UNICEF ZIMBABWE

Sectoral Report for HIV/AIDS for the period January to December 2016

Submitted in March 2017

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Cover Photo: *Unicef Zimbabwe/2016*

Caption: *Growth monitoring at a rural health facility in Matebeleland south*

Map of Zimbabwe

1.0 Executive Summary

The UNICEF HIV/AIDS programme is guided by the UNICEF Strategic Plan (2014 to 2017) and the Convention on the Rights of the Child (CRC). At a national level, the HIV/AIDS programme is guided by the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2015 – 2020, the Zimbabwe United Nations Development Assistance Framework (ZUNDAF 2016 - 2020) and the UNICEF Zimbabwe Country Programme (2016 to 2020). HIV/AIDS is the second outcome area in the UNICEF Strategic plan 2014 to 2017. The goal of this outcome area is to support global efforts to prevent new HIV infections and increase treatment during both decades of a child's life through improved and equitable use of proven HIV prevention and treatment interventions. The UNICEF HIV/AIDS programme is also guided by the Sustainable Development Goal 3 (SDGs 2016 – 2030), which seek to ensure health and well-being for all, at every stage of life. This advances the dual goals of preventing new HIV infections in children and adolescents and ending paediatric HIV and AIDS contributing to improved child survival and keeping families healthy.

Zimbabwe has recorded significant progress in the reduction of new HIV infections and AIDS related deaths. A decline in HIV incidence rates among adults aged 15 - 49 has been observed from 2.63% in 2000 to 0.48% in 2016, reducing the number of new infections from 110,989 in 2000 to an estimated 32,000 in 2016 among adults and from 35,893 in 2000 to 3755 in 2016 among children below 15 years. The HIV prevalence for both male and females adults (15-49) has stabilised at 14.6% and a declining trend is observed in younger adults (15-24) both male and female from the period 2011 to 2016. However, the number of people living with HIV still remains high at 1.2 million living with HIV of which 71,799 were children below 15 years of age in 2016. Prevalence remains higher among women at 16.7% compared to men at 12.4%, and women comprise 59% of all the people living with HIV, increasing the risk of new infections in children. There is geographical variation in the HIV prevalence in the country, ranging from 11.4% in eastern provinces to 22.3% in the south of the country. Young women 15 -24 years continue to have a higher prevalence rate being two to three times more likely to contract HIV than young men.

More people living with HIV are choosing to have babies, with the proportion of pregnant women already on ART at 43%. This demonstrates the confidence the populace now has in the PMTCT program and also the need to ensure continued service delivery for this effective intervention. As many as 25,846 new infections in children were averted by the programme as the Mother-to-child HIV transmission (MTCT) rate has declined from 31% in 2009, to less than 5% at six weeks and 7.8% post breast feeding in 2015.[1] Sexual violence among women and girls is still of grave concern, with as many as 18% of young women (15-19 years) reporting having experienced sexual violence.

In Zimbabwe, UNICEF contributes to the national HIV response as articulated in the National HIV and AIDS Strategic Plan (ZNASP 2015 - 2020)[2] and the efforts of UNICEF are also reflected in the

[1] Zimbabwe National HIV Estimates 2015

[2] Zimbabwe National HIV And AIDS Strategic Plan (ZNASP) 2015 – 2020

Zimbabwe United Nations Development Assistance Framework (ZUNDAF Outcome 6 - Universal access to HIV prevention, treatment, care and support). Within the Zimbabwe Country Office (ZCO), HIV interventions are mainstreamed into programme components of WASH, Education, Health and Nutrition, Child Protection, Social Policy and Research and Communication.

Based on the total population living with HIV, both adults and children ART coverage has increased steadily from 2011 to 2015, 36.8% to 61% and 23.5% to 73% respectively and ART coverage among HIV positive pregnant women increased from 25% in 2013 to over 93% in 2016. The existence of supportive policies has increased access to HIV-related services, and these strategies include: the New ART guidelines, The National Acceleration Plan for scale up of ART for children and adolescents, the National Life skills, Sexuality, HIV & AIDS in Education Strategic Plan, the National HIV Testing and Counselling Strategic Plan and HTC guidelines for children and adolescents. The advocacy done by UNICEF to ensure data disaggregation by age has led to availability of data for adolescents at national level.

Despite such increase in coverages, a big gap still remains in the support for children and adolescents living with HIV resulting in more children and adolescents lost from care compared to adults. Early infant testing remains a challenge with every third child not being tested. A significant proportion of women are being newly identified to be living with HIV in the breastfeeding period showing gaps in testing during the antenatal period, and demonstrating an unmet need for HIV preventive services for mothers. To ensure increased access to the service by most vulnerable children, UNICEF supported the scale up of implementation of HIV sensitive social protection project in 8 additional districts ensuring that HIV messages and services are provided during disbursement of cash transfers. Referral and follow up systems have been established to ensure that all in need of HIV services from such households can access them.

UNICEF Zimbabwe continues to focus its HIV work on preventing new infections in infants and keeping mothers alive; HIV care and treatment for children and adolescents; prevention of new infections among young people; care and treatment for adolescents living with HIV (ALHIV); reducing children and adolescent's vulnerability to HIV and mitigating the negative impact of HIV on children. UNICEF's activities contribute to the national response to HIV and AIDS and, therefore, results are primarily measured using national management information systems and specialized studies, along with routine programmatic data. This report provides details of the results achieved in 2016 using all sources of funding available to support the HIV and AIDS outcome area.

UNICEF would like to thank all donors who contributed to the achievements outlined in this report, with a special mention to the Government of Sweden for the flexible thematic funding support. We look forward to continued collaboration in 2017 to achieve more results for the women and children of Zimbabwe.

