DFID HEALTH RESOURCE CENTRE

EXPANDED SUPPORT PROGRAMME ZIMBABWE

SECOND ANNUAL INDEPENDENT REVIEW

February 2009

Final Report

Kathy Attawell
Tapiwanashe Bwakura
Alexis Ferrand
Irene Moyo

17th April 2009

DFID Health Resource Centre
5-23 Old Street
London EC1V 9HL
Tel: +44 (0) 20 7251 9555
Fax: +44 (0) 20 7251 9552

The DFID Health Resource Centre (HRC) provides technical assistance and information to the British Government's Department for International Development (DFID) and its partners in support of pro-poor health policies, financing and services. The HRC is based at HLSP's London office and consists of an international consortium of four organisations: HLSP Ltd, UK; Ifakara Health Research and Development Centre, Tanzania (IHRDC); ICDDR,B - Centre for Health and Population Research, Bangladesh and Sharan, India.

Expanded Support Programme Zimbabwe. Second Annual Independent Review

Kathy Attawell,Tapiwanashe Bwakura, Alexis Ferrand and Irene Moyo

DFID Health Resource Centre
5-23 Old Street
London EC1V 9HL
Tel: +44 (0) 20 7251 9555
Fax: +44 (0) 20 7251 9552

CONTENTS

ABBREVIATIONS

AIR	Annual Independent Review
ART	Antiretroviral therapy
ARV	Antiretroviral
BC	Behaviour change
CCM	Country Coordinating Mechanism (GF)
CDC	US Center for Disease Control
CHAI	Clinton Foundation HIV/AIDS Initiative
CHBC	Community and home based care
CIDA	Canadian International Development Agency
CSO	Civil society organisation
DAAC	District AIDS Action Committee
DAC	District AIDS Coordinator
DFID	UK Department for International Development
DHE	District Health Executive
DMO	District Medical Officer
DNO	District Nursing Officer
EC	European Commission
EGPAF	Elizabeth Glaser Paediatric AIDS Foundation
ESP	Expanded Support Programme
FBO	Faith based organisation
GF	Global Fund to Fight AIDS, TB and Malaria
GOZ	Government of Zimbabwe
HBC	Home based care
HIO	Health Information Officer
HMIS	Health Management Information System
HR	Human resources
IOM	International Organisation for Migration
IP	Implementing partner
JSI	John Snow Incorporated
M&E	Monitoring and evaluation
MCAZ	Medicines Control Authority of Zimbabwe
MER	More efficacious regimen
MIPA	Meaningful involvement of people living with HIV and AIDS
MOE	Ministry of Education
MOHCW	Ministry of Health and Child Welfare
MOPSLSW	Ministry of Public Service, Labour and Social Welfare
MOU	Memorandum of understanding
NAC	National AIDS Council
NARF	National AIDS Reporting Framework
NATF	National AIDS Trust Fund
NatPharm	National Pharmaceutical Company of Zimbabwe
NBSZ	National Blood Service of Zimbabwe
NGO	Non government organisation
OI	Opportunistic infection

OVC	Orphans and vulnerable children
PAC	Provincial AIDS Coordinator
PC	Primary care counsellor
PCN	Primary care nurse
PEP	Post exposure prophylaxis
PITC	Provider-initiated testing and counselling
PLHIV	Person living with HIV and AIDS
PMTCT	Prevention of mother to child transmission
PRP	Protracted Relief Programme
PSI	Population Services International
SIDA	Swedish International Development Agency
T&C	Testing and counselling
TB	Tuberculosis
TOR	Terms of reference
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
VHW	Village health worker
WG	Working Group
WHO	World Health Organisation
ZAN	Zimbabwe AIDS Network
ZINQAP	Zimbabwe National Quality Assurance Programme
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZNNP+	Zimbabwe National Network of People Living with HIV

ACKNOWLEDGEMENTS

The Annual Independent Review was conducted by a team of independent consultants – Kathy Attawell, Dr Tapiwanashe Bwakura, Alexis Ferrand and Irene Moyo. The views expressed in the report are those of the team.

The team would like to thank the many individuals at national and district levels who contributed to this review. Particular thanks are due to Patricia Darikwa for organising review logistics, NAC for making meeting space available for the team, and UNAIDS and UNFPA for providing transport.

EXECUTIVE SUMMARY

This report includes the findings and recommendations of the second Annual Independent Review (AIR) of the Expanded Support Programme (ESP). The purpose was to: review implementation progress and challenges, including follow up of AIR I recommendations; assess ESP policy coherence, aid effectiveness, planning and budgeting, management, coordination and administration; assess the impact of the socio-economic and political environment on implementation in 2008; and make recommendations to improve management and implementation and for future direction. The following summarises overall and specific achievements and challenges, and priority recommendations (full recommendations are included in section 5).

Overall achievements and challenges

- The ESP has continued to be an effective and flexible funding mechanism, which has been able to respond rapidly to emerging needs and address bottlenecks (for example, financing the national health worker retention scheme and emergency procurement of cotrimoxazole), and has demonstrated that pooled funding is feasible even in a challenging political and economic context.

- The ESP has provided important support for the national response, including for scale up of prevention and treatment services, for example, implementation of the National Behaviour Change Strategy, procurement of ARVs, and training for health workers – see Box below; critical health system functions, for example, support for the National Blood Service (NBSZ) and Medicines Control Authority of Zimbabwe (MCAZ); national and district coordination; and policy development, for example, the National ART/OI Strategic Plan 2008-2012 and NAC Strategic Plan 2008-2011.

Highlights of ESP achievements

- All 26 ESP and EC districts developed BC plans; between July 2007 and December 2008, 535 wards in the 26 districts completed community action planning (exceeding the target of 520 wards or 20 wards in each of the 26 districts).
- BC NGOs trained 3,244 community leaders (exceeding the target of 2,600 or 100 in each district) and 1,624 BC facilitators (2,081 leaders and 1,020 facilitators in ESP districts).
- The national target for 2008 for person exposures to inter-personal communication was 1,147,998; BC facilitators achieved 409,943 person exposures in the 26 districts between October and December 2008 (707,410 during April 2007 to December 2008).
- All 16 ESP districts have at least one site offering ART. As of December 2008, 27 hospitals in ESP districts had been approved as ART initiation sites, compared with six at the time of the first AIR. ART initiating sites in ESP districts represent about 25% of all sites nationwide.
- As of December 2008 17,621 patients were on ART in ESP districts (exceeding the overall target of 16,000), of whom 12,355 were initiated on treatment since the ESP started in April 2007, compared with 7,273 and 2,568 respectively at the time of the first AIR

- The ESP procured ARVs for 48,000 patients in 2008 (17,621 in ESP districts, the remainder through the national ART programme), 35% of the 133,863 on ART as of December 2008.
- In 2008 the ESP supported training for 401 health workers in PITC (84% of target), 359 health workers in ART/OI management (60%) and 186 primary care counsellors (94%). Training was conducted for 14 laboratory scientists and technicians in use of CD4, biochemistry and haematology equipment; CD4 machines were installed in 13 ESP districts.

- The ESP has continued to act as a valuable forum for dialogue, information sharing, partnership and coordination between government, donors, UN agencies and NGOs. ESP-supported activities are consistent with national policies and well coordinated with other donor-funded programmes. The Box below summarises responses to the question '*What have been the main achievements of the ESP?* in meetings with the ESP Working Group and district health teams from the 16 ESP districts.

- Contribution to scaling up HIV programmes and to strengthening the health system in a challenging context
- Improved coordination of HIV activities
- Brought together donors, UN agencies, government structures and civil society to respond to the epidemic in line with national priorities
- Scale up of behaviour change activities; leadership involvement and greater awareness at community level; anecdotal evidence of behaviour change
- Increased uptake of testing and counselling (T&C) services
- Increased provision of ART services; scale up of ART coverage and uptake of treatment; support to the national ART programme for site assessments
- Provision of drugs (ARVs), commodities (consumables and laboratory reagents) and equipment (CD4 machines, laboratory equipment and vehicles)
- Improved laboratory services
- Support to stabilise the human resources environment i.e. staff retention
- Support for capacity development through training e.g. on OI management, ART and capacity building of nurses and primary care counsellors
- Support for and improved M&E

- The ESP has made progress despite the difficult economic, political and health sector environment in 2008. Economic challenges included hyperinflation, difficulties in accessing local currency and the transition to official dollarisation. Political challenges included election-related violence, and restrictions and the subsequent ban on NGO field operations from April to September. Health sector challenges included health worker attrition, industrial action, shortages of basic drugs and supplies, transport and fuel, and the cholera outbreak from September 2008.

- The ESP implementing partners (IPs) in the main succeeded in adapting operational modalities to respond to these challenges, and accelerated activity during the last quarter of 2008 and the first quarter of 2009. IPs spent US$16.2 million in 2008 – 81% of funds requested in 2008 work plans. Allowing for the US$2 million reserved

for the retention scheme carried over to 2009, 92% of the total budget for 2008 was spent. This is a major achievement in the prevailing economic and political context.

- The review also identified a number of specific challenges for the ESP. These are discussed in more detail below and in the main report, but broadly relate to: WHO funds flow difficulties; mismatch between demand creation and availability of treatment services; delays in procurement of critical items of equipment; weaknesses in planning, coordination and monitoring and evaluation (M&E); and concerns about value for money and cost effectiveness.

Specific achievements and challenges

Behaviour change

- There was good progress in 2008 with implementation of the behaviour change (BC) component managed by UNFPA. District and wards BC plans were developed and planned activities, for example, training of community leaders and BC facilitators, were on track by the end of the year.

- Collaboration with health facilities and other service providers such as PSI has improved, ensuring that demand created by BC activities is linked to other services. However, while provision of testing and counselling (T&C) and prevention of mother-to-child transmission (PMTCT) services has increased to meet demand, largely through the efforts of other partners, provision of treatment and care services has not.

- There is anecdotal evidence of increased demand for condoms, as well as for T&C, and of positive impact on community attitudes and norms. UNFPA has developed an M&E plan intended to measure impact. This is important, since at present impact is not being captured or measured systematically. Good practices developed by BC implementing NGOs could be documented and shared more systematically, although these issues are addressed by NGO peer review meetings. No assessment of the BC approach was conducted, given the operational challenges in 2008, and no steps taken to address concerns raised by the first AIR about how activities will be institutionalised and sustained within government in future. Allowances paid to BC facilitators are not harmonised with incentives for other community volunteers.

- There is little evidence of efforts to target vulnerable groups. The UNFPA approach does not address the specific needs of groups who may be at elevated risk. In 2008 IOM completed a national situation assessment of mobile and vulnerable populations (MVPs) but has implemented limited activities.

Treatment and care

- All ESP districts have at least one ART initiating site. Although the number of sites increased from six at the end of 2007 to 29 (27 initiating and two follow-up sites) by the end of 2008, progress with site assessment was slow, especially in the second half of 2008 when only five sites were approved. Only five district assessment teams

were trained. Some trained teams lack support, for example transport, to conduct assessments, although vehicles are reported to have been delivered in early 2009.

- The overall target for the number of patients on ART in ESP-supported districts of 16,000 was exceeded. There are, however, significant disparities between districts. In seven of the 16 ESP districts, there are less than 500 patients on ART. Some districts have over 1,000 on the waiting list for treatment. Low treatment coverage is due to lack of access to initiating sites, because of distance and the cost of travel, lack of follow-up sites and outreach services, and user charges. Initiation of treatment was also slowed by industrial action by health workers, shortages of laboratory technicians, and wider health service capacity issues.

- Training in provider-initiated testing and counselling (PITC), ART/OI and rapid testing was implemented in ESP and other districts and good progress was made towards 2008 targets. Primary care counsellors were trained and retained with ESP support. Salary support for the Ministry of Health and Child Welfare (MOHCW) AIDS and TB Unit played a vital role in staff retention. There was little progress with training in paediatric ART and more efficacious regimen (MER) for PMTCT during 2008. Consequently, few facilities reported that they provide paediatric treatment, MER or follow-up of HIV-exposed infants.

- Progress with community and home based care (CHBC) has been poor. The CHBC national strategy and guidelines are almost finalised and work is ongoing on harmonising related tools and training materials, but this process has taken almost 18 months. The Zimbabwe AIDS Network (ZAN) did not implement planned activities in 2008. This is variously attributed by different stakeholders to delays in ZAN submitting a proposal, bureaucratic procedures for getting ZAN proposals approved by the MOHCW before submission to WHO, delays in MOHCW submitting proposals to WHO, and problems with the flow of funds from WHO.

Procurement

- UNICEF has procured ARVs for 48,000 patients; no stock outs of ARVs were reported in ESP districts. Support for MCAZ has streamlined the batch testing protocol, improving availability of ARVs. CD4 machines were installed in 13 districts and vehicles delivered to 11 districts.

- There have been significant delays in procurement of critical items of equipment that are non-standard for UNICEF. Lead time for procurement of biochemistry and haematology analysers was two years and, for some vehicles, one year. The 1,600 HBC kits procured and distributed are insufficient to meet demand and there is no system in place for kit replenishment.

Coordination, management and M&E

- Support has been provided for development of the National AIDS Council (NAC) Strategic Plan and to plan the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) mid-term review and a National AIDS Spending Assessment. ESP salary support for NAC is reported to have helped retain national and district staff. District plans have been developed and district coordination meetings held. NAC gender and

meaningful involvement of people living with HIV (MIPA) staff have established Technical Working Groups and developed policies and guidelines.

- This review highlighted similar concerns to the first AIR, about the lack of clear deliverables in NAC staff work plans and of a rigorous system for monitoring overall NAC and individual staff performance. District plans are still driven by partner activities rather than district priorities. District coordination forums are not consistently proactive in addressing bottlenecks or maximising use of available resources such as vehicles to enhance service delivery; this often depends on the initiative of district health teams and NGO partners. Gender is not yet well mainstreamed in district plans and IP work plans.

- Data is collected separately for the AIDS and TB Unit and is not integrated with the MOHCW Health Management Information System (HMIS). Multiple reporting at district level is complicated by shortages of stationery and communication problems. The interface between the NAC National AIDS Reporting Framework (NARF) and the MOHCW HMIS remains an issue. However, a draft national M&E plan has been developed to harmonise complementary systems.

Programme management and administration

- The ESP has followed up many of the recommendations of the first AIR. Recruitment of a Finance Manager by UNDP has improved financial reporting. The Management Guidelines have been revised to include standard proposal and reporting formats. The ESP Coordinator has continued to ensure the efficient functioning of the Working Group (WG). A consolidated annual report for Year 1 was produced, and a consolidated narrative and financial report for Year 2 is in preparation.

- UN agencies responsible for different programme components have continued to develop separate work plans and budgets and there is no evidence of integrated planning to ensure coherence between components. IP reports, although much improved as a result of using the standard reporting format, still focus on activities and do not systematically assess progress against national or ESP targets or log frame indicators. Data is not available for all the indicators in the ESP log frame and, since it is not used for reporting, the log frame appears to be somewhat redundant.

- Concerns about the extent to which the WG is able to fulfil its oversight role, including scrutiny of IP performance and costs, and about potential conflicts of interest, have not been addressed. Donors have started to hold *ad hoc* meetings to discuss specific concerns, but this is not reflected in the Management Guidelines or in reporting to the WG. The review team still considers that there is a need for independent technical and financial scrutiny of IP proposals, work plans and budgets and this role cannot be fulfilled by the core group as constituted in the revised Management Guidelines. The team also views the proposed Implementation and Evaluation Officer as unnecessary, since the TOR for this position to a large extent duplicate IP and NAC responsibilities.

- If donor commitment remains at a similar level to Years 1 and 2, there will be a significant shortfall in ESP funds available versus work plan budgets for 2009. The WG will need to look at the overall resource envelope as well as individual IP

budgets. Beyond 2009, there are likely to be significant demands on ESP funds, since EC funding beyond the end of 2009 is uncertain and it is not clear when GF Round 8 funds will start flowing.

- A challenge for the ESP is, therefore, how best to deploy available resources. Given the above, and the fact that the ESP cannot support all areas of the national response, the programme may need to make some strategic choices about funding. Some of the recommendations made by the review team, for example, the importance of maintaining BC activities, retaining health workers and procuring ARVs and other essential supplies and equipment, reflect this need to make strategic choices but do not mean that the review team considers other components of the ZNASP as unimportant.

