP plan for 2010. The cost of antiretrovirals in the budget (USD 7.18 million cost) was based on maintaining the 58,000 existing patient on treatment and initiating 14,000 new patients and works out at just under USD 100 per patient per year for drugs excluding overhead costs. The comparable cost figure for laboratory testing was USD 6.9 per patient per year and for CHBC USD 4.2 per patient per year.

Taking into account freight costs and the other related costs (overhead charges etc) and allocating them to drugs, lab testing and CHBC based on their relative costs (0.900 to 0.063 to 0.037) the figures increase to USD 128.6 per patient per year for drugs, USD 9.0 per patient per year for laboratory testing and USD 5.4 per patient per year for CHBC.

Table 26: ESP Treatment and Care Procurement Plan. Budget for 2010. (All figures in USD)

Activities	Budget
Procurement	
Antiretrovirals	7,179,353.70
Laboratory Reagents (excl freight)	500,000.00
CHBC	300000.00
Subtotal	7,979,353.70
Freight @ 10%	797,935.37
Total	8,777,289.07
Related Costs	
NatPharm storage and distribution	478,761.22
Clearance, sampling	79,793.54
UNICEF Operational costs @3%	280,075.31
UNICEF HQ Cost Recovery @ 7%	673,114.34
TOTAL	10,289,033.49

Source UNICEF Procurement Plan February 2010

Impact: Score 2

The ESP has clearly had a significant impact on increasing access by communities to prevention, treatment and care services. This has been noted in previous annual reviews and was obvious to the team during the field visits. People's lives have been dramatically changed for the better in recent years. This is most obviously a result of increased access to treatment. Asking people on treatment about its impact on their lives was sometimes met with sheer incredulity: through treatment people are alive and able to function and contribute personally, socially and economically.

Less obvious, but important nonetheless, is impact on the lives of those who have *not* become infected because of preventive interventions and more widespread treatment resulting in lower levels of infectivity. According to the prevalence and incidence data, this constitutes a very significant number of people and infections averted as noted in the section above on cost-effectiveness.

The BC interventions also demonstrate promising impact with the steeper decline in HIV prevalence in the 26 ESP/EC districts. A clear increase in knowledge has been accomplished and this is likely to have contributed towards:

- increased demand for HIV testing, condoms and treatment;
- decreased HIV-related stigma
- reduced reported partner concurrency;
- establishment of a more open and enabling environment for discussion of HIV and related issues

There has been some progress towards linking prevention and treatment. For example, in some sites visited, testing and counselling, STI management, condoms and support (as well as diagnosis and treatment) were all available and accessible. Also, in some districts there was stronger collaboration in the delivery of prevention and treatment activities. However, the limited degree of synergy across the ESP components has reduced the overall potential impact. NAC will need to strengthen the links between the various components of the national programme, not only to ensure greater efficiency but also to result in greater impact.

The funding support provided by the ESP has helped to create a massive improvement in the quality of life, health and well-being of targeted communities. The impact could be even greater if resources were targeted to the highest risk groups and geographical areas, as noted above.

Repeatedly identified as a *potential* barrier to access and adherence, no study has yet been undertaken in order to assess the actual impact of user fees.

Sustainability: Score 3

Although huge progress has been made, the response to HIV in Zimbabwe still needs to be scaled up in order to reach all those in need. This will require a larger investment over a longer period of time in order to achieve universal access. There is a real issue with sustainability of the national response, not just in terms of funding, but also regarding the availability of adequate numbers of qualified health staff to deal with the increased numbers of people in need of treatment. Moreover, the BCC programme currently has achieved approximately 30% coverage: the programme needs to be expanded to full coverage and sustained over time to promote adherence.

The need for psycho-social support at community level is extensive as people struggle to cope with the impact of the epidemic. In many locations, the focus of CHBC has shifted from provision of physical care to supporting treatment readiness and adherence[49]. There is considerable interest in promoting income generation activities, particularly in relation to nutritional support but it is unlikely that the ESP would be able to support such areas directly as there are probably more appropriate ways to assist with this. The CHBC programme needs to be reconceptualised and redesigned in response to these changes before being delivered and sustained throughout the country. According to the estimates of incidence and prevalence over the coming years, the need for a sustained, long-term response to HIV is not going to disappear.

[49] Some clients continue to need and receive physical care, but the proportion of the caregivers' workload devoted to this kind of care has decreased.

A number of potential synergies exist that, if exploited, could maximise the return on investments made: for example, strengthening linkages between food security, nutrition and people living with HIV. This would require proper planning and the inclusion of agencies with specific expertise in these areas to ensure an appropriate and professional approach.

However, on the bright side, impressive progress has been made and there is now a strong basis for a sustained and effective response, which can be built upon in future support. There is a need for continued funding support to the Human Resource Retention Scheme to maintain capacity for service delivery and to facilitate better integration of HIV-related services within the health system. The table below shows the flow of funds over the coming years.