2.0 Strategic Context of 2016

The UNICEF HIV/AIDS programme is guided by various national policies and guidelines. These include the ZNASP II (2015 – 2020), the National Health Strategy 2016 - 2020, the National eMTCT Strategic

Plan (2011-2016), the National Care and Treatment Guidelines, the National HTC Strategic Plan, The eMTCT strategy (2014 – 2018), the National Combination HIV Prevention Approach, the National Life Skills, Sexuality and HIV and AIDS Education Strategy (2012-2016) and the National Acceleration Plan for scale up of ART for children and adolescents (2016 – 2018). UNICEF's objective and expected results are reflected in the ZUNDAF Priority on Universal Access to HIV Prevention, Treatment, Care and Support and The National Action Plan for Orphans and Vulnerable Children III (NAP OVC III).

UNICEF's programme of cooperation with the Government of Zimbabwe (GoZ) seeks to promote every Zimbabwean child's right to access and to utilize quality basic social services. These basic services include access to basic education, Young Child and Survival (Health, HIV and Nutrition), water, sanitation and hygiene, social protection, and shelter. The country programme specifically focused on the reduction of various forms of vulnerability, ensuring gender equality, HIV prevention, survival, protection and care, as well as treatment and support.

The HIV epidemic continues to be a major public health concern in Zimbabwe, and has deep social and economic vestiges affecting the socioeconomic development of the country. The prevalence of HIV in the general population stabilised at 14% in 2016 from a high of 23% in 2003. This translates into 1.2 million people estimated to be living with HIV in 2016, of which there are 89,715 children aged 0 – 14 years. The estimate of adolescents aged 10 – 19 years living with HIV is not readily available. As many as 3,316 (10%) of the 32,335 of the new infections nationally occurred in children aged 0 – 14 years. Women continue to carry the burden of HIV comprising 60% of all the people living with HIV, while adolescent girls and young women 15 - 24 years continue to be at highest risk of contracting HIV.

Increased ART access over the last 5 years has contributed to the significant decline in AIDS mortality. However, the estimated number of AIDS related deaths in 2016 remains high at 17,961 among adults and 3,710 among children. On the other hand, due to lack of disaggregated data for adolescents, and specific programming targeted at this group, trends in AIDS related deaths are not known in this group. However, global reports have shown that while AIDS related deaths have gone down for the population, a 50% increase in AIDS-related deaths has been observed among adolescents.

To achieve results for children, UNICEF works in collaboration with other stakeholders to influence policy and guidelines at a national level and supporting programmes at implementation level. The upstream work includes adaptation of internationally proven strategies into local strategies and guidelines that facilitate access to HIV services, capacity building for accelerated national service scale up for women, children and adolescents, and introduction of new technology to increase access to HIV testing and monitoring services. The work also includes mobilising resources from multi-lateral funding streams and leveraging resources from partners to support implementation of service provision for women, children and adolescents. At service level, UNICEF supported the review of programming and planning for action plans guided by bottleneck analyses for districts with high unmet need for women, children and adolescents. Adolescent sexuality programmes in school were supported at national level while impact mitigation and HIV sensitive social protection activities were supported in selected districts. Major implementing partners were GoZ, NAC and NGOs.

Bi- and Multi-lateral organisations contribute the majority of funding for HIV services. These include the U.S. Government (PEPFAR) and the Global Fund to Fight HIV and AIDS, TB, and Malaria (GFATM). However, the domestic funding through The National AIDS Trust Fund contributed to about 16% of HIV Funding in 2016. The Heath Development Fund (2016 – 2020) formerly known as the Health Transition Fund (HTF 2011 – 2015) provides critical support for Health Systems Strengthening (HSS) and maternal/child health (MCH) which form a platform for provision of HIV services. Additional funds were also received through H4+ (SIDA and CIDA) to support integration of PMTCT and Paediatric in MNCH in 6 selected districts. Interventions that reduce vulnerability to HIV and that mitigate the impact of HIV and provision of HIV sensitive social protection were supported through the Education Development Fund (EDF 2016 - 2020) and Child Protection Fund (CPF 2016 - 2020) and Dutch Funds which are managed by UNICEF. The HIV thematic funds through UNICEF have played a catalytic role in accelerating implementation of high impact interventions targeting areas with greatest need and high yield for children which has provided evidence for scale up of similar interventions by other partners.

3.0 Results Achieved

The HIV/AIDS programme is aimed at ensuring that 80% of pregnant women, new-borns, children and adolescents have equitable access to and utilize high-impact, cost-effective and quality health interventions and practice healthy behaviours by 2020.

Significant progress has been made with most of the indicators exceeding the set targets for 2016. The proportion of HIV exposed new-borns receiving effective ARVs for PMTCT significantly increased to almost 100%, (98%) from 78% in 2015. In addition, the proportion of HIV positive pregnant receiving ART for PMTCT increased from 84% in 2015 to 95% in September 2016. This has resulted in the reduction of MTCT rate to an estimated 4% at six weeks and 7.2% at final determination in 2016 from 26% in 2009.There has been a significant increase in access to ART by HIV positive children 0-14 years between 2014 and 2016 from 38% to 83% respectively. The number of adolescents 10-19 years accessing ART increased from 62,845 in 2015 to 66,886 (26,501 males and 40,385 females) by September 2016. However, the HIV/AIDs related mortality in children remains high at an estimated 3,710 deaths in 2016.