Priority recommendations

I. Take immediate steps to complete planned activities and consolidate in 2009.

- Review the effectiveness of the BC approach and implement plans to document impact.
- Develop a less resource-intensive strategy for sustaining BC activities in current ESP districts beyond 2009.
- Review the role of IOM in coordination and implementation of services targeting MVPs once a national strategy is developed.
- Re-define WHO's role as an ESP technical partner and identify an alternative financial management partner to address funds flow problems.
- Establish targets for and accelerate site assessment, focusing on under-performing ESP districts and approval of follow-up sites.
- Deliver and install biochemistry and haematology equipment, outstanding vehicles, and X-ray processor for City of Harare.
- Plan for phase out of salary support to NAC as and when AIDS levy income increases and GF Round 8 support commences.
- Identify a national technical consultant team (comprised of non-recipients of ESP funds) to provide independent scrutiny of IP annual work plans, budgets and progress, reporting to the WG.
- Review work plans and budgets, including value for money, and likely commitment of funds for 2009 and identify priorities for funding within the available resource envelope.
- Work with the Global Fund to tender for management of pooled resources for the retention scheme from 2010.
- Plan for next phase of the ESP by end of third quarter of 2009.

II. Continue the ESP for a further two years to the end of the current ZNASP but as a more focused programme of support.

- The WG core group should consider changing the ESP to the ESF – Expanded Support Fund – focusing on flexible funding to fill gaps and to support scale up through appropriate IPs, if this does not have major implications for the MOU.
- The WG core group should consider the following direction for the ESP:
  - Shift from support to specific districts to national support, complementing GF Round 8 and other funding, and taking a pooled approach wherever possible.

  - Focus on support for critical health sector functions required to deliver HIV services, for example, human resources for health, through the retention scheme and training, procurement of ARVs and other essential HIV commodities and equipment, NBSZ and MCAZ.
  - Continue support to sustain BC activities in ESP districts until end 2011 and consider other ESP support for prevention, for example, for MVPs, in the context of overall funding for HIV prevention in Zimbabwe.
  - Phase out support for coordination, management and M&E through NAC as and when AIDS levy income increases and GF Round 8 support commences.
  - Decide whether the ESP needs to continue financing for CHBC activities, given the resources allocated to CHBC under GF Round 8.
- The WG core group should plan for integration of future ESP reviews into Joint Annual Reviews of the ZNASP.

1. INTRODUCTION

1.1 Expanded Support Programme

The Expanded Support Programme (ESP) aims to support scale up of the national HIV and AIDS response in Zimbabwe and achievement of the goals of the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP). The ESP proposal highlighted: strengthening national systems; establishing a common funding mechanism; providing resources and filling gaps; supporting a comprehensive district response; and ensuring prevention, treatment and care links. The three original results focused on provision of antiretroviral therapy (ART) as part of comprehensive HIV and AIDS services in initial ESP districts; implementation of an effective behaviour change (BC) strategy in these districts; and support for improved coordination and management of the response.

Implemented through UN agencies and other implementing partners who work in partnership with national authorities and NGOs, the ESP provides strategic support at national level and targeted support for 16 districts. The ESP complements existing resources and is financed through a Common Fund, to which Canada (CIDA), Ireland (Irish Aid), Norway, Sweden (SIDA) and the UK (DFID) committed US$50 million over three years. The first disbursements to the ESP were made in April 2007. The ESP Working Group (WG), co-chaired by the National AIDS Council (NAC) and one of the donors, currently CIDA, is responsible for programme oversight and decision-making.

1.2 Annual Independent Review

The Annual Independent Review (AIR) is a mechanism to enable the ESP WG, NAC, donors and implementing partners to monitor programme progress and management. The second AIR was conducted 17 February to 4 March 2009. The purpose (see TOR in Annex 1) was to review progress (including implementation of recommendations of the first AIR) and challenges, to assess specific aspects of the ESP (policy consistency; aid effectiveness; planning, budgeting and administration; coordination and management), and to consider the impact of the socio-economic and political environment on programme implementation. The review also considered how the ESP can contribute to strengthening the national response in Year 3 of the programme and beyond.

The findings and recommendations in this report are based on meetings with key stakeholders, consultation with the WG, focus group discussions with health staff from the 16 ESP districts, visits to four ESP-supported districts (Chikomba, Gutu, Matobo and Shurugwi), one GF-supported district (Chivi) and one district not receiving external donor support (Umguza) (see Annex 2) and review of background documents (see Annex 3).

Section 2 summarises progress with implementation of the recommendations of the first AIR. Section 3 summarises achievements and key issues in each of the core programme components, reviews coherence with national policy and the wider national response, and discusses the main findings concerning programme management, coordination and administration. Section 4 considers the wider context within which the ESP operates, in particular how the ESP has responded to human resource constraints – the specific issue considered by the first AIR – and the impact of the socio-economic and political environment on programme implementation during 2008. Section 5 considers future direction and includes the review team recommendations in full.

2. IMPLEMENTATION OF AIR I RECOMMENDATIONS

The first AIR made recommendations in the following areas: accelerating implementation of the treatment component; reviewing the approach to BC prior to scale up; reviewing the proposed approach to provision of services for mobile and vulnerable populations (MVPs); building district capacity to deliver HIV services, focusing on a strategic approach to support for human resources for health; coordinating and linking planning of programme components in Year 2; and reviewing and strengthening ESP governance, management, monitoring and reporting.

The majority of the recommendations were adopted by the WG in February 2008. There has been good progress with implementing recommendations on human resources for health. Progress with implementing recommendations on accelerating the treatment component, building district capacity and ESP governance, management, monitoring and reporting has been mixed. Review of the approach to BC and to provision of services for MVP and coordinated planning of programme components have not been taken forward. Table 1 summarises progress with implementing the recommendations.

Table 1: Implementation of AIR I recommendations

Main recommendation	Specific recommendation	Comments
1. The ESP should take immediate steps to ensure rapid implementation of the treatment component in the initial 16 districts	WHO and MOHCW should develop an action plan with clear targets and timeframes that includes: conducting rapid assessment of a minimum number of sites in each ESP district, if necessary using a national team; working with the DMO and health facilities in each district to identify priority needs; developing a strategy to improve service delivery capacity; implementing training for existing staff.	.National HIV Treatment and Care Work Plans for 2008 had targets and time-frames for site assessments. During the ESP review and planning meeting in July 2008, districts developed Year 2 work plans and identified potential ART initiating and follow-up sites; district plans included targets for site assessments. Due to constraints in accessing funds for site assessment visits, it was not possible to meet the targets. The site assessment model could be more efficient e.g. Chikomba has a team and potential sites identified but no vehicle.
	WHO and MOHCW should identify focal persons for ESP districts in the AIDS and TB Unit and establish mechanisms to improve communication with districts.	Focal person responsible for ESP districts identified in AIDS and TB Unit but no evidence of improved communication with districts.
	WHO and MOHCW should identify ways to ensure that resources flow more efficiently to districts. As a	WG co-chairs met with WHO to discuss how funds can flow more efficiently to districts.

	first step, WHO should stop requesting proposals from health facilities where approved district plans exist and consider direct disbursement of funds to health facilities.	Proposal template to be shared with districts during annual planning workshop February 2009. Despite MOHCW efforts to support the process, funds flow remained a significant problem, in part due to the economic environment and in part because of WHO systems. WHO and WG should have accepted and addressed this constraint before end of Year 2.
	WHO should routinely report to the ESP WG on the number of health facilities providing ART services and the number of ART patients in ESP districts.	Number of health facilities providing ART services and number of ART patients in ESP districts included in WHO quarterly reports.
	The WG should increase allocation of ARVs to ESP districts that exceed the target of 1,000 patients on treatment, and redistribute ARVs not used by ESP districts by March 2008 to the national programme.	ARVs not required by ESP districts reallocated to national programme; this has helped improve availability of ARVs.
	WHO and MOHCW should develop strategies to decentralise ART service delivery within ESP districts, which have the potential for wider replication.	Included in WHO April-December 2008 work plan. WHO reports that it is awaiting MOHCW guidance on scaling up decentralisation; greater efforts could have been made to assess additional initiation and follow-up sites without waiting for further guidance. AIDS and TB Unit reports that decentralisation efforts have been ongoing, with an increase in follow up sites, despite the fact that Standard Operating Procedures for Decentralisation of HIV Care and ART are not yet in place.
	The National TB Programme should take the lead with TA from WHO in reprogramming the TB/HIV component to ensure it complements activities supported by the GF. The City of Harare should immediately appoint a focal person to spearhead the	City of Harare has appointed focal person. There were no TB activities in Year 2 work plan but planned activities in Year 1 not completed according to City of Harare.

	implementation of planned activities.	
2. The ESP should monitor and evaluate implementation of planned BC activities as the component goes to scale and support NAC to develop a plan and budget for expansion of a minimum package of BC activities to other districts	UNFPA should conduct a rigorous assessment of the feasibility and effectiveness of the current approach, in particular of the functioning and support needs of BC facilitators in the first cluster of five wards in each district. The viability of the programme is anchored on their role, and the requirements for successful implementation of this component need to be identified before the programme commences rolls out to scale. UNFPA should use the findings of this assessment to support NAC to develop a plan and budget for expansion of a minimum package of BC activities to other districts. The ESP WG should consider seeking government funding commitment to expansion of the national BC programme, whilst appreciating that this may be challenging in the current economic climate.	TOR for external review developed but not taken forward due to disruption of activities between March and September 2008 and subsequent inability to identify a suitable consultant. A consultant was identified in the first quarter of 2009 and the review will commence in the second quarter of 2009. Not taken forward as assessment not yet conducted (see above). WG did not adopt this recommendation.
3. The ESP should review the current approach to provision of services for mobile and vulnerable populations	The ESP WG should explore how support can be provided to GOZ to develop a national strategy for MVPs. The IOM component should not be expanded until there is a national strategy in place that includes all vulnerable populations identified in the ZNASP. The ESP WG should ensure that the IOM work plan is integrated with district plans as the success of this component is dependent on links with existing services. The ESP WG should consider support for other service providers to ensure that there is a comprehensive approach to MVPs and that vulnerable populations that are outside the IOM mandate are reached by prevention,	No national strategy in place. IOM focused in 2008 on conducting a national situation assessment. Assessment report recently completed but not yet approved. IOM is developing a strategy and plans to develop a proposal by second quarter of 2009. No IOM work plan (see above). No steps taken to ensure other vulnerable populations are targeted by prevention, treatment and care services.

	treatment and care services.	
4. The ESP should provide additional support in Year 2 to build the capacity of the initial 16 districts to deliver HIV and AIDS services, including a strategic approach to support for human resources for health	The ESP should focus on ensuring that a minimum package of services – T&C, PMTCT, treatment and care – is available and that referral links between these services are established. As a first step, the ESP should identify gaps in service provision and develop a plan to address these gaps in collaboration with other donors and with organisations providing these services. The ESP should provide strategic support for human resources for health, infrastructure, training, equipment and supplies required to deliver these services. WHO needs to accelerate its current support for MOHCW in the area of human resources for health in Year 2 of the ESP. Support for human resources for health in ESP districts should follow the approach taken by the EC, which aims to strengthen the district health team. Incentives to recruit and retain additional doctors, to ensure that districts can deliver ART services, should be consistent with approaches taken in other districts.	No systematic approach to identifying or addressing gaps in collaboration with other donors or ensuring referral links in ESP districts (this is the responsibility of MOHCW and NAC) but there has been some degree of gap filling. ESP has moved towards support for a national response in e.g. training, procurement, HRH retention scheme, and AIR II recommends that future support continue in this direction, moving away from a district focus. The ESP played an important role in developing a national HRH retention scheme, working with MOHCW and donors to agree a harmonised approach. The process went beyond the AIR I recommendation, reflecting the findings of the national ART review in May 2008, which recommended a national approach to reduce internal migration and retain staff in all critical posts. The ESP has made a commitment to provide US$5.1 million in 2008 and 2009 to support the retention scheme.
5. The ESP should ensure that planning for Year 2 of the programme is coordinated and linked	The UN agencies should develop plans for Year 2 that are informed by district action plans. The agencies should conduct joint reviews of plans to ensure that activities are linked and phased and to develop a coherent and strategic approach to support for human resources. More specifically: UNFPA and its implementing NGOs should map expected impact of the BC component on demand for HIV and AIDS services	District plans have been developed through an Integrated District Development Process (IDPP). However, IP (and other partner) work plans appear to inform district plans rather than vice versa. IPs developed separate work plans for 2008 and 2009 and there is no evidence of any steps taken to ensure plans are linked or phased. No evidence of mapping expected impact of BC on demand for services. However, UNFPA reports that ART

	and collaborate with WHO and other partners to plan for these needs to be met.	service coverage is taken into account in selecting wards to be covered by the BC component. In some districts there is improved coordination e.g. on outreach for BC and T&C and treatment, although this is the result of individual initiative rather than a systematic approach; there is scope for further improvement in coordination with MOHCW clinics, which are the main provider of T&C services.
	UNFPA should establish a formal agreement with PSI and other T&C providers to develop a T&C plan and ensure that T&C services are available to meet demand created by the BC component.	UNFPA reports strengthened operational coordination with service providers including PSI T&C outreach; this was confirmed by district visits which found evidence of coordination between BC NGOs and PSI.
	WHO and UNICEF should work together to ensure that the treatment and care and procurement work plans for Year 2 incorporate activities to strengthen service delivery.	Improved availability of supplies and training has potential to strengthen e.g. rapid testing, PMTCT, ART/OI services. No progress with training and limited progress with supplies to strengthen CHBC delivery. Unclear to what extent WHO and UNICEF have coordinated efforts.
	The IOM work plan should be linked to the ESP BC and treatment and care components to ensure that mobile and vulnerable populations are reached with prevention, treatment and care services. This will require coordinated planning by IOM, UNFPA, WHO and UNAIDS.	No IOM work plan.
	Planning for ESP components should consider gender and MIPA as cross cutting issues and, where appropriate, involve PLHIV organisations to ensure that their perspectives are taken into account.	Gender not well addressed by or integrated into work plans. MIPA integrated into the BC component through BC NGO MIPA Officers; no evidence of PLHIV involvement in planning other ESP components Gender and MIPA guidelines for IDPP

		provided.
	The ESP WG should review plans submitted for Year 2 to ensure these will support delivery of a comprehensive package of HIV district services and individual agency work plans are linked and phased appropriately.	Unclear to what extent ESP WG reviews plans overall to ensure individual plans are linked and phased.
	In the longer term, WHO and UNAIDS should provide support to MOHCW and NAC to develop an integrated planning framework for all programme components at national and district levels.	As noted above, support provided by NAC to districts for IDPP; support provided by MOHCW to ESP districts for planning.
6. The ESP should review its governance and procedures and strengthen programme management, progress and financial reporting, and monitoring	The ESP Working Group should develop clear guidelines setting out procedures for submitting proposals, including the scope for CSOs to establish partnerships with UN agencies, and for review of and decisions about proposals. While the team does not recommend that the ESP fund activities that fall outside the core components of the programme and support to build district capacity to deliver these, these guidelines should include criteria for deciding what, if any, ad hoc funding requests it can meet if additional resources are committed.	ESP Management Guidelines have been revised to include proposal guidelines (although these appear to address existing IPs and do not specify scope for CSO partnerships). The revised Guidelines state 'Other plans addressing additional and new priorities may also be considered for funding once the initial ESP funding requirements are met, as long as these are anticipated in the ZNASP'.
	The ESP should strengthen programme management, reporting and monitoring through:	
	Recruitment by ESP donors of a Technical Manager to provide technical inputs into review of proposals and reports and ensure that ESP implementation and monitoring is on track.	Decision taken not to recruit a Technical Manager. There is still a need for independent technical scrutiny of IP proposals and reports and of ESP progress.
	Recruitment by UNDP of a Finance Manager to ensure that the FA fulfils its remit including financial reporting and resource tracking.	Finance Manager recruited by UNDP and this has improved financial management.
	Review of the TOR of the ESP Coordinator, together with the TOR for the Finance Manager and the	TOR developed for Finance Manager and Implementation and M&E Officer for the ESP