Table 27: Flow of funds

Funding for HIV/AIDS National Response 2005-2014**Funding Source**	**Commitment (USD million)**	**Type of funding**	**Period**	**Main HIV/AIDS intervention areas supported**
GoZ National Budget	164.4	On-budget; Domestic	2005 -2007	Prevention, treatment and care, mitigation and support; administration
Domestic sources including NATF	119,131	Earmarked; Off budget; Domestic	2006 -2008	Prevention, treatment and care, mitigation and support; administration
Expanded Support Program (ESP)	50	Basket; Off budget; External	2007 - 2009	Prevention, Treatment and Care, Support
Bilateral	263	Earmarked; Off Budget; External	2006-2008	Prevention, treatment and care, mitigation and support
Program of Support (PoS)	84.8	Basket; Off budget; External	2006-2009	OVC
GFATM Round 5	21.293	Earmarked; Off budget; External	2007-2010	Treatment and care; Administration
GFATM Round 8	296	Earmarked; Off budget; External	2009 -2014	Prevention, treatment and care, mitigation and support

Source: Draft ZNASP II 2011-2015

3.6 CONCLUSIONS/ LESSONS LEARNED

There is no clearly agreed framework for conducting impact assessments on large, complex programmes with various components and a wide range of implementing partners. In sector programmes like this where there are a number of funders and different programmes contributing to the same overall goal, it is extremely challenging to attribute changes to any one group or individual unless there are clearly stated specific outcomes identified that can really be linked to that group or individual. In this case the purpose of the ESP is to scale up the national response to HIV and AIDS in Zimbabwe but that purpose is shared by most partners who are contributing to the national response so there is nothing specific about the ESP contribution. Therefore, the best we can do is analyse how relevant, effective, cost-effective, efficient and sustainable the ESP contribution has been. While there is much general agreement on the success of the ESP in many areas, it is sometimes difficult to quantify that success and therefore, estimate its value over alternative approaches. Some degree of assessment on the value of the ESP compared to other programmes has been attempted but this is more on a relative funding basis rather than a real comparison as we are not able to undertake a full assessment of the other programmes in order to compare the same issues.

A retrospective impact assessment depends partly on the quality of the logframe and the extent to which the logframe guides the programme implementation and M&E. The logframe should include indicators that are measurable in the desired timeframe: the lack of availability of all the necessary data proved to be quite a constraint for the assessment team. Implementing partners are not reporting consistently against their own output indicators, which makes an assessment of their effectiveness somewhat difficult. In the ESP, the logframe was revised for the years 2010-2011 but many indicators for 2010 were not available easily or were provided extremely late during the assessment period. The indicators at the goal level may need to be reviewed in light of the findings in the Modes of Transmission (MOT) study showing increased incidence (in terms of actual numbers) in 2009 as a result of population growth and increased survival of PLHIV. Incidence will be a more sensitive indicator to show success in reducing transmission.

The ESP working group had not prepared a full set of reports with the key indicators for the start of the mission. This would have helped the team considerably and avoided a lot of time wasting. This was undoubtedly at least partly the result of a delay in the NAC/ESP receiving reports from the districts and provinces.

The decentralisation of interventions and spreading of resources to peripheral levels has clearly resulted in increased access to services. The availability of ART in most health facilities with trained staff, and CD4 machines in rural health centres, along with nurses and primary care health workers undertaking tasks usually performed by higher level staff, have all increased access tremendously. However, for the future, quality of care issues and M&E need to be resourced appropriately so that the full details of service delivery are captured and appropriate quality is assured.

The current modes of delivery have been necessary because of the unstable political and economic environment in Zimbabwe over the past few years. While they have proved to be effective and relatively efficient, there is a risk in the long term of undermining local capacity. In order to minimise this risk and start preparing for a more stable future environment, it will be important to keep this aspect in mind in the final year of implementation of the ESP and in any

future programme design by building in local capacity development processes, particularly for procurement of commodities.

An unforeseen positive impact noted above is the willingness of community bodies and health workers to contribute to ensuring service delivery activities using their own resources. This shows that there is huge commitment in the general population to address the weaknesses in the system and to participate in the development of their communities. It will be crucial for the future to build on this solid foundation of human strength.

3.7 RECOMMENDATIONS

1. As the programme is deemed largely successful, the current focus on BCC and treatment should be maintained this year, with a subsequent phasing-in of these areas of support to a new programme within the context of the ZNASP 2011-2015. There is little time to implement substantial changes in the programme in 2011, however, the ability of the programme to respond to priority needs of the national programme within its areas of focus has been highly valuable and should be continued.

2. The ESP should maintain its flexibility to ensure future alignment and response to emerging needs in the context of a changing epidemic. There should be a planning process throughout 2011 to decide on future support to the national response, as well as to develop an exit strategy from the current ESP. This process needs to take into account developments in the general health sector and how best to integrate support for HIV-related issues into the health system but at the same time facilitating a multi-sectoral response beyond the health system. This will ensure future relevance.