There is marked improvement in engagement of adolescents and young people in planning and monitoring of their interventions including development of national strategies and guidelines ensuring that issues of adolescents and young people are well articulated. The improved health workers' knowledge and skills on how to manage children has led to the formation of support groups for children and adolescents living with HIV. Adolescents report marked improvements in relationships with health workers and support received from care givers following the latter's training on how to manage and support adolescents living with HIV. The use of Community Adolescents Treatment Supporters (CATS) has encouraged other adolescents to open up and freely discuss their experiences thereby reducing stigma and promoting adherence to HIV treatment.

The HIV/AID programme supported training and mentoring of health workers on Paediatric ART management, child and adolescent HIV counselling, and collection of dry blood samples for Early Infant Diagnosis (EID). It facilitated the capacity development of Ministry of Health and Child Care (MoHCC)

officials and partners at national and provincial level on equity focused and evidence based planning and programme implementation. This led to increased technical support and resource allocation commitments by MoHCC and partners towards 44 poorly performing districts on paediatric and adolescent HIV which accelerated achievement of 2016 results. Financial and technical support was provided to conduct HIV Testing Services (HTS) campaigns in three selected provinces targeting HIV hot spot districts including 10 UNICEF supported districts.

The use of social media through a short message service (sms) mobile platform (U-Report) is a medium for sharing information with adolescents and young people on HIV prevention methods, access to services and other ASRH issues. It is also a platform to assess knowledge amongst adolescents and young people through questionnaires and polls. Up to 54 000 adolescents and young people were reached in 2016 and the intention is to scale up to 300 000 enrolled onto the U-Report.

Thematic funding was used to build capacity of national and provincial monitoring officers in monitoring and evaluation of HIV program. These officers are now able to report along the whole HIV care continuum, reflecting age and gender disaggregation. In addition, there are now responsible for supporting their respective districts in the development of evidence based plans.

Working with UNAIDS, EGPAF, the Zimbabwe Medical Association of Doctors and the National Aids Council, thematic funding contributed financial and technical support towards a symposium on Paediatric and Adolescents held in November 2016. Recommendations from the symposium informed the identification of priorities and effective approaches for child and adolescent programming for 2017.

In collaboration with WHO, technical and financial support was provided for the adaptation and dissemination of the new ART guidelines, and the revision of the Operational and Service Delivery Manual for the Prevention, Care and Treatment of HIV in Zimbabwe (OSDM) to ensure issues of children and adolescents are clearly articulated. Implementation of these guidelines will create opportunities for increasing access to ART for children and adolescents living with HIV. This however, will require health system strengthening approaches, including integration of HIV and MNCH platforms, to accelerate identification of children and adolescents living with HIV.

Working in collaboration with UNFPA, UNESCO and WHO, technical assistance was provided in the development of the ASRH strategy including an M&E Framework (2016-2020). The strategy incorporates a multi-sectoral approach at strengthening comprehensive sexuality and life skills education; HIV prevention; and integrates sexual and reproductive education; all aimed at reducing teenage pregnancies, new HIV infections among adolescents and young people. The ASRH strategy will be launched and disseminated in 2016.

To reduce vulnerabilities among children and adolescents, thematic funding contributed to the support of implementation of HIV sensitive social protection programmes using the Harmonized Social Cash Transfer platform as an entry point in twelve districts.[3] This has enhanced identification and linkage into care of children living with HIV from vulnerable households to health facilities, as well as referral of

[3] Gokwe North, Bulilima, Binga, Zvimba, Mwenezi, Rushinga, Mudzi, Mwenezi, Mazowe, Chipinge, Mutare, Gweru

vulnerable HIV infected children, adolescents and pregnant women for other social services e.g. education subsidies, nutrition support.

School based HIV interventions

In order to change behaviour, young people need to know about their risks and how to protect themselves. School-based comprehensive reproductive health, sex, HIV and life skills education is an effective way to reach a large number of young people. Literature also supports teachers as a trusted source of information for children and adolescents. Consequently teachers should be capacitated to deliver the correct and age appropriate messages. Zimbabwe had an estimated 579,917 ECD, 2,659,624 primary school and 1,065,104 secondary school learners in 2016.

UNICEF supported the capacity building of 3,999 (1,921M and 2,078F) teachers who were trained in Life Skills, Sexuality HIV and AIDS Education in 2016. The training was led by the NAC with the UN partners (UNICEF, UNFPA and UNESCO) providing technical and financial support. The training support resulted in strengthening of Ministry of Primary and Secondary Education's capacity to implement a comprehensive Life Skills, Sexuality, HIV and AIDS Education programme. To date, 64% of schools have at least one teacher trained in Life Skills, Sexuality HIV and AIDS Education using the new Life Skills, Sexuality, HIV and AIDS Education training manual

In 2016, NAC with the UN partners (UNICEF, UNFPA and UNESCO) supported the MoPSE to develop/write the Guidance and Counselling Life Skills, Sexuality, HIV and AIDS Primary School Syllabus. The Secondary school syllabus was finalised 2015.

HIV sensitive social protection interventions

Programme efforts in 2016 saw the enhancement of the cash plus model (cash and care), which is also one of the key focus areas of the UNICEF ESAR Social Protection Regional Priority 5. This enhancement was done through the promotion of HIV services at Harmonised Social Cash Transfers (HSCT) payments in 23 districts reaching a total of 64,274 households. This was partly in response to the findings of the 2014 HSCT Impact Evaluation which established that there was limited harmonization of the cash intervention with other child protection and social service interventions. Therefore, the programme scope utilised the pay points to enable partners such as Africaid to provide HIV related information and services through 253 Community Adolescent Treatment Supports (CATS). As the system is embedded in community structures, Children Living with HIV and AIDS (CLWHA) who were exposed to violence, abuse and exploitation were automatically referred to access social welfare, justice and specialist healthcare services. Innovative approaches were pioneered as UNICEF jointly addressed disability and HIV which increase the vulnerability of a CLWHA. JF Kapnek provided disability services at the payments in collaboration with Africaid. At total of 4,062 (2,087F; 1,975M) children received services through the integrated case management system.