	Technical Manager, to ensure that all key programme management functions are covered. The role of the ESP Coordinator should be expanded beyond communication and liaison to include preparation and analysis of consolidated technical and financial reports in collaboration with UNAIDS and the Finance Manager.	Operations Team. A consolidated annual report for April 2007-March 2008 was produced. However, this does not report on progress against targets and indicators in the log frame and provides limited analysis of overall achievements.
	The ESP Coordinator and ESP Finance Manager should, following consultation with donors, UN agencies, NAC and MOHCW, develop a standard narrative and financial reporting format for all ESP components that focuses on progress, challenges and reporting against targets and indicators.	Standard narrative and financial reporting formats have been developed and adopted by IPs. However, narrative reports focus on activities, do not discuss outcomes or impact and do not consistently report against targets or indicators in the log frame. ESP planned to recruit an Implementation and M&E Officer, instead of a Technical Manager, to 'ensure transparent, high quality and consistent reporting on ESP outcomes and impact'.
	The ESP Coordinator, ESP Finance Manager and ESP Technical Manager should prepare a consolidated ESP 6-monthly progress and financial report, including reporting on progress against targets and indicators in the log frame.	Annual progress report produced for Year 1; annual progress and financial report for Year 2 due April 2009. Quarterly financial summaries are produced. There are no plans to produce consolidated 6-month progress and financial reports (although the Management Guidelines state that these will be provided to the NPF).
	The core members of the ESP WG should hold a separate review meeting every 6 months to review this consolidated report and the performance of UN agencies and other partners.	A core group of the WG has been established in principle under the revised Management Guidelines 'to attend to the management and strategic direction of the ESP' but this core group has not met and the wider WG meets monthly as before. Donors have started to hold ad hoc meetings as required to address specific management issues.
	The ESP log frame should be revised to reflect changes since the programme commenced and to ensure that baseline data for all	The ESP log frame has not been revised and baseline data is not available for all

	indicators is included.	indicators.
	The ESP WG should require UN agency partners to provide baseline data for ESP components by March 2008. This should be used by the ESP Coordinator to review the ESP log frame, consolidate available baseline data, and report to the ESP Working Group on gaps in baseline data.	Baseline data for ESP components has not been provided to enable the ESP Coordinator to consolidate in the log frame and report to the WG on gaps.
	The ESP WG should ensure that UN agencies have consistent and appropriate plans for M&E and data collection in place to support reporting on progress towards targets and capturing results, both for individual components and the overall ESP log frame.	Not taken forward by all IPs; UNFPA has developed an M&E plan for the BC component. The TOR for the Implementation and M&E Officer include development of an M&E plan for the ESP; monitoring activities; providing information on core output indicators; and engaging with the NAC to ensure that ESP impact is monitored and contributes to national outputs. AIR II suggests this post is not required as these tasks are the responsibility of IPs and NAC.
	NAC should take the lead in ensuring that ESP indicators are aligned with NARF indicators.	NARF indicators currently under review.

3. KEY FINDINGS

3.1 Programme implementation in Year 2

The initial design of the ESP focused on three components: provision of ART as part of comprehensive HIV and AIDS services to a substantial number of adults and children in 16 districts, including procurement of essential commodities, implemented through WHO and UNICEF respectively; implementation of an effective BC strategy in 16 districts, implemented through UNFPA; and improved coordination between implementers and lead UN agencies, partners, and donors, implemented through UNAIDS.

The scope of the ESP expanded in response to additional proposals submitted by WHO, IOM and UNAIDS in 2007 and, in 2008, the programme planned to fund the following components: prevention – BC, interventions targeting MVP and PMTCT; ART, CHBC and related procurement of drugs, equipment and commodities; coordination and management; and M&E. In 2008, the ESP also provided support for HIV-related activities of the NBSZ and for strengthening the quality assurance capacity of MCAZ.

The following summarises key achievements and issues identified by the second AIR.

3.1.1 Behaviour change

The BC component is being implemented in 16 districts with ESP support and a further 10 districts with European Commission (EC) support. The component is supported and coordinated at national level by UNFPA in collaboration with NAC, which is responsible for the National BC Programme, and implemented at district level by 8 NGOs contracted by UNFPA. The component supports key aspects of the National BC Strategy, specifically creation of an enabling environment and adoption of safer sexual behaviours and reduction of risk behaviours through community mobilisation and interpersonal communication. It uses a model that encompasses community assessment, working through community leaders and BC facilitators (selected from community opinion leaders) and promoting community dialogue through an adapted version of the Stepping Stones methodology.

Activities in the 2008 work plan included: district and ward action planning; support to NGOs including funding BC staff positions and training; training for community leaders and BC facilitators at ward level; referral for T&C and other HIV services; sensitisation of FBO networks; promotion of PLHIV involvement; development of BC materials and tools; condom distribution; and a mid-term KABP survey and qualitative research. Targets were revised in July 2008 because of the challenging environment and changes in the ESP programming year which became April 2008 to December 2008 instead of the planned end in March 2009.

<u>Achievements</u>

- The BC component is well coordinated by NAC and UNFPA and activities are in line with the National BC Strategy. Despite the challenging political and economic environment in 2008, BC NGOs succeeded in the main in meeting programme targets. Community sensitisation activities resumed in August-September and NGOs stepped up training activities during the last quarter to make up for lost time.

- All 26 districts developed BC plans which include detailed activities, timeframes and responsibilities. Between July 2007 and December 2008, 535 wards in the 26 districts completed a process of community action planning (exceeding the target of 520 wards or 20 wards in each of the 26 districts). In three districts visited by the team, 24 of 24 targeted wards had been sensitised.

- There has been good progress in training community leaders and BC facilitators. BC NGOs trained a total of 3,244 community leaders (exceeding the target of 2,600 or 100 in each district) and 1,624 BC facilitators (2,081 leaders and 1,020 facilitators in ESP districts). In Shurugwi district, for example, 198 community leaders were trained, including chiefs, councillors, church and political leaders, more than double the target. Inclusion in the training of BC facilitators from other NGOs operating in the district, for example, SWAPA, a former commercial sex workers organisation that reaches out to bar clients and small scale miners, helped to ensure consistency of BC messages. The total number of person exposures achieved by BC facilitators in the 26 ESP and EC supported districts between October and December 2008 was 409,943 (the total for April 2007 to December 2008 was 707,410).

- Training was also conducted for NGO BC staff – 26 BC Officers, 26 BC Support Officers and 26 MIPA Officers – and NAC staff – 10 Provincial AIDS Coordinators (PACs) and 90 District AIDS Coordinators (DACs). Vehicles were provided to NGO partners for each of the 26 districts.

- With ESP and EC funding, UNFPA has supported a 26 week radio programme 'Love Carefully' on Radio Zimbabwe, which generated a large number of listeners and will be evaluated to inform a follow-up programme. UNFPA also supported the production of brochures in Shona and Ndebele promoting accurate risk perception, responsible practices, couple communication and relationships skills and of manuals for community leaders and BC facilitators.

- Anecdotal evidence indicates that community and opinion leaders are promoting safer sexual practices and discouraging risky behaviours. For example, some religious and traditional leaders are reported to be talking about the risks of multiple concurrent partnerships and promoting condom use, churches have requested information and invited implementing NGOs to meetings to promote BC, community leaders are challenging incorrect beliefs about HIV, and parents are reported to be discussing sexual issues, including condom use, with their adolescent children. In Matobo district, for example, community leaders are reported to be discouraging activities such as all night parties that contribute to high risk behaviour, while in Chikomba district, BC activities are believed to have played an important role in increasing uptake of T&C.

- Some ESP districts visited reported that community leaders have become more willing to disclose their status and, in some cases had joined support groups, and this is also thought to have contributed to a reduction in stigma and discrimination. Another factor is the involvement of PLHIV as BC facilitators and support by MIPA Officers for the establishment of PLHIV support groups. In Gutu, for example, the MIPA Officer had helped to establish a men's support group, which is helping to encourage men to seek T&C and to disclose their HIV status.

- Field visits also highlighted differences between ESP and non-ESP districts. For example, in Chivi and Umguza, the non-ESP districts visited by the review team, stigma and discrimination, fear of disclosure of HIV status and negative perceptions about condom use among community leaders appeared to be greater than in ESP-supported districts visited.

- The BC component has strengthened linkages with HIV service providers. Implementing NGOs have established links with district health teams and PSI to ensure that T&C services are available following BC activities and with health facilities so that they can refer community members for services. In some districts, for example, Shurugwi, BC NGOs are sharing transport with district health teams to enable health workers to conduct outreach services and increase ART initiation.

- UNFPA has developed a detailed M&E plan, which is linked to the national M&E system. Indicators developed for the component have been incorporated as BC indicators in the NARF. The M&E plan includes output, outcome and impact indicators, targets, responsibilities and methods of collecting data. BC NGO reports are detailed and standardised. Monthly reports by BC facilitators, quarterly field visits and quarterly peer review meetings are used to monitor process and output indicators. UNFPA has also conducted joint monitoring with NAC in four provinces.

Key issues

- There were differences between districts in achievement of targets; six districts did not achieve their targets while others exceeded targets. For example, Matobo trained BC facilitators in only five of the 24 targeted wards, whereas Chikomba exceeded its target for training. This was mainly because some districts were more adversely affected than others by restrictions on NGO activities during 2008. As a result of these restrictions, BC NGOs had to close offices or scale back implementation and community activities ceased in all districts between March and June. Although some districts were able to resume activities in July, the political environment in others and the continued NGO ban delayed resumption of activities until September.

- The first AIR highlighted concerns about the future financing of BC activities. Based on the 2009 budget, the current level of activity costs around $100,000 per district per year. Global Fund (GF) Round 8 support for roll out of the BC component to all other districts assumes continued ESP and EC support for activities in the current 26 districts. No action has been taken to develop a less resource-intensive approach to sustaining BC activities in the 26 districts. Individual NGOs have developed innovative approaches to reduce costs, for example, of training, but these approaches have not been systematically applied across the BC component. Resources required should be less over time as vehicles, initial training and other up-front costs decrease and provincial NGOs start to see returns to scale.

- The first AIR also highlighted concerns about institutional sustainability, since there is limited local government involvement in or ownership of BC activities. Although BC facilitators are well linked to community and ward structures and district BC forums have been established, it is still unclear how districts will sustain activities as there is

no provision to develop the capacity of district staff to manage, support and monitor BC activities once ESP funding ends.

- Assessment of the feasibility and effectiveness of the current approach was not implemented in 2008 because of the difficult operating environment. Consequently, a related recommendation, that UNFPA should use the findings of this assessment to support NAC to plan and budget for a minimum package of BC activities, has also not been implemented.

- There has also been no review of the impact of activities on demand for services. However, field visits indicate that demand created by the BC component still outstrips provision of services, an issue raised by the first AIR. Although provision of T&C has expanded during 2008 and links have been established between the BC NGOs and government and other providers of T&C such as PSI, availability of treatment and care continues to lag behind. Links between BC NGOs and district health teams appear to depend on individual initiative in specific districts, and there is no consistent approach. For example, in Gutu and Chikomba, both of which have more than 1,000 people on the waiting list for ART, there was no evidence of efforts to share transport and conduct joint outreach activities.

- Some issues were highlighted concerning the approach. For example, while Stepping Stones involves working with groups of younger and older men and women, some respondents noted that young people are under-represented in sensitisation meetings and that more effort is needed to incorporate youth peer educators in BC activities. And, while leaders are speaking out and discouraging risky sexual behaviour, some interviewed during field visits appear unconvinced about the feasibility of reducing multiple partnerships. The review also raised questions about whether training political leaders is an appropriate strategy, with some anecdotal reports of disputes when there is a change in political leadership and trained former leaders continue to 'hold on' to BC activities.

- Partner NGOs take different approaches to incentives for BC facilitators, with some paying a monthly allowance of US$10, others providing a food basket to the value of US$10 and others providing food or other incentives on a more *ad hoc* basis. Lack of harmonisation within the BC component, and with incentives for other cadres of community volunteer, is an issue. Delays in payment of allowances to BC facilitators have affected volunteer morale, for example, in Shurugwi. This also raises questions about the sustainability of activities should funding for allowances cease.

- M&E largely focuses on process indicators, with limited systematic measurement of outcomes and impact. While assessing impact is a challenge, plans to scale up nationwide a methodology whose impact is as yet not known is an issue. However, this should be addressed by the M&E plan, which includes measurement of impact.

- In 2008, UNFPA planned to conduct a baseline survey, secondary analysis of DHS data to compare ESP and non-ESP districts and a mid-term KABP survey and qualitative research. Survey work for the baseline was completed in the first quarter of 2008 and the report was produced in February 2009. The KABP survey and qualitative research have been deferred to the 2009 work plan.

3.1.2 Services for mobile and vulnerable populations

The ZNASP defines a range of population groups as vulnerable, including OVC, commercial sex workers, prisoners, resettlement communities, MSM and people with disabilities. It notes that 'Mobile populations will be reached through intensified programming in specific geographic areas, further mainstreaming of HIV in sectors such as mining, transport, construction, agriculture, uniformed services, informal cross-border trade and sex work'.

Following the first AIR, the aim of the IOM component was revised to focus on promoting an appropriate policy and service delivery framework for MVPs to access HIV prevention, treatment and care services. The 2008 work plan included: providing MVP with access to HIV and AIDS services (T&C, PMTCT, ART, condoms and STI) through implementing partners in four ESP districts (Mutasa, Makonde, Gutu and Hwange); increasing capacity to plan, implement, monitor and coordinate interventions for MVP in these districts; and conducting a national situation assessment of mobile and migrant populations' access to HIV services in order to identify gaps and develop appropriate interventions.

Achievements

- The situation assessment, which focused on vulnerable populations identified in the ZNASP (with the exception of OVC and disabled people), was the main activity in 2008. The assessment has been completed and a draft report produced, which has yet to be adopted. The report is expected to inform the development of a national strategy and a proposal to ESP for a component targeting MVP.

- Stakeholder consultations and preparations for field work were conducted in the second quarter of 2008. IOM reports note that activities for MVP were coordinated in eight ESP districts. These activities included HIV and AIDS awareness campaigns, distribution of 15,805 female and 138,226 male condoms, and sensitisation of community leaders from the border areas of Mutasa district, in partnership with FACT Mutare, which facilitated MVP participation in the development of the ward plan for BC.

- IOM and UNFPA held a workshop for BC staff and other stakeholders to disseminate the findings of a sex work study conducted in 2008 with funding from DFID.

Key issues

- Implementation has been slow. Research for the situation assessment was delayed until the last quarter of 2008 due to restrictions on field work. The review team has some concerns about the quality of the report. Delay in completing the assessment has delayed development of a national strategy.

- Review of IOM quarterly reports suggests that the extent to which MVP have been provided with access to HIV and AIDS services (T&C, PMTCT, ART, condoms and STI) is limited. Respondents met by the team in Gutu district, for example, noted that populations such as truck drivers and sex workers are not reached with targeted interventions.

3.1.3 Treatment and care

The treatment and care component implemented by the MOHCW with technical support from WHO aims to expand HIV treatment and care services in the 16 ESP districts. The component is intended to foster a district approach to service delivery, with particular emphasis on improving access and equity, and to support implementation and replication of service delivery models for rapid scale up of HIV treatment and care.

The ESP Year 1 work plan was based on the national ART roll out plan, with a target of at least 16,000 PLHIV on treatment (1,000 in each ESP-supported district) based on national targets (see below). The same target was set for Year 2. The component was expanded in the last quarter of 2007 to include strategic support for CHBC and, in 2008, to include introduction of the more efficacious regimen (MER) for PMTCT.

National ART targets

As of 2007, an estimated 1.6 million Zimbabweans were living with HIV, of whom 479,000 adults and 24,000 children were in urgent need of ART. National targets of 250,000 on treatment by the end of 2007 and 340,000 by the end of 2008 were revised to 170,000 adults and 15,000 children on treatment by the end of 2008 and 210,000 adults and 20,000 children on treatment by the end of 2009.

Activities in the 2008 work plan included: training district assessment teams in all 16 ESP districts; conducting site assessments for health facilities including clinics; infrastructure upgrading to enable provision of HIV services; training for health workers in OI/ART management, PITC and rapid testing; deployment, training and allowance support for primary care counsellors (PCs); strengthening quality assurance for laboratory HIV diagnosis and monitoring; support for staff salaries in the AIDS and TB Unit; support for introduction of drug resistance surveillance and of the MER. Support for CHBC included development of a National Strategic Plan, harmonisation of guidelines and tools, training community health workers, training and roll out of community mobilisation and empowerment for improved access to treatment, care and support (CMEAST) and development of a National Volunteer Policy.