3. The Modes of Transmission study provides a comprehensive summary of the main ways to reduce HIV transmission in Zimbabwe and should be used as a reference for all future programming decisions on prevention, in collaboration with partners to ensure that each intervention area is covered systematically and adequately. The choice of interventions for a future programme should be aligned with the findings in the MOT study of the drivers of infection and the resulting recommendations on the array of prevention options most appropriate for Zimbabwe. According to what other partners are supporting or focusing on and gaps identified, the future ESP or a new programme should complement these efforts and fill the gaps. While treatment is likely to remain a major focus, there should be an equal emphasis on prevention. The new data emerging from the CDC trials on pre-exposure prophylaxis should be tracked and inclusion of this prevention area in a future programme should be considered.

4. The ESP stakeholders should advocate for the participation of new donors and increased funds. As the programme has been largely successful, there is a strong case for attracting more partners. At the same time, in view of the apparently improving economy, the ESP group should also lobby for increased government commitment of resources.

5. The focus on 16 districts needs to be reviewed for a future programme. As the HIV prevalence is fairly homogeneous across the country at provincial and district level, there

is a need to target resources more specifically to areas identified as hot spots and to most at risk populations. The MOT study provides direction on these areas and groups, and the ESP WG should work together with the NAC to find ways to target resources appropriately. Implementing partners should already start to adjust their programmes accordingly so that at least for the remainder of 2011 resources are targeted as much as possible to those most in need. This will help to address equity issues.

6. The ESP WG should again review the indicators in the logframe to ensure their relevance, appropriateness and feasibility of measurement. The treatment indicator regarding health professionals trained should now be revised to reflect an outcome of the training, and treatment targets should be amended in view of the changed initiation guidelines. CBHC indicators should be adjusted to reflect the changed needs in communities. The indicators for the coordination and management, M&E output area should be adapted to reflect quality issues in planning and reporting from PACs and DACs. For the future, it will be important to design a programme where the outcomes are clearly attributable to the supporting agencies and appropriate indicators are defined.

7. For the remainder of the programme and in a future programme, it should be ensured that IPs report specifically against the logframe indicators relevant to their area of work: this requirement should be incorporated into specific MoUs. This will help to assess effectiveness more easily.

8. The process of reviewing IPs' plans should be reviewed to maximise synergy across components. Representatives from the various IPs should hold a general planning meeting together once their individual plans are prepared to seek areas of convergence and cooperation. This should be supplemented by establishing or strengthening district level coordination mechanisms which should be complemented by the monitoring arrangements of the overall programme. This will enhance efficiency and effectiveness at the local level.

9. A process of data quality auditing should be incorporated into the M&E system to ensure that data coming from lower levels is appropriate and accurate with verification mechanisms established, for example, submission of supporting documents.

10. The ESP should continue to support decentralisation but put in place measures to monitor the quality of implementation so that as activities are further spread into lower levels of implementation there are appropriate supervisory and monitoring arrangements put in place to support this process. These can be incorporated into the implementation plans of the IPs.

11. The government should be supported to develop policies that are supportive of the task shifting that is occurring by necessity and was observed in the field, for example, nurses providing ART. With the extreme shortage of human resources in the health sector, it is important to use all people available to the best of their capacity: however, this needs a supportive legal environment to be implemented effectively and a strong monitoring and quality assurance system. Supportive mechanisms should also be established at community level for the cadres performing a multitude of tasks to support health service delivery.

12. In a future programme the ESP could consider a research component to investigate a number of areas, for example, an assessment of the effectiveness and efficiency of task shifting processes, an assessment of the impact of user fees. This could also be undertaken with other partners in the health sector which have a specific interest and expertise in research.

13. The ESP should facilitate systematic local capacity building for longer term sustainability (e.g. for procurement). As the situation in Zimbabwe gradually becomes more stable, there will presumably come a time when funds can start to be channelled through alternative means, either government or other local agencies. There should be a specific investment made over the coming months and years to ensure that there can eventually be a smooth transition to more locally appropriate channels. This should be incorporated into the agreements with the various IPs where appropriate. In the meantime, the current mechanisms for funds management and disbursement may need to be reviewed and appropriate adjustments made by the ESP WG in areas where they impact on the actual programme implementation capacity and outcomes.

14. The ESP should capitalise on the investments and achievements (e.g. HRRS, task shifting) to continue health systems strengthening. As HIV-related health issues become more and more integrated into the general health system, there will be greater efficiencies gained throughout the health sector. This will contribute to a more holistic and comprehensive health system, which should be supported by all external partners. In addition, the ESP and the national response to HIV can benefit from the community systems strengthening which has taken place and complements the health system development.

3.8 NEXT STEPS

1. This report should be widely disseminated to all key stakeholders so that the future of the programme can be debated and agreed in a transparent and collaborative manner.
2. The ESP working group should finalise the 2011 programme according to the short term recommendations if accepted.
3. This should include a process of more intensive documentation of key lessons learned for specific areas.
4. The ESP WG should begin planning for future support to HIV-related activities beyond 2011 bearing in mind the recommendations on moving towards a system of harmonisation with, and strengthening of, the health sector.
5. Following the decision on how to support future health and HIV interventions, the ESP WG should develop a clear exit strategy within the next 3-6 months for those areas that will not receive future support and ensure that other partners will carry forward appropriate experiences.

ANNEXES