Building on the successes of 2015, UNICEF introduced the HIV-sensitive parenting orientation to HSCT households through a partnership with Africaid which enabled learning of parenting skills. CLWHA do not only suffer from stigma and discrimination, but are often neglected. They are denied medication and

proper care because of their status as they sometimes do not have fixed board. Rather multiple relatives provide accommodation and have limited understanding of care needs for a child on ART. In order to address this neglect gap, the programme twinned Village Health Workers (VHW), Community Child Care Workers (CCCWs) and CATS in educating parents and caregivers on the rights of CLWHA. This has been integrated in the capacity development curriculum for the community social welfare workforce training.

Some of the milestones achieved in supporting HIV sensitive Social protection include:

- **HIV/AIDS services and support for adolescents**: Thematic funding was used to support HIV/AIDS services and support for adolescents. Children in residential care institutions who are living with HIV had limited access to information and support on drug adherence. UNICEF in partnership with Child Protection Society (CPS) and Africaid designed and supported the training of Heads of Institutions and Care-givers so that they have knowledge on how to support CLWHA. A total of 56 (34F; 22M) Child Welfare Officers and 141 (99F; 42M) Heads of Institutions and care-givers were trained. Through this initiative, for the first time children in residential care institutions received support from CATS. They provided counselling and linked the children to other peers for support on drug adherence. A total of 321 (164F:157M) children in residential institutions were supported. In the Midlands Province, the CATS sensitized personnel at health facilities to provide adolescent responsive health services responding to the needs of those that are referred from residential care institutions.

- **HIV/AIDS Information for care givers:** Information dissemination remains a key focus priority to reach-out to parents and care-givers. UNICEF supported CPS to review the national residential care guidelines so that they address care and support for CLWHA in order to build a protective place for children. A total of 102 residential care institutions participated in the review process. In addition to this, with support from CPS and Africaid, 49% (n=102) reviewed their health policy such that it addresses access and adherence to Antiretroviral treatment for children. All this success is attributed to the positive engagement with Government so that institutions are equipped to support HIV services required by adolescents.

- **Health and Child Welfare Linkages:** Service seeking behaviour was compromised as CLWHA in HSCT households that were not accessing protection services. Given the drought, families paid more attention to survival than child protection. UNICEF in partnership with World Education Inc. (WEI) and the Ministry of Public Services, Labour and Social Welfare introduced the transport voucher system. This addressed one of the many hindrance factors that affected CLWHA from accessing child protection services. Therefore when referrals were made for additional services through the case management the tendency was that children in HSCT families did not avail themselves. Linked to this, districts also received an emergency fund so that they assist critical child protection cases. In terms of continuous community based support, CATS, CCWs and HSCT Focal Persons worked together in ensuring sustained community support on an ongoing basis as part of efforts to build a protective environment for children.

The Results Assessment Framework

Indicator	Baseline	Target 2016	Results achieved
Proportion of HIV infected pregnant women who received ARV prophylactic regimen to prevent transmission	59%	90%	N/A (Change of regimen to ART)
Proportion of HIV exposed children who received ARV prophylaxis.	74%	95%	98%
Proportion of HIV infected pregnant and/or lactating women eligible for HAART who receive it for their own health	31%	80%	95%
Proportion of HIV infected infants and children who receive HAART:	37%	90%	73% (81% of eligible children)
Proportion of HIV infected adolescents eligible for and receiving HAART	TBD (denominator population not available)	90%	90.3% Adolescent females (10-19yrs) 79.3% Adolescent males (10-19yrs)
Percentage of men/women 15-19 who have received HIV testing and counselling and know their results.	12% for women, 7% for men,	80% for women /80%for men	46.3% females and 35 % males

3.1 Key Strategic Partnerships and Inter-Agency Collaboration

The key partners for implementation of programmes are the Ministry of Health and Child Care (MoHCC), Ministry of Primary and Secondary Education (MoPSE) and the National AIDS Council. UNICEF also supported and collaborated with NGOs: the Clinton Health Access Initiative (CHAI), Organisation for Public Health Interventions and Development (OPHID), Kapnek, AfricAid and the Zimbabwe National Family Planning Council to accelerate implementation of PMTCT, Paediatric ART and HIV integrated ASRH interventions including meaningful involvement of ALHIV. There is continued collaboration with the Centre for Disease Control and Prevention (CDC) under the implementation of the DREAMS project targeting adolescent girls and young women.

Through the ZUNDAF framework, UNICEF works with other UN agencies to have coordinated support and programming on HIV. The joint UN effort developed a consolidated framework for implementation of adolescents and young people, a population noted to have poorer HIV outcomes compared to the general HIV population. In 2016, UNICEF worked with UNFPA and UNESCO to support NAC with the

capacity building of 3,999 (1,921M and 2,078F) teachers who were trained in Life Skills, Sexuality HIV and AIDS Education in 2016.

3.2 Value for Money

In 2016, the country adopted the 'Treat All' guidance in which all people living with HIV will be provided with anti-retroviral therapy (ART). This approach removes limitations and barriers to access of laboratory testing before ART commencement and is another step towards universal access to HIV treatment and care. Furthermore, earlier treatment has the further advantage of simplifying the operational demands on programmes. The 'Treat All' approach is supported by integration of HIV into MNCH platforms and differentiated care packages to assist decongestion of health facilities. All these contribute to greater efficiencies and reductions in the cost of service delivery.