Achievements

- During 2008, ESP provided support through this component for finalisation of the National ART/OI Strategic Plan 2008-2012.

- The ESP has made progress in Year 2 in increasing access to ART. All 16 ESP districts have at least one site offering ART services and, as of December 2008, 27 hospitals in ESP districts had been approved as ART initiation sites, with a further two hospitals offering ART follow-up services (see Table 2) – compared with only six hospitals approved at the time of the first AIR. As of 31 December 2008 there were 17,621 patients on ART in the ESP districts (exceeding the overall target of 16 000), of whom 12,355 were initiated on treatment since the ESP commenced in April 2007 (compared with 7,273 and 2,568 respectively at the time of the first AIR). A further

32,000 PLHIV benefited from ARVs procured by the ESP through the national ART programme.

Table 2: ART coverage in ESP districts as of December 2008

Province	ESP districts	No. ART initiating sites	No. on ART
Matabeleland North	Hwange	3	3085
	Nkayi	2	458
Matabeleland South	Kezi-Matobo	2	1315
Midlands	Shurugwi	1	336
	Chirumanzu	3	1938
	Mberengwa	2	399
Masvingo	Bikita	2	1063
	Gutu	1	524
Mashonaland West	Makonde	2	2729
Mashonaland Central	Guruve	1	1651
	Mbire	1	0
Mashonaland East	Chikomba	2	258
	Hwedza	1	81
	Marondera	1	2148
Manicaland	Mutasa	2	306
	Nyanga	1	581

- The ESP has provided salary support for the AIDS and TB Unit, which has helped to retain key staff and attract staff to vacant posts, and has funded allowances for 186 PCs in ESP districts, which has contributed to staff retention. The MOHCW would like to rationalise secondees in the AIDS and TB Unit but it is unclear how reducing distortions will be reconciled with retaining key staff.

- National ART/OI and T&C training for health workers and training for PCs and PC supervisors was conducted in 2008 with ESP support. Good progress was made towards targets considering the difficult operating environment (see Table 3). A total of 401 health workers (84% of target) were trained in PITC, and 359 (60% of target) in ART/OI management. A total of 186 PCs (94% of target) were trained and their continued support improved service delivery of T&C services.

Table 3: Treatment and care component – Progress towards training targets

Training area	Target 2008	Achieved (April-Dec 2008)
ART/OI management	480	359
PITC	480	401
T&C for children	480	120
Rapid HIV testing	240	144
PC supervisors	32	21

- There is good coverage of T&C and PMTCT services in ESP districts – for example, all 29 health facilities in Gutu district provide T&C and the number tested increased to 7,110 in 2008 – although this is attributable to other partners not the ESP.

- In principle, MOHCW structures for coordination and supervision of CHBC in districts are in place and link CHBC programmes with clinical care. NGOs providing CHBC register with the District Medical Officer (DMO), while the community sister is responsible for supervising their activities. CBHC coordination and linkages at district level exist with health centres keeping client registers, health workers involved in training of home based carers, and CHBC caregivers referring clients identified in the community to health centres.

Key issues

- Although the overall target of 16,000 patients on ART was met, equity of access is a serious concern and there are significant disparities between ESP districts (see Table 2). Seven of the 16 districts (44%) have less than 500 patients on ART. Differences between districts in the number of patients on treatment to some extent reflect the type of facility – for example, the Marondera site and Chinhoyi hospital in Makonde are provincial hospitals and therefore have greater capacity – and how recently sites have been approved, for example, Chitsungo mission hospital in Mbire was only approved in the last quarter of 2008. But differences also reflect the number of sites, the availability of follow-up sites and the provision of outreach services.

- Continued slow progress in assessment of facilities as initiating or follow-up sites is a major constraint to scaling up treatment access. Only nine assessments were carried out between April and December 2008. Twelve of the ESP districts (75%) have no ART follow-up site and seven (44%) have only one ART initiating site. In Gutu, for example, where there are more than 1,000 patients on the waiting list for treatment, there is only one ART initiating site serving the whole district, there are no follow-up sites and no outreach services. Patients who cannot afford to pay for transport are effectively excluded from treatment.

- Assessment teams were trained in only five districts in 2008; training for the remaining 11 ESP districts is now planned for 2009. A team was re-trained as trainers at national level in 2008. Cascade training of districts was planned for 2008, but only two provinces were able to conduct trainings. It seems that the ESP has not responded to the suggestion made by the first AIR that it considers an alternative to the cascade training of trainers approach, given the human resources context and the urgent need to speed up the process of facility assessment. Even where teams have been trained, they have been unable to conduct assessments in some districts due to lack of transport. At Chivu hospital in Chikomba district, for example, a fully trained assessment team was available and had identified three potential ART initiating sites and five potential follow up sites but lacked a vehicle and fuel.

- ESP reports do not disaggregate patients on ART by age (though NARF data is disaggregated) but field visits indicate that very little progress has been made in provision of ART to children. At all the sites visited most health workers were not trained in paediatric OI/ART and paediatric formulations were not available. There is

little or no follow up of women who have received PMTCT and of HIV-exposed children. None of the districts visited are implementing the MER for PMTCT.

- Financial barriers to treatment access and adherence are also a significant issue. While ARVs, cotrimoxazole and fluconazole are free, fees are charged for consultations, investigations (such as X-rays and laboratory tests) and essential drugs for other opportunistic infections. Field visits indicate that fees charged vary from one facility to another. In addition, while some facilities only charge HIV patients an initial consultation fee, others charge a fee for every visit; some PLHIV met by the team reported that this has prevented them from collecting their ARVs and that as a result they had stopped treatment. Shortages of food, exacerbated by the NGO ban, are also reported to have resulted in PLHIV stopping treatment.

- Other factors also affected treatment scale up in 2008. These include industrial action by health workers during the last quarter of the year, which slowed down the rate of initiation of patients on ART as most facilities were only able to maintain patients already on treatment; and the cholera outbreak, which diverted health workers to cholera control activities. CD4 machines installed with ESP support are in some cases not being used due to shortages and internal migration of staff – for example, the laboratory scientist at Chivu hospital moved to Mutoku, a GF-supported district and there was no laboratory scientist at Gutu district hospital. Districts visited by the review team reported stock outs of cotrimoxazole and other essential drugs.

- The difficult economic context and WHO funds flow problems contributed to suspension of or delays in training and other planned activities. A recent official quote from WHO AFRO spokesperson, Collins Boakye-Agyemang, stated that '*One of the wrong perceptions is that WHO is an implementing agency'.*

- While laboratories in ESP districts are all registered with the Zimbabwe National Quality Assurance Programme (ZINQAP), ZINQAP annual charges and funds flow problems meant that most laboratories did not participate in proficiency testing. Planned ZINQAP training of laboratory scientists on quality assurance did not take place and no quality assurance and supportive visits to lower level laboratories were conducted in 2008.

- Delays in receiving allowances were reported to have resulted in some PC resignations. The ESP pays PCs an allowance of US$50 a month, but PCs supported by other donors such as the GF and Clinton Foundation HIV/AIDS Initiative (CHAI), receive US$100 a month. PCs, with the exception of those employed by the MOHCW, mostly in nurse aid posts, are not currently included in the national retention scheme, which prevents harmonisation of allowances. This will need to be reviewed to avoid a situation where some are employed by the MOHCW while others remain outside formal MOHCW employment – PCs are not currently recognised as a formal cadre – and do not benefit from national salaries or the retention allowance.

- Planned TB/HIV activities (included in the work plan for Year 1 not in the work plan for Year 2) have not been completed. Ward renovation remains incomplete as funds ran out and the BRTI protocol has not been taken forward because funds administration issues are unresolved.

- There has been very limited progress with implementation of planned activities to strengthen CHBC. Activities that should have been completed in 2008 – finalising and disseminating the CHBC National Strategic Plan, National Guidelines and related training materials, and training of trainers and CHBC providers – are included in the 2009 work plan.

- Delays in finalising the strategic plan, guidelines and other materials are attributed to the poor capacity of contracted consultants. The CHBC Technical Working Group has taken over and anticipates completing the work by March 2009. ZAN has identified NGOs in the 16 ESP districts, which are ready to go ahead with implementation of CHBC, but did not implement planned activities in 2008. This is attributed by different stakeholders to delays in ZAN submitting a proposal, bureaucratic procedures for getting ZAN proposals approved by the MOHCW before submission to WHO, delays in MOHCW submitting proposals to WHO, and problems with the flow of funds from WHO. A constraint is that WHO can only transfer funds to international NGOs and cannot directly fund local NGOs such as ZAN.

- The MOHCW is the designated lead for CHBC implementation, but there is no focal person for CHBC within the Ministry. The National CHBC Coordinator is based at NAC. WHO indicated that they would prefer to support a Coordinator based in the MOHCW. The CHBC Technical Working Group is chaired by the MOHCW Nursing Division, with NAC as Secretariat, but the role of the AIDS and TB Unit is unclear.

- NGOs and CBOs are the main providers of CHBC and coverage is patchy. In districts visited where different NGOs and FBOs are active in CHBC, lack of harmonisation, coordination, adherence to national standards and of role clarity vis-à-vis health workers at community level was evident.

- Approximately 1,600 HBC kits have been procured and distributed through health facilities to secondary caregivers in the 16 ESP districts. Procurement of kits was included in plans for 2007 and kits were ordered in February 2008, arrived in August, and were distributed in September and October 2008. A further batch of kits was ordered in August 2008 and arrived in February 2009. Supplies are inadequate to meet demand and there is no plan for kit replenishment.

- The ESP will fund payment of a monthly allowance of US$10 to secondary caregivers in ESP districts from January 2009. It is unclear how this will be sustained as secondary caregivers are not included in the MOHCW establishment and there has been limited progress in developing a National Volunteer Policy.

3.1.4 Procurement and logistics

The procurement component, implemented through UNICEF, in collaboration with MOHCW, NatPharm, MCAZ and WHO, aims to support the treatment and care component of the ESP, supporting treatment for a minimum of 48,000 patients in 2008, 16,000 in the 16 ESP districts and 32,000 through the national ART programme.

UNICEF's work plan for 2008 included procurement of ARVs, essential drugs, blood bags and reagents, laboratory equipment and reagents as well as HBC kits, vehicles, computers, and viral load machines to support expansion of early infant diagnosis.

Achievements

- ARVs procured in 2007 and in January 2008 were distributed to existing and new ART sites during 2008 under the supervision of the Logistics Sub-Unit. No stock outs of ARVs were reported in ESP districts visited.

- Training was conducted for 14 laboratory scientists and technicians in use of CD4, biochemistry and haematology equipment, and CD4 machines were installed in 13 of the 16 ESP districts.

- Delivery of the full complement of vehicles earmarked for the MOHCW and for NAC was completed. IT equipment for NAC and laboratory equipment for MCAZ was also delivered. The latter has assisted MCAZ to streamline the batch testing protocol thereby improving the supply of ARVs.

- During Year 2, UNICEF also procured supplies – vehicles, laboratory test kits and blood bags – in response to a request from the NBSZ and supplies for the National Medical Reference Laboratory. An emergency order for cotrimoxazole was also made to address shortages of supplies.

- UNICEF has implemented procurement for Year 2 through its regular office procurement rather than through outsourcing to UNICEF Procurement Services or UNOPS. This is expected to produce savings resulting from reduced handling costs.

Key issues

- Implementation of procurement was delayed during the first six months of 2008 due to delay in submission of certified financial statements for the first year, required to facilitate disbursement of funds. Funds for procurement to support implementation in 2008 and 2009 were only received in August 2008.

- Procurement of biochemistry and haematology analysers and TB diagnostic materials was significantly delayed since these items are not routinely procured by UNICEF and an MOU was required to outsource procurement to UNOPS. Delays were also experienced in delivery of vehicles, other equipment and commodities, due to problems with UNICEF Supplies Division and customs clearance. There has been a two-year lead time for procurement of biochemistry and haematology analysers and a one-year lead time for procurement of vehicles. It does not make sense for UNICEF to persevere in procurement of items that are non-standard for UNICEF, given the resulting delays; this could perhaps have been handled more efficiently through a pass through arrangement with another procurement agency.

- As noted in section 3.1.3, some equipment procured, for example, CD4 machines, is not being used due to shortages of key staff.

- Procurement for the NBSZ was not included in the 2009 work plan and budget, although a request was anticipated. The budget does not provide for upgrading or refurbishment of infrastructure should the need for this be identified during site assessments

3.1.5 Coordination and management

The coordination and management component, implemented through UNAIDS in partnership with NAC, is designed to strengthen the national response to HIV and AIDS, with a focus on support for the Three Ones (see section 3.2.4).

Activities in the 2008 work plan included: funding for staff positions at NAC; support for finalisation of the NAC strategy; support for evidence-based, integrated district HIV and AIDS planning; support for stakeholder meetings at provincial and district level and for training of PACs and DACs; and support for mainstreaming of MIPA and gender in all programmes in the national response.

Achievements

- NAC states its achievements as including reduced incidence and prevalence of HIV, development of the ZNASP, the national BC strategy and the NARF.

- UNAIDS secured a consultant to facilitate development of the NAC Strategic Plan July 2008-June 2011. The Strategic Plan addresses a number of issues highlighted by the first AIR, including the need to strengthen the role of NAC as a focal point for information about the national response, improve tracking of resources and introduce performance indicators and a performance management system for staff. UNAIDS is supporting NAC to conduct a National AIDS Spending Assessment. The performance management system is reported to be similar to the one used in the public sector and NAC has conducted training in results-based management for staff, although many of those trained have since left.

- During 2008, ESP continued to fund NAC staff salaries at national level and commenced payment of allowances to staff at district level. According to information provided by NAC, the ESP covered the salaries of 187 or 56% of employees in 2008. This is reported to have played an important role in retention of staff, although NAC also reports that many of the challenges it faces are due to high staff turnover, resulting in the need to repeat training on the mandate and role of NAC.

- District HIV and AIDS action plans were developed in all districts through an Integrated District Planning Process (IDPP), a management tool kit developed by NAC, and this process informed an exercise to cost the ZNASP.

- Funding was provided for all provinces and districts to hold quarterly stakeholder and coordination meetings; in some districts fewer meetings were held than planned due to the challenging environment in 2008. Quarterly coordination meetings appear to be more effective when combined, or alternated with, BC or treatment coordination meetings, reducing the need for key stakeholders to attend multiple meetings.

- NAC recruited a MIPA Officer in Year 2. Key outcomes in 2008 include the establishment of a PLHIV forum, which is comprised of organisations such as ZNNP+, ZAN, Public Personalities Against AIDS Trust and the Network of Positive Women, and a MIPA Technical Working Group (TWG), which is promoting integration of PLHIV in the planning, implementation and M&E of interventions. The TWG has improved coordination while the forum works closely with MOHCW and has been involved in GF proposal development.

- ESP funding has enabled NAC, with support from UNAIDS, to work with ZNNP+ to strengthen its governance structures in preparation for its role as a sub-recipient of GF Round 8 funds, specifically review and revision of the ZNNP+ constitution; to establish coordination structures for PLHIV organisations in three provinces; and to produce and distribute MIPA IEC materials. MIPA Officers working with BC NGOs have facilitated the establishment of support groups, although few MIPA Officers are linked to national PLHIV organisations and networks.

- NAC also recruited a Gender Officer in Year 2. Key outcomes in 2008 include establishment of a Gender and HIV TWG, which comprises representatives from line ministries (e.g. Women's Affairs, Public Service, Justice), NGOs and UN agencies (e.g. UNIFEM, UNAIDS, UNFPA, UNICEF); finalisation of the NAC Gender Policy, which provides a framework for mainstreaming gender into the national response and which has been distributed to provinces, and development of a draft gender training manual, which will be used to support training in districts in 2009. Provincial Gender Forums are planned but so far only one, in Midlands, is active.

<u>Key issues</u>

- NAC reports that district plans are available for all provinces, but did not provide examples in response to requests from the review team, making it difficult to comment on the quality of plans overall. Review of plans provided by DACs in the districts visited suggests that these are still largely a compilation of the activity plans of partners working in the district rather than a reflection of district priorities.