UNICEF ensured transparency and value for money by using UNICEF's procurement processes and procedures in the procurement of medicines and supplies required for the programme. This was because UNICEF was able to achieve economies of scale and efficiencies through open competition and applying international competitive bidding procedures. Due to its robust procurement systems and its global reach, UNICEF was able to contract the best possible suppliers on the market at competitive prices for essential commodities. UNICEF's innovative contracting terms as well as expanded and diversified supplier base contributes to price reductions and savings thereby delivering value for money.

3.3 Constraints, Challenges and Lessons Learned

Achievement of the above results in 2016 were made amidst some challenges, constraints and lessons learned:

- There is still a proportion of the population that are not being reached by HIV services for various reasons. These include the populations living in new settlements, populations displaced by natural disasters, and groups that do not utilise health services for religious reasons or for fear of discrimination and stigma.
- The traditional models of case finding were yielding lower numbers of children and adolescents identified to be living with HIV. In addition, there are leakages along the cascade, particularly the linkage into treatment and care of those found to be living with HIV, if there are identified using community based testing approaches.
- The quality of care has been seen to be compromised in facilities which have high volumes of patients and inadequate numbers of health workers. Children and adolescents are often considered a difficult group by health workers and do not receive age appropriate counselling and support.
- The service delivery level has been strengthened to analyse and utilise data; however, further support is required from higher level to support implementers to coordinate programmes in an integrated manner to reduce inefficiencies.
- In order to identify children and adolescents living with HIV in a more cost effective manner, targeted testing approaches, such as the family centred approach and index testing, yield better results. The pilot project using the family centred approach is demonstrating that a child has greater support when all family members are involved in the care. There are opportunities for greater linkages and

integration of the work of the community workers if the service delivery is brought closer to homes of people living with HIV.

- The El Nino induced drought crisis has a provided a platform for strengthening programming for humanitarian crises for HIV service delivery, and integration with other emergency preparedness and responses.

3.4 Risk Assessment and Risk management

At a programmatic level, the HIV programme has matured and has a well-developed system, but is yet to be fully integrated into other platforms such the maternal, child and nutrition platform and health information system. Opportunities are being availed through Global Funds against AIDS, TB and Malaria (GFATM) and PEPFAR for enhancement of complementarities and integration. Further, the health system of the country is heavily dependent on external financing, with up to 80% of the HIV programmes supported by Global Funds against AIDS, TB and Malaria (GFATM) and US government PEPFAR program Additional resources are from the National AIDS Levy, the UN agencies and NGOs. The funding landscape shows diminishing resources for HIV programming yet the country requirements are likely to increase as HIV programme scales up the 'Treat All" approach. The 'Treat All' approach will see an immediate increase in the number of PLHIV being initiated on treatment, but will result in reduction of new HIV infections in the longer term, and reduced HIV program costs in the future. However, the capacity of the country to generate more domestic resources to complement external support are constrained on the back of a poorly performing economy. A pragmatic approach within the Ministry of Health and Child Care (MoHCC) is required to leverage programming for HIV on other funding streams and vice versa. The health system has over the years invested in capacity development of health workers in HIV service delivery. A sustainable long term approach for continued skills transfer and retention within the system if service delivery for women, children and adolescents is to be maintained or improved.

To manage financial risk, UNICEF uses the Harmonised Approach to Cash Transfers (HACT) which focuses on strengthening national capacities for management and accountability, with a view to gradually shift to utilizing national systems in the management of financial resources. The adoption of the harmonized approach is a step in implementing the Rome Declaration on Harmonization and the Paris Declaration on Aid Effectiveness, which call for a closer alignment of development aid with national priorities and needs. The HACT approach initially conducts a micro assessment of the implementing partners' financial management systems with a view to firstly facilitate capacity development where weaknesses and strengths of the implementing partners are and agreed upon and secondly assists in the establishment of appropriate cash transfer modalities, procedures, and assurance activities to be applied by UNICEF. Spot checks where financial verification visits are conducted at intervals determined by the results of the Micro-Assessment. Finally in cases where more than US$ 500,000 is expected to be transferred per year the implementing partners undergoes a 'special audit' of its financial management systems. This is similar to a Micro-Assessment but provides a much more in-depth analysis of the IPs systems.

4.0 Financial Analysis

This section provides information on the financial resources that were available to support HIV/AIDS results in 2016. It also specifically indicates how these results were distributed to support the organizational targets within the HIV/AIDS outcome area.

In 2016, the overall resources available to support HIV/AIDS from UNICEF's core budget (Regular Resources) and Other Resources raised from donors amounted to **US$ 4,220,000** as indicated in Table 1 below:

Table 1: Planned Budget for Outcome Area 2: HIV/AIDS
Zimbabwe

Output Areas	Funding Type[4]	Planned Budget[5] (US$)
02-05 HIV # General	RR	3,720,000
	ORR	500,000
Total Budget		**4,220,000**

Table 2 below shows the country level thematic contribution in 2016 from the Government of Sweden. The total amount allocated for the HIV/AIDS programme was **US$665,662** indicated as the contribution amount in table 2.

Table 2: Country-level thematic contributions to Outcomes Area 2: HIV/AIDS
Zimbabwe

Donors	Contribution Amount[6] (US$)	Programmable Amount[7] (US$)
Government of Sweden	665,662	622,114
Total	**665,662**	**622,114**

The greatest expenditure in terms of organization targets was in the Prevention of Mother to Child Transmission (PMTCT) and infant male circumcision. Expenditure under this organizational target accounted for 37 per cent of the total expenditure for the outcome area as illustrated in table 3 below.

[4] RR: Regular Resources, ORR: Other Resources – Regular, ORE: Other Resources – Emergency.
[5] Planned budget for ORR and ORE does not include estimated recovery cost.
[6] Contribution amount: This is the total amount received from the Government of Sweden
[7] Programmable amount: This is the amount available for programming which is derived from contribution amount less cost recovery

Table 3: Expenditures in the Outcome Area 2 by Programme Area: HIV/AIDS Zimbabwe

Organizational Targets	Expenditure Amount[8] (US$)			
	Other Resources - Emergencies	Other Resources – Regular	Regular Resources	All Programme Accounts
02-01 PMTCT and infant male circumcision		597,419	398,660	996,079
02-02 Care and Treatment of Children affected by HIV and AIDS		437,279	37,928	475,207
02-03 Adolescents and HIV/AIDS	800	866,329	50,519	917,647
02-05 HIV # General		161,309	139,818	301,127
Total	**800**	**2,062,335**	**626,924**	**2,690,060**

Out of an expenditure of **US$2,690,060** from all sources of funds (as shown in Table 3), the table below shows the component of this expenditure that directly related to thematic funding. From the analysis below, thematic funds were very key in supporting all organizational targets for HIV/AIDS. However, most funds were utilized to support Adolescents and HIV/AIDS, as this was an area that was underfunded in the programme.

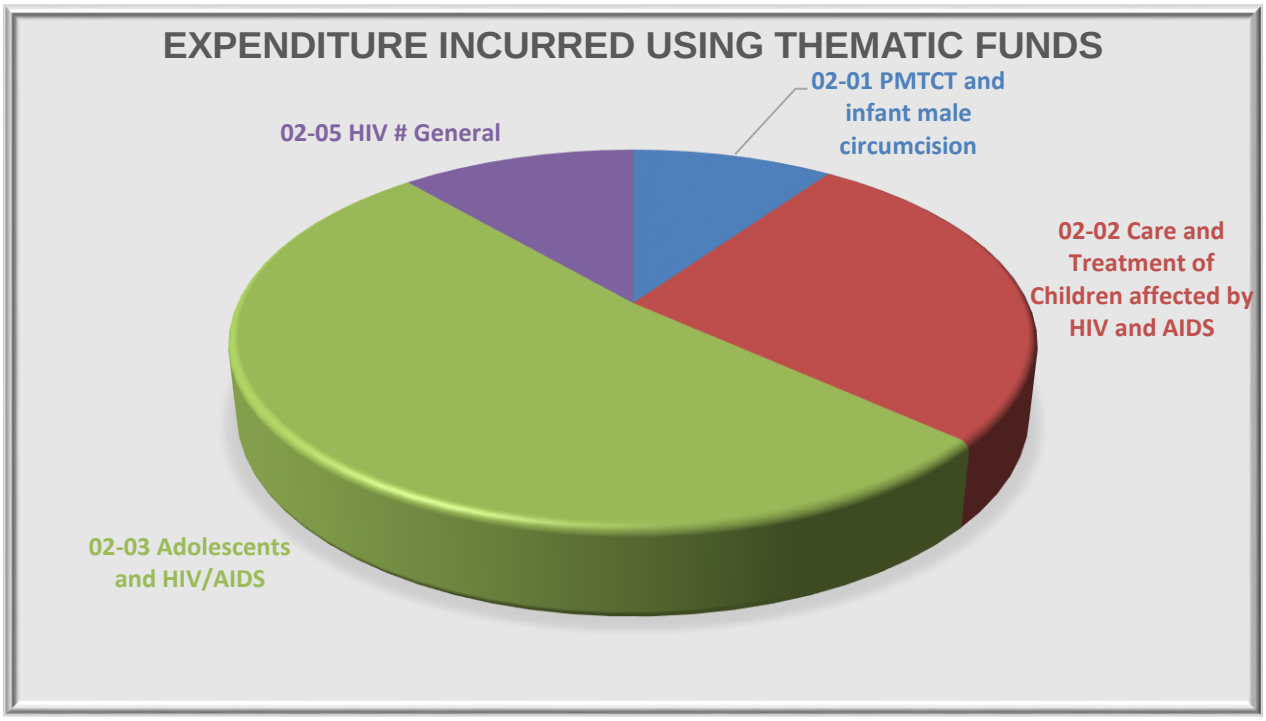
Table 4: Thematic expenses for Outcome Area 2 by Programme Area: HIV/AIDS Zimbabwe

Organizational Targets	Expenditure Amount[9]
02-01 PMTCT and infant male circumcision	84,703
02-02 Care and Treatment of Children affected by HIV and AIDS	235,585
02-03 Adolescents and HIV/AIDS	453,864
02-05 HIV # General	98,842
Grand Total	**872,995**

The pie chart below illustrates the key expenditures incurred using thematic funds in 2016.