- The calibre of DACs appears to be variable. In some districts visited, DACs are knowledgeable about HIV activities in their district and have taken a proactive approach to coordination. In others, coordination of activities is due to the initiative of partners in the district rather than to the DAC. This reflects the challenges of staff retention and training highlighted by NAC.

- Examples of work plans and performance appraisals were provided by NAC in response to a request from the review team – these were for a sample of DACs but not for national or provincial staff. These work plans focus on process – key tasks are convening quarterly stakeholder and coordination meetings and collecting data – and lack clear objectives and deliverables. Performance appraisal does not appear to be particularly rigorous.

- NAC salary levels at national level are high relative to MOHCW salaries, but NAC believes that these are not comparable since NAC is a parastatal and its staff do not receive the same benefits as civil servants. UN rates were used to establish salary

levels. In 2008, NAC paid allowances to DACs and, as of 2009, will pay salaries. It is unclear how salary levels for DACs were arrived at.

- There has been slow progress in strengthening sub-national PLHIV structures, limiting meaningful participation of PLHIV and accountability and communication between PLHIV representatives and the broader community of PLHIV. Meaningful involvement has also been constrained by immediate problems facing PLHIV, in particular increasing poverty and lack of food. At national level, PLHIV participation in TWGs, with the exception of the CHBC TWG, is limited. ZNNP+ remains weak – it currently has no budget – and there is little evidence of PLHIV activism on issues such as access to treatment.

- The Gender Policy has some gaps. For example, strategies for prevention highlight improving the distribution, marketing and use of female condoms but do not mention strategies to increase use of male condoms, and strategies for equitable access to treatment, care and support do not address under-utilisation of services by men.

- Gender is not well integrated in ESP proposals, work plans or reports, although gender issues are addressed by the BC component. There does not appear to be any interaction between IPs and the Gender and HIV TWG, whose mandate includes technical support to mainstream gender in HIV and AIDS programmes. Efforts have been made to ensure a gender balance among BC facilitators but most are women. The same applies to CHBC caregivers, although the Gender Policy highlights the need to increase the involvement of men in care and support. Gender disaggregated data, for example, on low ART uptake by men, is not used for planning.

3.1.6 Monitoring and evaluation

The M&E component, implemented through UNAIDS in collaboration with NAC, aims to strengthen the national HIV and AIDS M&E framework. Activities in the 2008 work plan, which aimed to improve timely submission and sharing of quality data and information about progress with the national response, included: improving data quality and validation; ongoing M&E training including on use of the Country Response Information System (CRIS) for DACs and other partners in all districts; strengthening tracking of resources and commodities; logistical support; supply of equipment and stationery; and support for operational research.

Achievements

- The national M&E system was reviewed and a national M&E action plan has been developed, with support from the GF, which spells out the relationship between the NARF and other information systems including the HMIS.

- District M&E training has been conducted as planned, including training for 30 NGOs through ZAN, and districts and provinces are implementing CRIS.

- The Gender and HIV TWG developed 22 gender and HIV indicators to be included in the NARF. Ten NAC provincial M&E and 10 ZAN provincial officers were trained to

collect gender disaggregated data and they will in turn train district officers. The MIPA TWG has also made recommendations on indicators for the NARF.

- Through ESP, UNAIDS supported a research meeting, attended by government, academic, UN and civil society representatives, which identified and prioritised HIV and AIDS research issues and recommended updating the research database and improving coordination of research.

Key issues

- M&E was challenging in 2008 due to the difficulties of data collection and reporting in the political and economic environment. Health facilities visited by the team had no functioning means of communication. Limited activity resulted in little or no reporting by NGOs, schools and health facilities.

- Lack of integration of the MOHCW AIDS and TB Unit M&E system and the overall HMIS, and the interface between the NARF and the HMIS, remain key issues. Health sector data, for example on T&C, PMTCT and ART, is collected separately by the AIDS and TB Unit from data collected through the HMIS. NAC has concerns about data quality, verification and validation, and the shortage of Health Information Officers at district level is a critical constraint. The GF Round 8 proposal highlights M&E weaknesses and includes a specific component to support the HMIS, through support for Health Information Officers, computerisation and communications.

- District health staff noted that they have to submit many separate reports, for example to the AIDS and TB Unit, the Provincial Medical Director, the DAC and in some cases to partners supporting activities in the district. Separate reporting is time consuming and lack of stationery is a constraint.

3.1.7 Planning and integration of programme components

- The second year of the ESP, like the first, saw development of separate IP work plans and budgets. For example, WHO and UNFPA conducted separate district planning processes for the treatment and BC components. There is little evidence of integrated planning to ensure coherence between the different components at national or district levels. This, according to NAC, is because 'the ESP is there to fill gaps and should not been seen as a separate programme'.

- Differences in the pace of implementation of the BC, procurement and treatment and care components remain a concern. Progress reports and WG meeting minutes indicate that the BC component continues to create demand, for example for T&C and treatment services, which cannot be met by the health system.

3.2 Programme coordination and support for the national response

3.2.1 Policy consistency

- Support for the national response to HIV and AIDS is the main focus of the ESP. Activities funded by the programme are consistent with national policies and strategies, including the National HIV/AIDS Policy, ZNASP 2006-2010, National Behaviour Change Strategy 2006-2010, National HIV Testing and Counselling Strategic Plan 2008-2010 and national policies and plans on PMTCT and ART.

- The three main ESP components are consistent with three of the four ZNASP strategies: prevention; treatment and care; and coordination and management. The ESP is not supporting the fourth strategy: mitigation. The treatment and procurement components support implementation of the national ART plan. Planned CHBC training activities will support the implementation of the new national strategic plan and guidelines for CHBC. The BC component supports implementation of the national BC strategy. As noted earlier, there is no national policy or strategy for provision of services to MVP. The coordination and management component supports the Three Ones. The ESP, through financing for the national human resources retention scheme, is also supporting the objectives of the MOHCW National Health Sector Strategic Plan and Human Resources Policy.

3.2.2 Contribution to national objectives and targets

- According to the 2007 HIV estimates, there were 479,796 adults and 24,194 children urgently in need of treatment in Zimbabwe. As of December 2008, an estimated 133,863 PLHIV were on ART, leaving around 350,000 in need of treatment.

- The ESP is making an important contribution, procuring ARVs for around 48,000 patients – 17,621 in ESP districts and the difference through the national ART programme. The rest of the 133,863 are accounted for by GF Round 5, which is supporting treatment in 22 districts, USG, which provides support for 40,000, MSF, which provides treatment support for 11,000, and the private sector, which serves an estimated 10,000. The GF Round 8 proposal noted that there were 101 ART initiating sites of which 27 were in ESP districts. The ESP procurement plan for 2009 includes procurement of ARVs for 58,000 patients (26,000 in ESP districts and 32,000 through the national programme).

- The ESP has also made an important contribution to achievement of national BC targets, supporting coverage in 16 districts. National targets for the number of people reached with inter-personal communication were 1,147,998 in 2008 and 1,721,997 in 2009. The total number of people reached by BC facilitators in the 26 ESP and EC districts between April 2007 and December 2008 was 707,410.

3.2.3 Coordination with government and other donor programmes

- National coordination is generally good, although there are many forums and technical task forces (see examples in Box below) and potentially some scope for streamlining. The ESP WG is considered to be one of the more useful forums.

- National Partnership Forum (NPF)
- Country Coordinating Mechanism (CCM) (HIV, TB and malaria sub-committees)
- ESP Working Group
- Health and WASH cluster
- Health Development Partners Meeting
- National ART Partnership Forum (Procurement and Logistics, Paediatric ART sub-committees; PMTCT Partnership Forum; MER Working Group)
- Testing and Counselling Partnership Forum
- Behaviour Change Technical Support Group; Condom Programming Technical Support Group
- Steering Committee on Male Circumcision (Policy and Resource Mobilisation, Service Delivery and Training, Communications and Advocacy sub-groups)
- National M&E Advisory Group
- Laboratory Support Forum
- CHBC Technical Working Group
- Clinical Mentorship and Attachment Working Group
- Reproductive Health Commodity Security Steering Committee

- At national level, the ESP is well coordinated with government and complements other donor-funded initiatives. WG members attend GF CCM and NPF meetings and participate in other national coordination and technical forums. Coordination between the ESP and other major donors for HIV and the health sector, including the USG and the EC, is good and there is no programming duplication or geographical overlap. The ESP works well with NAC and the MOHCW. The national human resources retention scheme is harmonised and draws on pooled resources from the ESP donors, EC, UNICEF, UNFPA, and AusAid. NAC is negotiating with the GF for Round 1 and 5 resources to be pooled with the national scheme.

- However, the increasing reliance on donor resources for HIV and health will require greater engagement with national authorities. In particular, the MOHCW, beyond the AIDS and TB Unit, and funding partners, need to engage to ensure that there is effective coordination and efficient use of resources. The Human Resources Task Force which oversees the national retention scheme for health workers, chaired by the MOHCW, is a good example of effective engagement.

- The BC component of the ESP is harmonised with EC-supported BC and UNFPA is supporting the same 8 NGO partners to implement the same approach in the 16 ESP and 10 EC districts. District visits indicate that BC activities are well coordinated, through BC forums, and district visits found evidence of strengthened BC NGO operational coordination with government and NGO service providers such as PSI.

- The links between the ESP CHBC component, which focuses on training for NGOs, and proposed activities under strengthening community health systems in the GF Round 8 proposal, are less clear. The multiplicity of community volunteers, supported through vertical programmes and NGOs, need to be coordinated more effectively and their relationship with village health workers (VHWs) and links to local health facilities clarified. Sustainable and harmonised approaches to incentives for these different cadres of volunteers need to be established, and the ESP should ensure that the programme supports coordination and harmonisation.

- Work plans and budgets were revised because of the change in the ESP programming cycle from April to March to January to December. However, the ESP is now aligned with the Government of Zimbabwe annual planning, budgeting and fiscal cycle.

3.2.4 Support for the Three Ones

- Zimbabwe has a national strategic framework, the ZNASP. UNAIDS, through the ESP, is currently considering how to support NAC to take forward the planned mid-term review of the ZNASP, which was due to be completed in the last quarter of 2008, and to plan the next strategic framework. Activities in the ESP 2008 and 2009 work plans are consistent with the mandate of NAC and the priority objectives and activities in the NAC Strategic Plan. The ESP has provided important support for NAC efforts to strengthen the national M&E system.

3.2.5 Geographical coverage

- The ESP was designed to target 16 districts initially, with the potential to expand to a further 10 districts, depending on donor resources. The first AIR recommended that the ESP continue to focus on the initial 16 districts during Year 2. During Year 2, a significant proportion of ESP funding has been allocated to national efforts, for example, for procurement of ARVs, training of health workers and support for the human resource retention scheme. There is a consensus that this is the right direction – given the need to ensure equitable coverage of services in all districts – and that the ESP should shift from a focus on specific districts to national support.

3.3 Programme management and administration

3.3.1 Decision making and oversight

- The WG is responsible for ESP decision making and oversight. The ESP Management Guidelines have been revised, stating that the WG '*monitors the overall effectiveness of the programme*', and '*monitors and reviews implementation annual reports on broad activities, indicators and progress towards ESP outcomes'*. Meeting minutes show that the WG reviews individual proposals, work plans and budgets and approves allocation of funds, but the extent to which it monitors overall resource allocation and overall progress towards outcomes is less clear.

- WG meetings are open to all stakeholders and the first AIR highlighted concerns that this might compromise the ability of the WG to fulfil its decision-making and oversight role, as well as concerns about potential conflict of interest, since the WG comprises UN and government agencies that are ESP fund recipients.

- To address these concerns, a core group has been established to address management issues that it would not be appropriate to discuss in the wider WG and the Management Guidelines revised to clarify the respective roles of the wider WG and of the core group. These state that the WG '*provides a platform to share information on ESP progress and to seek ideas and views from other partners on common subjects*', while the objective of the core group is '*to attend to the management and strategic direction of the ESP*'. As currently constituted – NAC, MOHCW, ZNFPC, NatPharm, ZAN, ESP donors, UNAIDS, UNDP and one IP – the core group is not in a position to provide independent oversight.

- The wider WG has continued to meet monthly, rather than quarterly as proposed in the Management Guidelines, and separate core group meetings have not been held. Monthly meetings take up a considerable amount of WG and ESP Coordinator time. It may make more sense for the wider WG to meet quarterly, continuing as a platform for sharing information on ESP progress and related issues. This could be immediately preceded by a quarterly meeting of the core group to consider management and strategic issues and to review quarterly reports, with the core group reporting on key decisions to the wider WG.

- Meeting minutes indicate that, while the WG raises important questions about IP progress and performance, the extent to which it has been able to address under-performance has been limited. Donors have started to hold *ad hoc* meetings to discuss concerns about performance.

- The first AIR noted a lack of clarity about access to ESP funds by non-UN actors, in particular civil society organisations, and of criteria to guide WG decisions about *ad hoc* proposals that fall outside the core approved work plans of the UN partner agencies. The revised Management Guidelines state that '*Other plans addressing additional and new priorities may also be considered for funding once the initial ESP funding requirements are met, as long as these are anticipated in the ZNASP'* and provide guidelines for proposal submission and a standard proposal format, although these appear to be largely aimed at existing IPs.

3.3.2 Programme administration and support

- The ESP Operations Team initially comprised the ESP Coordinator, who is employed by UNAIDS and reports to the NAC Chief Executive Officer and to UNAIDS. In Year 2 a Finance Manager was recruited by UNDP, in response to the recommendations of the first AIR, and this has improved financial monitoring and reporting. The recommendation that a Technical Manager be recruited was not adopted. There is, however, still a need for independent scrutiny of IP proposals and costs.

- The role of the Operations Team, as set out in the revised Management Guidelines, is to ensure compliance with the guidelines, coordinate planning and budgeting,

convene and service the WG, coordinate and manage the AIR process, ensure coordination and communication with other HIV and AIDS programmes and partners, and ensure delivery of the ESP through integrated district service strengthening.

- The Operations Team has largely fulfilled its role in ensuring compliance with the guidelines, coordinating planning and budgeting processes, providing support to the WG and managing the AIR process. The effective functioning of the WG – regular meetings, efficient production of minutes and follow up of action points – is attributed to the ESP Coordinator.

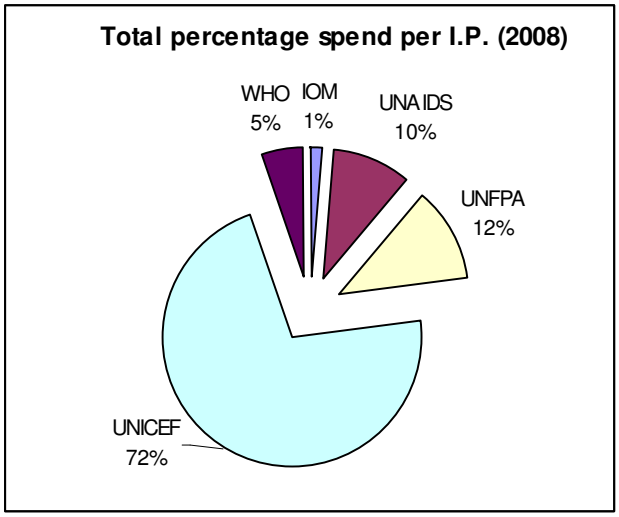
- Tasks related to ESP delivery through integrated district service strengthening (e.g. updating and costing district plans and ensuring that there is summary information on activities planned and implemented for the programme components for ESP districts; providing information on core output indicators for the ESP districts; providing technical support and supervision for implementation) have not been taken forward, since these are in the TOR for the Implementation and Evaluation Officer who has not been recruited. The review team does not consider this position necessary, since most of these tasks should be the responsibility of NAC and the IPs.

3.3.3 Budgeting, resource allocation and balance of funding

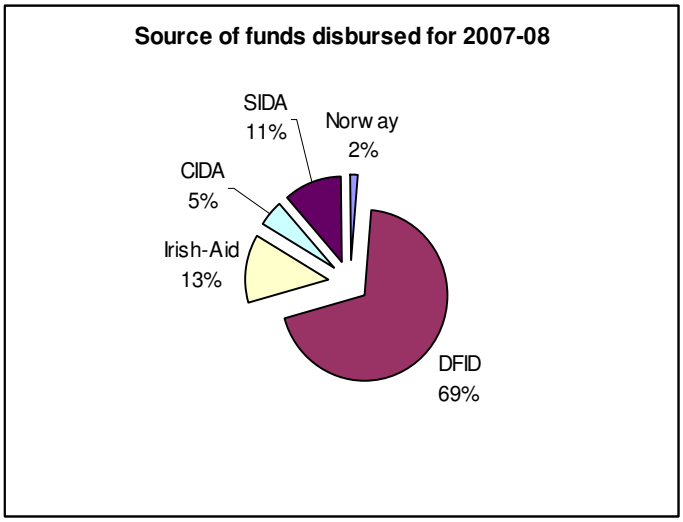
- Budgeting and resource allocations are based on annual work plans submitted by each IP and funding available from ESP donors. Additional *ad hoc* requests to fund critical gaps are considered. All funding requests are reviewed by the WG and formally approved by the co-chairs, and the process ensures a degree of transparency and accountability. There is no overall budget. Each IP submits an individual bid for resources and there does not appear to be any discussion of budgetary trade-offs between work plans prior to submitting these to the WG.

- IPs spent US$16.2 million in 2008, representing 81% of the US$19.9 million requested in the 2008 work plans. (In Year 1, IPs spent US$11.8 million against a total approved budget of US$16.1 million) Allowing for the US$2 million reserved for the retention scheme, which was carried over to 2009, 92% of the total budget for 2008 was spent. UNICEF and UNFPA had the highest levels of expenditure against budget (101% and 83% respectively), and IOM and WHO the lowest (75% and 49%).

- Budgetary allocations in Year 2, as in Year 1, were primarily driven by the treatment component (procurement, training and salary support). This is reflected in the 77% of total spend in 2008 that was accounted for by UNICEF and WHO (an increase from 67% in Year 1). Behaviour change represented 12% of total spend and coordination and M&E 10% of total spend in Year 2 (a decrease from 18% and 13% in Year 1).



- A total of US$16.6 million was transferred to the FA in 2008, a slight reduction on 2007 (US$16.8 million was provided by donors in Year 1). Funding provided by each donor – amount and the percentage of the total allocated – remained stable between 2007 and 2008. Donors have not yet committed contributions for Year 3, as they are awaiting the financial status report for 2008. The ESP lacks clear guidelines to determine what the programme will fund when faced with competing priorities and insufficient funds to meet funding requests, as appears likely in 2009.



3.3.4 Disbursement modalities and funds flow

- Disbursement and funds flow in 2008 were more or less affected by hyperinflation, depending on the IP and the currency in which disbursements were made. Disbursements by UNICEF were primarily for procurement, and effectively in US$ to international providers, so were less affected. Disbursements for UNFPA-supported activities, primarily implemented by NGOs, faced considerable challenges due to

hyperinflation but these were largely overcome. UNAIDS disbursements are mostly through NAC. Spend on US$-based salaries and allowances was less affected, while spend on other areas of activity was more substantially affected, although it is unclear whether this was due to disbursement challenges or absorptive capacity.

- The WHO system was unable to overcome the challenges of hyperinflation as it works through the MOHCW system which had greater constraints in making payments in US$. WHO is constituted as a technical rather than an implementing partner and problems associated with WHO systems have been highlighted in WHO quarterly reports and WG meeting minutes. Participants at the WG meeting held at the beginning of the AIR highlighted the bureaucratic process of getting resources deployed for programme implementation and time spent on financial administrative issues to ensure funds are received and noted that the system is too rigid for a dynamic environment like Zimbabwe. WHO and the WG need to review current arrangements to enable WHO to focus on its comparative advantage as a technical partner and to ensure more efficient flow of funds.

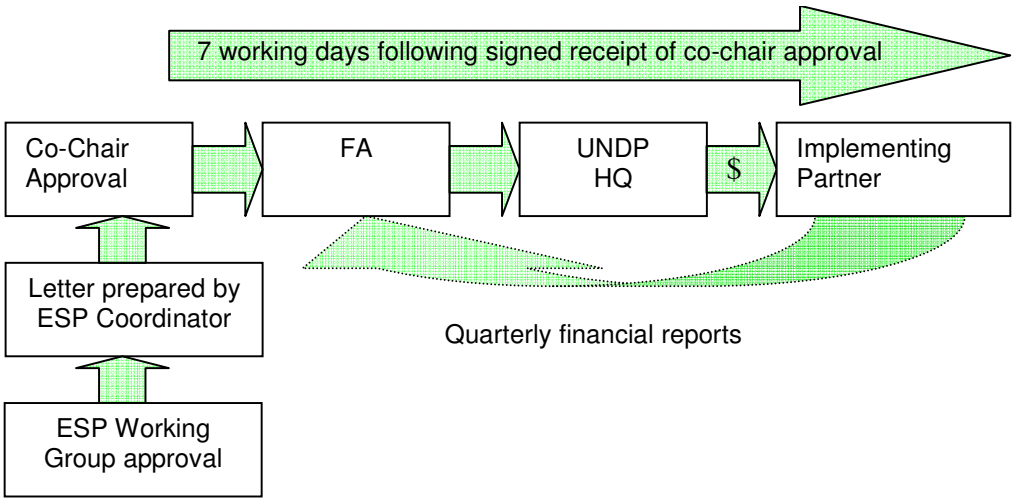
- The timing of donor disbursements and relatively large disbursements to IPs means that a substantial amount of funds are held by IPs at zero interest. Donors accept this because UN IPs are not-for-profit organisations that channel funds back into core activities. The recent UNICEF US$5 million contribution to the health retention scheme from core resources is an example of this. The addition of a for-profit IP means that timely management of resources is critical to avoid criticism that unused resources are not attracting interest. However, current close-to-zero interest rates paid on all major currencies reduce the chances of this being raised as a concern.

3.3.5 Fund administration and financial reporting

- The treasury functions of the Fund Administrator (FA), UNDP, are clearly stated in the ESP management guidelines and in the MOU between UNDP and ESP partners. Funds are disbursed by the FA to UN agencies based on a treasury plan derived from annual plans approved by the ESP WG. The WG instructs the FA on how much and when to disburse funds and to whom. The FA prepares and manages the annual treasury plan and UN agencies are responsible for accounting for funds received.

- Fund administration and financial reporting is clear and timely, although this depends on financial feedback from IPs. Improved financial reporting has helped the WG to have a clearer overview of spending. However, it has not helped with ensuring value for money (see section 3.3.6) as this is beyond the remit of the FA and IP financial reports do not include value for money analysis or information to enable this to be reviewed. No consideration has been given to audit of IPs.

Process in place to transfer funds to Implementing Partners



- Processing of payments by the FA through UNDP systems is timely, provided the authorisation letter and other relevant information is provided to the FA. The disbursement chain includes fund flow from donors to the FA, from the FA to the UN agencies and from UN agencies to implementing partners. Donor disbursements based on an agreed contribution schedule have worked efficiently. Implementing partners such as NGOs report no delays in receiving funds.

3.3.6 Aid effectiveness and cost effectiveness

- The ESP is an effective funding model. The pooled mechanism reduces transaction costs and enables the ESP to respond flexibly to emerging needs. It also works as closely with national systems as possible in the current context, including alignment with the ZNASP and other government policies and support for the health system.

- Using the UN system is an effective mechanism which generally provides value for money even when not necessarily the cheapest option. However, the ESP may need to move to a more flexible approach involving in a wider group of IPs as aid modalities evolve in Zimbabwe. In the longer term this may involve shifting towards a formal SWAp, but in the shorter term could include funding a wider pool to support the national retention scheme; similar arrangements may be appropriate for other areas of significant spend, for example, procurement of drugs, training and laboratory support. This would ensure the ESP is further in line with the Paris Declaration principles.

- There should be more focus on cost effectiveness. Areas that merit attention include:

- *Vehicles* – Various respondents noted that the Nissan Twin-Cabs procured were less reliable then other vehicles and there were clearance issues in some districts. Others were unclear why Toyota Land-Cruisers had been purchased for the MOHCW

(although these were apparently requested by some districts because of the terrain), since this is a high cost option; in addition the Land-Cruiser version selected is less optimal in terms of durability and clearance than the Hardtop version. These observations highlight the need for criteria to ensure ESP procures the most appropriate vehicles. There is also a need for a clear framework regulating vehicle registration and use, for example, establishing a pool of ESP-funded vehicles at district level so that available vehicles can be used optimally, registering which staff are permitted to use and are accountable for vehicles, and clarifying rules regarding personal use of vehicles.

- *Drugs and equipment* – As discussed earlier (see section 3.1.4), UNICEF may not be best placed to procure non-standard items; delays have been substantial and represent a cost in terms of impact. Freight costs are budgeted at 15% of cost but actual costs are usually substantially lower, at around 7%, with 'savings' reprogrammed into the ESP. Operational costs are therefore 3% for UNICEF Zimbabwe plus the 7% for freight costs, and these are close to commercially competitive overhead costs. The UNICEF HQ overhead is the main additional cost that donors need to compare with procurement via a competitive tender.

- *Training* – This is a substantial cost area of the ESP. Multiple funding sources have resulted in lack of harmonisation. There is a strong case for sector-wide negotiation and agreement of costs, with scope to reduce training costs in general. A standard sector-wide training allowance, set at an acceptable minimum level, would reduce costs and allow resources to be shifted to reward health workers for their work rather than the current situation where staff seek income through training courses. Per diem rates paid by ESP to district teams for site assessments also need to be reviewed as these appear to be higher than MOHCW rates.

3.3.7 Monitoring and progress reporting

- Progress reporting has improved since the first AIR. A consolidated ESP annual report was produced for April 2007-March 2008 by the ESP Coordinator. Since April 2008, all IPs have used a standard reporting format for quarterly reports. However, quarterly reports continue to focus on activities and there is little or no analysis of overall progress against national or work plan targets or indicators either in these reports or in the consolidated report. ESP donors highlighted concerns about lack of focus on results in reports.

- The ESP management guidelines only specify the need for the AIR and imply that the national M&E system will serve the purpose of capturing ESP programme outputs. With the exception of the BC component, which has collected baseline data for additional indicators, the ESP is expected to use the existing information system for both baseline information and data collection to track progress. However, as noted earlier, there are concerns about completeness of reporting – NARF compliance is approximately 90% for NGOs and 70% for government.

- Although the indicators in the ESP log frame are largely based on the indicators in the national M&E framework, the ESP log frame has additional indicators and

baseline and 2008 data are not available for all of these. This makes the log frame somewhat redundant and, together with the fact that the IPs do not report against it, means it is difficult to review progress against the log frame.

4. WIDER CONTEXT

This section considers the wider context within which the ESP operates, in particular how the ESP has responded to human resource constraints – the specific issue considered by the first AIR – and the impact of the socio-economic and political environment on programme implementation during 2008.

4.1 Human resources for health

The first AIR was asked specifically to consider the issue of human resources for health (HRH). Key issues identified were health worker attrition, due to the economic situation, low wages and poor working conditions, and lack of a harmonised approach by donors to addressing staff recruitment and retention. The AIR recommended that:

'*The ESP should provide strategic support for human resources for health ….. Support for human resources for health in ESP districts should follow the approach taken by the EC, which aims to strengthen the district health team. Incentives to recruit and retain additional doctors, to ensure that districts can deliver ART services, should be consistent with approaches taken in other districts.'*

In Year 2, in response to this recommendation:

- The ESP supported the MOHCW to reach agreement with all funding partners on a national harmonised retention scheme for health workers, which will support all staff registered by the Health Services Board (HSB) on the existing MOHCW establishment and health workers at Harare and Bulawayo City Health facilities. The plan is based on a draft HRH Situation Report and MOHCW HRH Stabilisation Policy and was developed by a Task Force led by the MOHCW in which ESP and other donors participated.

- Basic salaries will be paid by the government and the scheme will pay a US$ tax fee top up. Donors – ESP, EC, UNICEF, UNFPA, and GF – have agreed to pool resources to support a harmonised national approach. This will replace the previous situation where the GF, through Round 5, targeted specific cadres of health worker in 22 districts, and the EC, through the Vital Health Services Support Programme provided institutional and salary support in a further 24 districts, resulting in an internal human resources market in the health sector and low motivation of staff not covered by these retention packages.

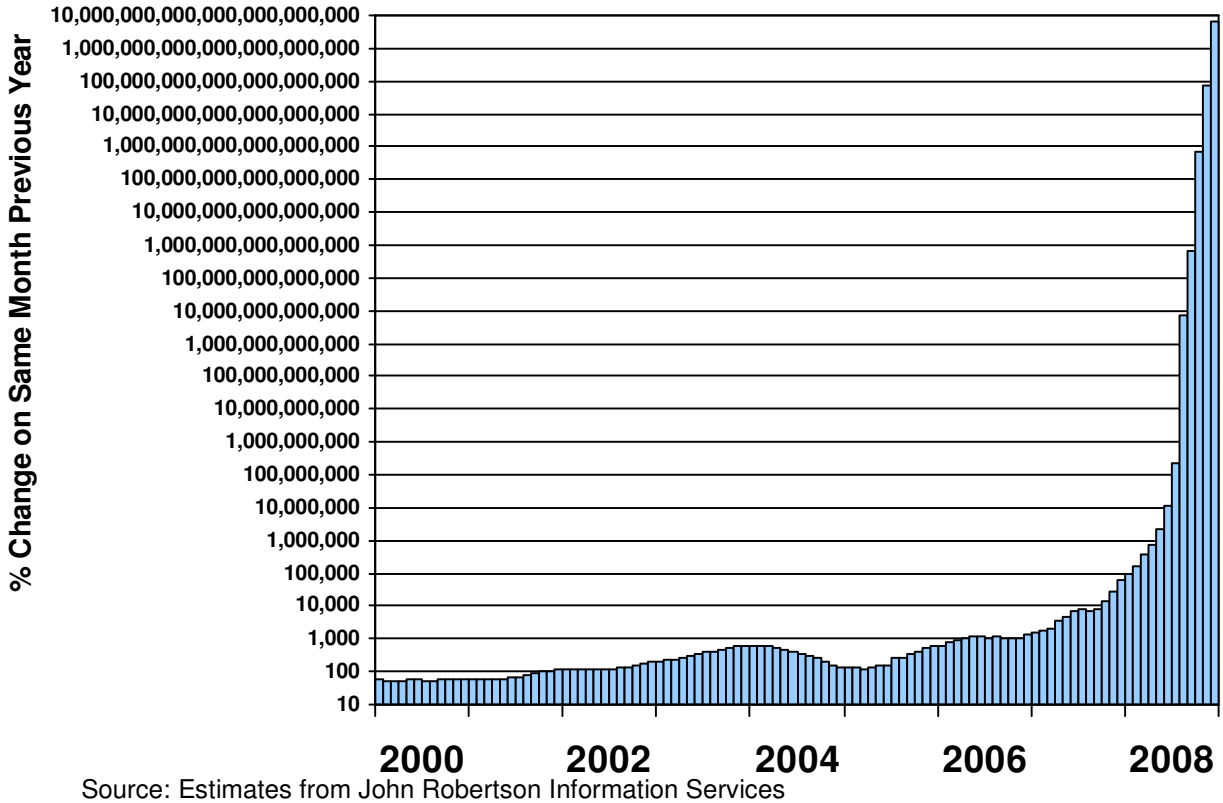
- Agreement on a national scheme was achieved through provision of technical assistance to the MOHCW, commitment of significant funding from the ESP and working with other funding partners, in particular the EC, which also supported the process. Supporting a national scheme rather than an ESP-district only approach delayed implementation of a retention allowance for health workers in ESP districts who will receive their first payment in March 2009 (for January and February), but is considered a price worth paying to achieve a national harmonised scheme. ESP and EC commitments have leveraged substantial extra funding for the scheme (an additional US$10 million from UNICEF, AusAid, UNPFA and additional amounts from DFID and CIDA) which will ensure coverage of all eligible health workers in 2009.