[8] Expenditure figures provided do not include recovery cost, and are indicative figures obtained from UNICEF Performance Management System

[9] Total Utilized figures exclude recovery cost and are indicative figures obtained from UNICEF Performance Management System

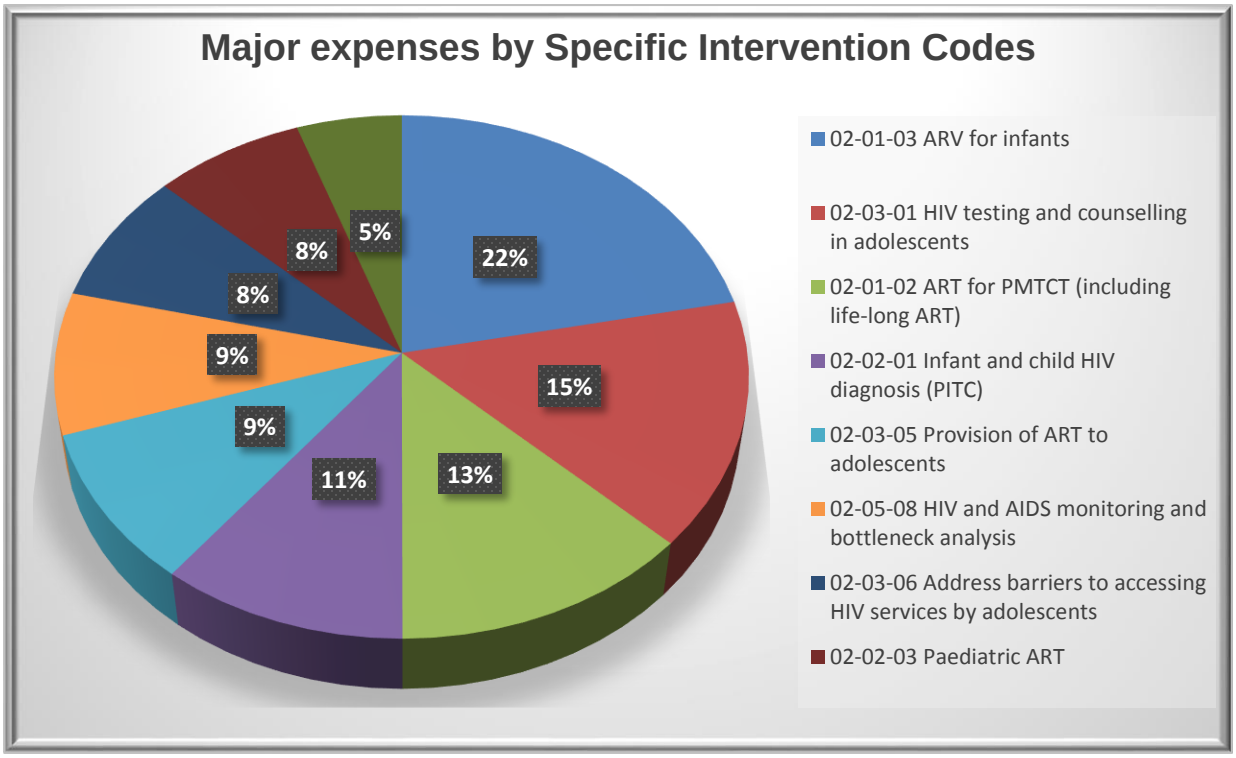


UNICEF also analyses expenditures using Specific Intervention codes. Specific Intervention Codes refer to one of four codes that used to identify an activity in UNICEF's Performance Management System. They enable compilation of data on expenditure by organizational target and key result area. In 2016, the following were the major expenses incurred in HIV/AIDS outcome area, analysed using Specific Intervention Codes.

Table 5: Expenses by Specific Intervention Codes for Outcome Area 2: HIV/AIDS Zimbabwe

Specific Intervention Code	Total Utilised (US$)
02-01-03 ARV for infants	547,214
02-03-01 HIV testing and counselling in adolescents	382,763
02-01-02 ART for PMTCT (including life-long ART)	325,065
02-02-01 Infant and child HIV diagnosis (PITC)	265,626
02-03-05 Provision of ART to adolescents	237,394
02-05-08 HIV and AIDS monitoring and bottleneck analysis	219,863
02-03-06 Address barriers to accessing HIV services by adolescents	206,194
02-02-03 Paediatric ART	192,739
08-09-06 Other # non-classifiable cross-sectoral activities	134,577
Total	**2,511,435**

The pie chart below illustrates the major expenses incurred by Specific Intervention Codes in 2016.



5.0 Future Work Plan

The HIV and AIDS Programme component aims at achieving equitable use of proven HIV prevention and treatment interventions for at least 80 per cent of pregnant women, children and adolescents in Zimbabwe by 2020. These interventions will contribute to achievement of SDG 3 on good health and wellbeing, specifically contributing towards ending the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases by 2030. In 2017 the HIV programme plans to achieve and support implementation the following outputs and activities:

Increased service delivery capacity to provide essential rights- and gender-sensitive HIV information and services for women, children and adolescent girls and boys, including in humanitarian situations.

- Continued capacity development and service delivery support for the roll out of the 'Treat All' approach
- Decentralization and scale up of paediatric and adolescent responsive HIV testing and ART services through integration of services into child health services
- Support of decentralised EID testing and Viral Load monitoring
- Demonstration of targeted testing approaches and differentiated care packages
- Strengthened linkages and capacity for provision of HIV sensitive social protection services
- HIV programming for emergency preparedness and response

Strengthened leadership, commitment, accountability and capacity for evidence-based equity-focused planning and budgeting for scale-up of HIV and AIDS prevention and treatment interventions for children and adolescent girls and boys

- Capacity building of national, provincial and district level HIV staff for evidence based planning, monitoring and age/gender disaggregated reporting
- Strengthening coordination of HIV programmes and resources at all levels to ensure efficiency in resource allocation and utilization.
- Supportive supervision, monitoring, research and evaluation as well as documentation of best practices on eMTCT, Paediatric ART and Adolescent HIV.
- Support for pre-elimination for eMTCT

Enhanced capacity of children, adolescents and caregivers to adopt behaviours that empower them to prevent HIV and facilitate utilization of relevant HIV and AIDS services.