- It is too early to judge the impact of the national scheme on staff retention and service delivery. However, in districts visited by the team, health workers had returned to work as a result of US$ voucher payments received from GOZ, so it seems likely that regular payment of a top-up in foreign currency will contribute to staff retention. However, this will depend on communicating clearly to staff that this is a top-up only and on GOZ capacity to start paying meaningful salaries. In addition, the proposed top-up will be more modest than that provided to specific cadres of staff under GF Round 5 as the objective is to retain staff nationally at levels that can, over the medium term, be re-absorbed by Zimbabwe's national budget. There are concerns about retention of staff previously covered by the GF, doctors in particular, once the value of the top-up they receive is reduced.

4.2 Socio-economic and political environment

The economic and political situation made it extremely difficult to plan, budget and implement activities in 2008. The following (see also Annex 4 and Annex 5) challenges were identified as significant constraints to programme implementation:

- Hyperinflation, difficulties in obtaining cash and commodities, lack of transport and fuel. Annual inflation reached 89.7 sextillion percent and, by November 2008, when Z$ ceased to be used in any substantial way, prices were doubling every day (Hanke Hyperinflation Index www.cato.org/zimbabwe).



Source: Estimates from John Robertson Information Services

- Deterioration of basic health services, as the economic situation compromised the ability of the GOZ to finance core health system functioning. From around April-May 2008, health facilities effectively received no government subsidy in terms of purchasing value. Due to increasing inflation the GOZ was unable to compensate the health sector for escalating costs in Z$. Capture of GF resources by the Reserve Bank of Zimbabwe affected the flow of financing for HIV and TB – around US$7 million in the case of NAC which is the GF Round 5 Principal Recipient for HIV. The GF Round 8 proposal highlights health system weaknesses – including 50% vacancy rates, deteriorating infrastructure, lack of appropriate laboratory services, stock outs of drugs and supplies – as barriers to scale up of HIV services.

- Delays in payment of salaries, industrial action by health workers during the last quarter of the year, and the cholera outbreak, which diverted health workers to cholera control activities. The virtual closure of the health service in late 2008 meant that health workers were not available for training.

- Shortages of drugs and supplies, with procurement of essential medicines dependent on donor support. Health workers in districts visited reported shortages of essential drugs, laboratory supplies and equipment, stock outs of basic items such as gloves and stationery for prescribing and record keeping, and lack of transport and fuel. District health teams from the 16 ESP districts highlighted a range of challenges (see Box below).

What have been the main implementation challenges for the ESP?

- Lack of transport, for example for supportive supervision, outreach or to get to training venues.
- Funds flow to allow implementation of planned activities and reimbursement of allowances and travel costs.
- Erratic supplies of some drugs, old or poorly maintained equipment, shortages of stationery
- Staff attrition.
- Inability to provide paediatric treatment and MER due to lack of training and appropriate formulations and drugs.

- Increasing poverty exacerbating difficulties in accessing services, especially for those without access to hard currency. Inability to afford the cost of travel to health facilities, fees for consultations and other costs are significant barriers to uptake.

- Illegal but widespread use of US$ for purchases in Q3 and Q4. This was a constraint for UN agencies and NGOs in terms of ability to obtain value for money, though some were more adaptable that others in ensuring effectiveness. While official dollarisation has helped to stabilise the situation, it has created its own challenges including the high US dollar prices of goods and services.

- Political instability and violence prior to and following elections in March and June 2008 and the restrictions and subsequent ban on NGO field operations between April and September 2008, which resulted in the cessation of most activities at district and community level.

The extent to which the ESP has responded to these challenges is discussed below:

- At a policy and resource allocation level, the flexibility of the ESP has enabled it to adapt to changing needs in a complex economic and political environment. The WG and the partnership with UN agencies have facilitated the effectiveness of the ESP as an aid instrument in this context. Implementation through the UN has helped to manage risk, in terms of aid effectiveness, and political concerns, including those of donor governments. It has also had other benefits, including leverage with the GOZ, which allowed the UN to be the first to be approved to make legal payment in US$ for local products and services in late 2008.

- All IPs aside from UNICEF, which procured in US$, were affected to different degrees by hyperinflation. Although they were using the UN rate, this was not changed often enough to keep up with inflation. However, IPs mostly adapted to deal with the difficult operating environment, finding ways to continue some activities or postpone plans.

- Capacity to adapt depended to some extent on IP internal systems and procedures. For example, UNFPA has paid NGO staff salaries in US$ since 2007 and adjusted its approach to training, for example using community structures and local procurement of food items rather than relying on formal training venues. The involvement of local community leadership from the start is reported to have mitigated the impact of the NGO ban to some extent, allowing BC NGO partners to continue with their work. BC facilitators were asked to come and collect their allowances individually, as meetings were banned. WHO found it more difficult to adapt, because of its systems, and had a slower implementation rate because of problems related to transactions in Z$ prior to dollarisation.

- In the context of hyperinflation, some spend resulted in high costs in US$, and in some cases it would have been better to put spend on hold. In these cases, responsibility for balancing 'reasonable costs' against delivery of targets was unclear, although these practical challenges were discussed at the ESP WG.

- IPs have accelerated activities as the economic and political situation has started to improve. For example, BC NGOs rapidly increased activities following the lifting of the NGO ban, and increased numbers of health workers have been trained in the first quarter of 2009 as payments can now be made for training facilities in US$.

5. RECOMMENDATIONS

Future direction

The future direction of the ESP needs to take account of the wider context, in particular assumptions about continued funding for aspects of the national response and the need to revitalise the health sector. Achievement of universal access depends on effective prevention programmes and on a functioning health system, in particular addressing the deterioration in basic health services and the shortage of human resources for health.

The ESP is primarily a funding mechanism rather than a programme with an overall plan and budget and an increasing proportion of its budget is allocated to the health sector response to HIV and to national support. There is a general consensus that the ESP should continue, focusing on providing critical support to the health system and shifting from a district to a national approach.

GF Round 8 promises more substantial funding for five years, for national scale up of BC, ART and CHBC. Round 8 will cover 70% of the estimated cost of the retention scheme during the first two years, reducing to 60% in the subsequent three years, and assumes ongoing support from ESP and other donors for the remainder. GF Round 8 also assumes continued ESP and EC for BC in the current 26 districts and from ESP and other donors for treatment of 116,500 adults. Other donor funding for Zimbabwe is uncertain at present and will depend on political and economic progress made under the Government of National Unity.

Recommendations

I. Take immediate steps to complete planned activities and consolidate in 2009.

Specifically:

<u>Behaviour change</u>

- UNFPA should review the effectiveness of the BC approach and implement plans to document impact.
- UNFPA should develop a less resource-intensive approach, including good practices developed by partner NGOs, to sustaining activities in current ESP districts beyond 2009.
- The WG core group should review the role of IOM in coordination and implementation of services targeting MVPs once a national strategy is developed.

<u>Treatment and care</u>

- The WG core group should re-define WHO's role as an ESP technical partner and identify an alternative financial management partner to address funds flow problems.
- WHO and MOHCW should establish targets for and accelerate site assessment, focusing on under-performing ESP districts and approval of follow-up sites.
- WHO and MOHCW should ensure all initiating sites have transport to enable them to provide outreach services and support to follow-up sites. This should include coordinated use of BC and DAC vehicles as well as transport provided to the district hospital.

- The WG should engage with MOHCW to ensure user fee harmonisation is properly communicated and with MOHCW and the vital medicines fund to ensure free provision of OI drugs.
- WHO and MOHCW should step up paediatric treatment training.
- WHO and MOHCW should review the training and procurement implications of accelerating provision of MER, HAART for positive women, and follow up of exposed infants.
- WHO and MOHCW should phase out allowances for PCs in nurse aid posts and plan for phase out payment of allowances for remaining primary care counsellors who are not formally employed when GF Round 8 support for allowances commences.
- MOHCW should identify a CHBC Focal Person to enhance linkages between CHBC and clinical care.
- WHO and MOHCW should develop a replenishment plan for HBC kits and ensure both secondary and primary care givers have access to materials appropriate to their needs.

Procurement

- UNICEF and the WG core group should consider a pass through arrangement to expedite procurement of specific items or services or for value for money reasons.
- UNICEF should deliver and install biochemistry and haematology equipment, outstanding vehicles, and X-ray processor for City of Harare.

Coordination, management and M&E

- The WG core group should plan for phase out of salary support to NAC as and when AIDS levy income increases and GF Round 8 support commences.
- UNAIDS and NAC should strengthen and ensure implementation of NAC performance management system.
- NAC should revise DAC job descriptions to incorporate deliverables including proactive coordination between partners and capacity building for district planning and budgeting based on district priorities.
- UNAIDS and WHO should harmonise ESP support for NAC M&E with GF Round 8 support for integrating MOHCW M&E and strengthening HMIS.
- NAC and UNAIDS should strengthen provincial and district PLHIV structures.
- NAC and IPs should strengthen gender mainstreaming.

Programme management and administration

- The WG and ESP Coordinator should identify a national technical consultant team (comprised of a panel of two or three experts who are non-recipients of ESP funds) to provide independent scrutiny of annual work plans and budgets and of quarterly reports, reporting to the WG. The WG should determine the TOR for and select the panel and could establish a call down contract through UNDP. Consideration could also be given to using technical capacity available from non-recipients of ESP funding within the WG.
- The WG core group and technical consultant team should review work plans and budgets, including value for money, and likely commitment of funds for 2009 and identify priorities for funding within available resource envelope.
- The WG core group should ensure IPs continue to report on a quarterly basis but include reporting of progress against national and work plan targets and analysis of qualitative as well as quantitative changes and results.

- The WG should consider holding quarterly rather than monthly WG meetings and quarterly core group meetings.
- The ESP Coordinator should revise the Management Guidelines to include donor group meetings and the role of the technical consultant panel. The Management Guidelines should also be revised to include guidelines on operational relationships with organisations such as NatPharm, since currently all payments are made on the basis of a 'verbal agreement'.
- The WG core group should stop recruitment of the ESP Implementation and Evaluation Officer.
- The WG core group should work with the Global Fund to tender for management of pooled resources for the retention scheme from 2010.
- The WG core group should plan for next phase of the ESP by end of third quarter of 2009.

II. Continue the ESP for a further two years to the end of the current ZNASP but as a more focused programme of support.

Specifically:

- The WG core group should consider changing the ESP to the ESF – Expanded Support Fund – focusing on flexible funding to fill gaps and to support scale up through appropriate IPs, if this does not have major implications for the MOU.

- The WG core group should consider the following direction for the ESP:

    - Shift from support to specific districts to national support, complementing GF Round 8 and other donor funding, and taking a pooled approach wherever possible.
    - Focus on support for critical health sector functions required to deliver HIV services, for example, human resources for health, through the retention scheme and training, procurement of ARVs and other essential HIV commodities and equipment, NBSZ and MCAZ.
    - Continue support to sustain BC activities in ESP districts until end 2011 and consideration of other ESP support for prevention, for example, for MVPs, in the context of overall funding for HIV prevention in Zimbabwe.
    - Phase out support for coordination, management and M&E through NAC as and when AIDS levy income increases and GF Round 8 support commences.
    - Decide whether the ESP needs to continue financing for CHBC activities, given the resources allocated to CHBC under Global Fund Round 8.

- The WG core group should plan for integration of future ESP reviews into Joint Annual Reviews of the ZNASP.

ANNEX 1 TERMS OF REFERENCE

1. Background

The Expanded Support Programme is a three year programme with a provision for external review at the end of each year. This programme is funded by the pooled resources in the Common Fund meant to scale up the activities which are being carried out in the country to fight HIV and AIDS in Zimbabwe. The donors who have been contributing to the Common Fund are: DFID, CIDA, SIDA, Norway and Irish Aid**.** These five partners have committed over US$ 50 million over a period of three years.

The main purpose of the ESP is to enable multiple bilateral donors to support the national HIV/AIDS response in Zimbabwe with the assistance of a range of implementing agencies. The ESP will facilitate a significant increase in the flow of funds to complement existing resources in financing gaps towards the attainment of the following goals of the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP):

- *Reduced transmission of HIV*
- *Reduced impact and improved quality of life of those infected and affected by HIV and AIDS*
- *Strengthened coordination of the HIV and AIDS Response at all levels*

This is being implemented through:

- Provision of ART as part of comprehensive HIV and AIDS services to a substantial number of adults and children in initial districts, including procurement of essential commodities and support to community home based care;
- Implementation of an effective behaviour change strategy in each district;
- Improved coordination between implementers and lead UN agencies, partners, and donors and monitoring and evaluation.
- PMTCT

The implementing partners are the UN agencies working with national authorities and non-state actors.

The Annual Independent Review (AIR) is a management instrument, designed for NAC, the bilateral partners, implementing partners and members of the ESP Working Group to monitor progress in the implementation of the annual plans and to verify that management; policy and programming responsibilities are met. Its provisions are set out in the ESP documents. Over time, the AIR should also be a mechanism for monitoring impact of the programme and its relationship to other major HIV and AIDS programmes in the country.

The AIR focuses on reviewing the achievements of ESP programmes on the ground as well as any other priority area that may be selected jointly by the Working Group. As a contribution to the implementation of the Paris Declaration the AIR replaces any individual donor review missions that might be required for monitoring the ESP funds.

Year I of the Programme was reviewed in January 2008 and the report of the review is attached to the terms of reference.

The ESP Working Group, being the decision making body of the ESP, has commissioned the AIR and will select 2-3 of its own members (but at least one) to accompany the external review team. The ESP Coordinator will oversee the logistics of the review and will take primary responsibility for arranging the AIR ensuring the following areas are covered:

- Facilitate the review planning and implementation process;
- Finalise the TOR for the AIR and the individual TOR for consultants;
- Facilitate the recruitment process of the review team;
- Facilitate the field visits;
- Support the organisation of interviews with key informants; and
- Support the review team in other ways both before and during the review.

2. Purpose

The purpose of the AIR is to obtain a comprehensive view on how ESP is doing against set targets looking at:

- The extent that the ESP has contributed to the implementation of HIV and AIDS policy in Zimbabwe as the programme is meant to be implemented within national guidelines and policies.
- The extent that ESP implementation has contributed towards the realisation of the sector objectives and targets as foreseen in the ESP document.
- The extent to which monitoring and evaluation issues have developed with the support of the ESP recommendations on how this can further be improved on.
- The challenges and constraints in implementation of the ESP and realising set objectives and targets. This is the second year of implementation and the review is meant to identify and document the challenges as a way to ensure smoother implementation and also to provide a platform for decisions for the funding partners for another phase of ESP.
- The extent to which the recommendations of year I AIR were implemented and the extent to which these have improved the delivery of the programme

3. Specific objectives

In the course of evaluating the progress made by the ESP, the team will be asked to comment on the following areas:

Policy consistency:

- Comment on the role of the ESP in supporting national HIV and AIDS policies and strategies as expressed through the ZNASP, the ARV roll out plan, care and support, the National Behaviour Change Strategy and other strategies as appropriate.
- Note whether there are any pros or cons of the geographical coverage of ESP expressed by stakeholders and what these are and the new thrust of delinking ART commodities procurement from districts.
- State the role of the ESP in supporting the achievement of the Three Ones.

Planning and budgeting:

- Assess the current status of the ESP measured against its objectives as laid out in the ESP document programme document, the individual approved plans and budgets.
- Assess the balance between the funding of treatment and prevention activities and how this can best relate to the spread of the resources in the Common Fund.
- Comment on whether the ESP programmes are, or are likely to contribute to, strengthening equity, improving access, improving quality and whether the instruments to ensure that that these are inbuilt in the programmes are there.

Aid effectiveness:

- Assess the extent to which the ESP coordinates with and is complimentary to other HIV and AIDS programmes (GF, EC, USAID) and how has this influenced the impact on the ground of the different support channels.
- Taking into account the overall country operating environment for HIV and AIDS programmes, comment on how ESP adjusted to the rapidly deteriorating socio-economic and political situation and make recommendations on how best it can deal with this in future and also comment on the structure of ESP and how its structure allows for flexibility in a changing environment.
- Assess ESP coordination and the role of the Working Group, providing recommendations for improving and strengthening coordination and management in light of broadening harmonisation.

Administration, management and coordination:

- Assess the coordination of ESP at district level and also coordination activities in general at national and district level.
- Review the robustness of fund administration and disbursement systems and modalities at the fund administrator level, implementing partner and sub grantee level specifically on how efficiently funds are moved to outputs.
- Assess the robustness of the procurement and logistics system for the ESP including the relationship with national authorities. Are commodities and equipment getting to users?
- Assess the capacity of the health delivery service in the country taking into consideration the model of implementation of ESP.