- Targeted packages of services for adolescents and young people including parent child communication, peer led support for children, adolescents and young people, out of school approaches, adolescent responsive health services
- School based comprehensive life skills, reproductive, and HIV education
- Linkages to HIV sensitive social protection

Table 6: Planned Budget for 2017 Outcome Area 2: HIV/AIDS
Zimbabwe

Output	Funding Type	Planned Budget	Funded Budget	Shortfall
OUTP 2.1: HIV Service Delivery Capacity	RR	222,102	116,448	105,654
	ORR	1,174,806	618,467	556,339
OUTP 2.2: HIV/AIDS Policy And Management	RR	91,398	90,000	1,398
	ORR	373,282	355,324	17,958
OUTP 2.3: HIV/AIDS Services Utilized	RR	91,398	68,400	22,998
	ORR	861,524	318,466	543,058
OUTP 2.10: Programme Support Costs	RR	271,505	221,600	49,905
	ORR	600,388	500,539	99,849
Sub-total Regular Resources	**RR**	**676,403**	**496,448**	**179,955**
Sub-total Other Resources - Regular	**ORR**	**3,010,000**	**1,792,795**	**1,217,205**
Total		**3,686,403**	**2,289,244**	**1,397,159**

6.0 Expression of Gratitude

UNICEF Zimbabwe would like to extend its gratitude to the Government of Sweden for providing funding that enabled the country office to be more responsive to HIV and AIDS issues affecting children, adolescents and women of Zimbabwe. Funds provided by the Government of Sweden have led to accelerated implementation for children and adolescent programmes through implementation of

catalytic programmes that were taken on board by other partners based on lessons learnt. UNICEF will continue supporting and improving equitable access to a quality and comprehensive 'continuum of HIV treatment and care' in Zimbabwe in collaboration with the government, local and international Non-Governmental Organizations, the donor community and other key stakeholders.

List of Acronyms

ASRH	Adolescent Sexual Reproductive Health
CATS	Community Adolescent Treatment Supporter
CCWs	Community Case Workers
CLWHA	Children Living with HIV and AIDS
CPF	Child Protection Fund
EDF	Education Development Fund
EGPAF	Elizabeth Glaser Paediatric AIDS Foundation
EID	Early Infant Diagnosis
eMTCT	elimination of Mother to Child Transmission
GFATM	Global Fund Against AIDS, TB & Malaria
GoZ	Government of Zimbabwe
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
HSCT	Harmonised Social Cash Transfers
HTC	HIV Testing and Counselling
HTS	HIV Testing Services
IEC	Information, Education and Communication
MCH	Maternal and Child Health
MNCH	Maternal, Nutrition and Child Health
MoHCC	Ministry of Health and Child Care
MoPSE	Ministry of Primary and Secondary Education
MTCT	Mother to Child Transmission
NAC	National AIDS Council
NAP	National Action Plan
NGOs	Non-Governmental Organisations
OSDM	Operational and Service Delivery Manual
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother to Child Transmission
SIDA	Swedish International Development Cooperation Agency
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
WEI	World Education Inc.
WHO	World Health Organisation
ZNASP	Zimbabwe National AIDS Strategic Plan

Annex 1: Case Studies and photos

Peer-led model gives hope to HIV positive adolescents and young people

BULILIMA | *" I am no longer ashamed of my HIV status, I found a family which gives me love and support each time I meet them, apart from *Zviyeto (CATS) I have friends from the support group who also visits me whenever they are free."* said Francisca

Francisca in the company of a CATS, Case Care Worker and Health Care Worker

14-year-old Francisca resides in Sinotsi Village; she dropped out of school when she was 9 years old because of financial constraints. She desires to enrol and continue with her education if she gets support in the form of school fees, uniforms and stationery.

Francisca stays with her grandmother and her siblings. She has never met her father her whole life. In her family, there is no one who is formally employed. They survive through party time household chores.

Francisca and her family

From a tender age, Francisca used to suffer from different illnesses. She spent a lot of time in and out hospital. The Village Health Care Worker for Sinotsi village Ms Tambudzai Hikwa noted Francisca's challenges and encouraged Francisca's grandmother to take her for an HIV test at the nearest health facility.

She tested HIV positive. Francisca's grandmother found it difficult to cope as she had no information and knowledge on HIV care and support. This was exacerbated by the fact that, at the time, personnel at the health facility had little knowledge and information around care and support for children, adolescents and young people with HIV.

Francisca demonstrating the use of our story counselling game that is used to herald the importance of adherence

This however changed when the Ministry of Health and Child Care (MoHCC) and Africaid with support from UNICEF Zimbabwe trained twenty-seven Community Adolescents Treatment Supporters and nurses from different health facilities in Bulilima district on HIV prevention, treatment, care and support for HIV positive children and adolescents. This was a marked turn-around for both service providers at health facilities, Case Care Workers, Village Health Care Workers, adolescents and young people with HIV in terms of adolescent-friendly service provision.

Soon after the CATS training, Francisca and her grandmother were asked by the Primary Counsellor if they were willing to have an adolescent who would visit Francisca at their household discussing issues on care, support, positive living, adherence among other HIV related issues and to be part of community support groups, which are facilitated by the Community Adolescent Treatment Supporters (CATS).

"I want to thank the Village Health Care Workers for linking Francisca to adolescents and young people of her age through the CATS, even now, I feel so much relieved as my niece is now happy and they can play different games with her friend from Africaid" said Francisca's grandmother.