The critical assessments should be followed with recommendations to be considered in the third year of implementation of the programme. Recommendations should be limited to implementable, measurable suggestions that derive directly from the review. Bearing in mind that too many recommendations will dilute capacity to implement**,** the team should suggest a carefully selected prioritised set of recommendations that will have clear impact on the programme.

Some of the indicators for ESP are available in the ESP log frame, which will be made available to the consultants. Each work plan has process indicators, which are available on each work plan.

Specific theme for 2008/9

Each year, the AIR team will be asked to look at a specific thematic area for closer analysis. This year, the ESP WG requests the AIR to look critically at the *Effect of the socio-economic and political environment on the implementation of the programme.*

4. Process and methodology

The AIR will be carried out at the end of each financing cycle and in the first quarter of the programming cycle in order to verify results and review performance and achievement for the 12 months prior. The AIR will also address any specific questions posed by the Working Group and will make recommendations for the coming year.

The AIR will be conducted by a review team made up of independent consultants and delegated members of the ESP Working Group (WG). The team will be made up of up to six members of which four should be independent external consultants one of whom will be the Team Leader. Each of the consultants will have specific tasks to fulfil and this will be detailed in TOR for individual consultants. The core ESP WG will ensure that they will be available to act as the reference group to support the AIR team. This group will be available to provide support and guidance as necessary to the team and will also monitor and validate the review process and ensure that the team is able to complete the assignment.

Desk review
The team will consult all available documentation in preparation for the review, including reports by implementing partners.

Participatory review
The starting point for contact in country could be a preliminary meeting with the ESP WG in which further understanding of TOR can be given and the AIR Team should consider adopting a participatory element into the review process during this meeting. One way to do this would be for the team to facilitate a self-assessment exercise for the ESP WG to assess its operational and technical strengths and challenges. The self assessment results could be used to as a baseline against which to assess the implications of the overall review findings and recommendations.

District visits
The review team will choose at least two districts to inspect the ESP sites and observe progress. The districts and the sites to be visited should be agreed with the team at the outset of the mission.

Interviews with key informants
The team will conduct a range of interviews with key informants and stakeholders (including implementing partners and their national counterparts), and will visit and interview the National AIDS Council, the Ministry of Health and Child Welfare (policy, technical and managerial levels), NatPharm, the district and provincial authorities in the selected districts and at least one health service facility in the Harare vicinity for comparator issues on resource consumption. Other partners and civil society in the 16 districts should also be included as key informants.

5. Deliverables

The review team will produce the following deliverables:

1. Before the team starts its work it has to produce a technical offer in which they present their understanding of the work to be done and how they intend to do it

2. An initial consultation with the full ESP working group summary.
3. A report showing preliminary findings to be delivered at the end of the three week data collection period to the Working Group.
4. A final report with an executive summary showing clearly identified and prioritised recommendations to be delivered within two weeks of the conclusion of the data collection period. This should be provided in both electronic and hard copies.

6. Timeframe

The AIR team will work in country over three weeks and will produce a preliminary report at the end of that three week period. The final report will be due in two weeks thereafter.

7. Reporting

The Team Leader of the review team will work under the guidance of the ESP Co-Chairs. The review team will report to the ESP Working Group through the Co-Chairs.

8. Review team

The review team should contain skills and expertise in the following areas:

- Evaluation and review
- Public health service delivery
- Health information systems management/ Monitoring and evaluation systems
- Financial management
- Human resources
- Macroeconomics
- Social development (political situations, equity, gender and human rights)
- Institutional strengthening, systems and logistics support, pharmaceutical services support.

The ESP Core Team will select the team of consultants and suggestions for possible candidates will be sought from the bigger ESP WG.

ANNEX 2 PEOPLE CONSULTED

National

MOHCW

Dr O Mugurungi, Director, AIDS and TB Unit

Dr Tsitsi Apollo, Coordinator, AIDS and TB Unit

Mr B Dupwa, Treatment and Care, AIDS and TB Unit

Mr S Mashumba, PMTCT/M&E, AIDS and TB Unit

Dr Mpeta, Assistant ART Coordinator, AIDS and TB Unit

Mr D Mangwanya, Director, Laboratory Services

Mr J Whande, Deputy Director, Laboratory Services

Mr O Chitsatso, Chief Medical Laboratory Scientist, NMRL

Mr B Murwira, Acting Chief, National TB Reference Laboratory

Mr A Kadye, Laboratory Scientist, National TB Reference Laboratory

Mr A Mtambara, Laboratory Logistician

Mr Rangarirai Chiteure, GF CCM Coordinator

Dr Jane Mudyara, Human Resources Director

Mr Joshua Katiyo, Acting Coordinator, Health Information and Disease Surveillance

Mr Zamile Musekiwa, Finance and Administration Manager, NBSZ

City of Harare

Dr P Chonzi, Director, Health Services

Dr Clemence Duri, Deputy Director, Health Services (and TB Programme)

Mr Richard Chigerwe, Assistant Director, Administration, Health Services

MCAZ

Ms Gugu Mahlangu, Technical Director

Ms Chipo Kuleya, Assistant Director, Laboratory

Ms Bridget Dube, Senior Analyst

NatPharm

Mr Charles Mwaramba, Operations Director

Ms Caroline Mashingaidze, Supervisor, Logistics Sub-Unit

Mr Richard Sabumba, Logistics Officer, Logistics Sub Unit

NAC

Dr T Magure, Chief Executive Officer (and Co-Chair, ESP Working Group)

Mr R Yekeke, Operations Director

Mr A Manerji, Finance Director

Ms , Human Resources Director

Mrs M Dube, Communications Director

Mr E Nyamutswa, Audit Director

Mr Amon Mpofu, M&E Director

Mr Silibele Mpofu, MIPA Officer

Mr Oscar Mundida, BC Coordinator

Ms Caroline Siweru, CHBC Coordinator

Ms Vimbai Mdege, Gender Coordinator

ESP Implementing Partners

Dr Kwame Ampomah, UNAIDS Country Coordinator, UNAIDS

Mr Emmanuel Baingana, M&E Adviser, UNAIDS

Prof Francis Onyango, Medical Officer, WHO

Dr Christine Chakanyuka, NPO, WHO

Dr Clemens Benedikt, HIV Prevention Programme Manager, UNFPA

Mr Samson Chidiya, NPO, HIV Prevention Key Affected Populations, UNFPA

Mr Sunday Manyenya, Planning, Monitoring and Evaluation Officer, UNFPA

Mrs Priscilla Mujuru, NPO, HIV Prevention Behaviour Change, UNFPA

Dr Tete, Migration Adviser, IOM

Ms Joyce Severegi, IOM

Dr Alex Zinanga, UNDP

Mr Lare Sisay, Deputy Resident Representative, UNDP

Ms Judith Sherman, Chief, HIV/AIDS Section, UNICEF

Chengetanai Mangoro, Project Officer, UNICEF

Dr Colleta Kibassa, Chief, Youth and Child Survival Department, UNICEF

Ms Coumba Toure Kane, Consultant, UNICEF

Mr Thomas Wushe, Managing Director, Crown Agents

Ms Muchaneta Mwonzora, Team Leader, Health Supply Chain Services, Crown Agents

Ms Lindiwe Chaza-Jangire, Director, ZAN

Ms Judith Chitando, CHBC Coordinator, ZAN

ESP Donors

Dr Allison Beattie, Health Advisor, DFID

Ms Rachel Yates, Social Development Advisor, DFID

Mr Goran Engstrand, Country Director, SIDA

Mr Julius Musevenzi, Programme Officer, SIDA

Ms Sonja McLeod, Advisor, Royal Norwegian Embassy

Mr Tendayi Kureya, Consultant, Irish Aid

Ms Marie Nyiramana, Head of Aid, CIDA (and Co-Chair, ESP Working Group)

Mr Lovemore Tinarwo, Senior Development Officer, CIDA

Other Donor Agencies

Mr Peter Halpert, HIV/AIDS Team Leader, USAID

Ms Ruth Walkup, CDC

Dr Mungai Lenneiye, Acting Country Manager/Senior Social Protection Specialist, World Bank

Mr Paolo Barduagni, Health and HIV and AIDS Adviser, Social Sectors, EC

Mr Alexio Mangwiro, Country Manager, Clinton HIV/AIDS Foundation

ESP Operations Team

Mrs Patricia Darikwa, ESP Coordinator

Ms Albertina Chingono, ESP Finance Manager

Other

Mr Dave Alt, Chief of Party, SCMS, JSI DELIVER

Sipho Mahlangu, Acting National Coordinator, ZNNP+

Tendai Mhaka, Programme Officer, ZNNP+

Tonderai Chiduku, Acting Advocacy Officer, ZNNP+

District

Chikomba

Mrs A Chiwanza, District Nursing Officer, Chivhu General Hospital

Mrs Z Matthews, Sister in Charge OPD, OI/ART Focal Person, Chivhu General Hospital

Dr R Paradza, GMO, Chivhu General Hospital

Dr I Kundiona, GMO, Chivhu General Hospital

Mrs P Mutubuki, Matron, Chivhu General Hospital

Mr C Pfomae, Pharm Tech, Chivhu General Hospital

Mrs J Mutsvairi, District health Services Administrator, Chivhu General Hospital

Mrs T Muketowa, Acting Sister in Charge, Chivhu General Hospital

Mrs L Ncube, Community Health Nurse, Chivhu General Hospital

Mr C Matarutse, District Health Information Officer, Chivhu General Hospital

Mr T Katho Katiyo, District Environmental Health Officer, Chivhu General Hospital

Mr W Dube, Provincial AIDS Coordinator, Mashonaland East

Mr C Mapfumo, District AIDS Coordinator

Mr Walter Chikanya, Provincial Manager, Zichire

Mr Caleb Chibindi, District BC Programme Officer, Zichire

BC Faciliators

Chivi

Dr Tapiwa Murambi, District Medical Officer, Chivi Hospital

Mrs J Tasara, District Nursing Officer, Chivi Hospital

Mrs O Gandawa, Matron, Chivi Hospital

Mr A Muchena, Lab Scientist, Chivi Hospital

S Rakatsinziwa, Pharm Tech, Chivi Hospital

T Tivafukidze, District Environmental Health Officer, Chivi Hospital

L Beta, Environmental Health Officer, Chivi Hospital

I Mututuvari, Nutritionist, Chivi Hospital

H Chigariro, Health Promotion Officer, Chivi Hospital

N Hamutyinei, Acting Accountant, Chivi Hospital

Mr Evos Makondi, Provincial AIDS Coordinator, Masvingo

Gutu

Mrs F Mavedzenge, District Nursing Officer

Mr P Mukuwe, District Health Education Officer

Dr T Mhonde, GMO, Gutu Mission Hospital

Mrs B Ziki, Sister in Charge, OI/ART Focal Person, Gutu Mission Hospital

Mrs Irene Sengwe, Sister, Gutu Mission Hospital

Mrs E Nudzamba, Matron, Gutu Mission Hospital

Mrs L Makanyire, District AIDS Coordinator

Ms Moleen Pindeni, District Manager, Regai Dzive Shiri

Ms Rutendo Samatanga, MIPA Officer, Regai Dzive Shiri

Mr Mathias Basera, BC Support Officer, Regai Dzive Shiri

Ms Marjorie Gwete, BC Support Officer, Regai Dzive Shiri

Ms Elisabeth Makanyire, student on attachment, Regai Dzive Shiri

Mrs Rumbidzai Muwani, BC Facilitator

Mrs Hedwick Makumbe, BC Facilitator

Mrs Shamiso Mudiywa, PLHIV Support Group

Mr Ephraim Mutasa Kwaedza, PLHIV Men's Support Group

Matobo

M Chandawila, OI/ART Focal Person, Matobo District Hospital

S Ndlovu, STI/HIV Focal Person Tshelanyemba Hospital

C Matonsi, A/DNO, ESP District Coordinator, Matobo District Hospital

DMO, GMOs and District Community Nurse, Matobo District Hospital

World Vision

BC Facilitators; traditional leaders; patients at Maphisa Hospital

Shurugwi

D Chimuchembere, DMO, Shurugwi District Hospital

M Mano, A/DNO, Shurugwi District Hospital

A Choguya, OI/ART Focal Person, Shurugwi District Hospital

Nurses and Environmental Health Officer, rural district hospital

Mr Mapurisa, BC District Programme Officer, MASO

Mr Rubaya, PAC, Midlands

Z Grant, NAC Provincial M&E Officer, Midlands

Ms Mariyo ZAN Provincial Officer, Midlands

Shurugwi Town support group; community leaders; BC Facilitators

SWAPA

Umguza

Mr Dingaan Ncube, PAC, Matabeleland North

Mrs Sara Hove, DAC

Nurses and ART patients, Nyamandlovu District Hospital

S Moyo and S Dube, nurses, Ntabazinduna Rural Clinic,

Ward 4 Councillor, CBD, religious leaders, PLHIV, traditional healer, WAAC women affairs and youth representatives

ANNEX 3 DOCUMENTS REVIEWED

National policies, plans and reports

Central Statistical Office and Macro International Inc. Zimbabwe Demographic and Health Survey 2005-2006. October 2007.

GOZ. PMTCT and paediatric HIV prevention, treatment and care national plan 2006-2010. MOHCW, December 2006.

GOZ. HIV and AIDS care. Plan for the nationwide provision of antiretroviral therapy 2005-2007. MOHCW, December 2004.

GOZ. National HIV/AIDS policy. 1999.

MOHCW. Emergency short term human resource retention policy: Harmonised and nationwide approach in collaboration with all funding partners. December 2008

MOHCW. Review of the national HIV and AIDS treatment and care programme 2004-2007. May 2008

MOHCW et al. Draft guidelines on community and home based care.

MOHCW and WHO. Zimbabwe national guidelines on HIV testing and counselling. October 2005.

MOHCW et al. National community home based care standards. 2004.

NAC. Zimbabwe HIV and AIDS district atlas. December 2006.

NAC. Zimbabwe national behavioural change strategy for prevention of sexual transmission of HIV 2006-2010.

NAC and UNFPA. Comprehensive review of behavioural change as a means of preventing sexual HIV transmission in Zimbabwe. 2006.

NAC, MOHCW and UNAIDS. Zimbabwe national HIV and AIDS strategic plan 2006-2010.

NAC, Strategic Plan July 2008-June 2011.

Zimbabwe Vulnerability Assessment Committee. Urban food security assessment. January 2009 national report.

ESP documents

<u>Management</u>

Management guidelines in respect of the common fund for the ESP in support of the Zimbabwe national HIV and AIDS response. Revised July 2008

Management guidelines in respect of the common fund for the ESP in support of the Zimbabwe national HIV and AIDS response. November 2006.

MOU between implementing partners and UNDP as the fund administrator regarding the ESP. 28 November 2006.

MOU/JFA among the funding partners, NAC and UNDP as the fund administrator for support to the common fund for the ESP in Zimbabwe.

Letter of intent among the funding partners, NAC and UNDP as the fund administrator and the implementing partners linked to the common fund for the ESP in Zimbabwe. 17 November 2006.

Minutes of ESP funding partners meeting, 28 January 2009.

Proposals

IOM. Scaling up HIV and AIDS services for migrant/mobile and vulnerable populations in Zimbabwe. .

WHO and MOHCW. HIV/AIDS treatment and care: ESP proposal for year 3.

MOHCW, NAC, CIDA, SIDA and DFID. Expanded Support Programme to scale up access to HIV and AIDS prevention, treatment and care in Zimbabwe. May 2006.

MOHCW and WHO. Proposal for strengthening the community based component of HIV and AIDS treatment, care and support in Zimbabwe with support from the ESP. 2007

GF Round 8 proposal (HIV, HSS components).

Work plans

UNAIDS, NAC annual plan 2009.

UNFPA, HIV prevention behaviour change work plan 2009.

UNICEF, Procurement work plan 2009.

WHO, Treatment and care (excluding procurement) work plan 2009.

IOM. Improved access to HIV prevention services by migrant/mobile and vulnerable populations work plan 2008.

UNAIDS. Management and coordination work plan July-December 2008.

UNAIDS. Monitoring and evaluation work plan 2008.

UNFPA and NAC. HIV prevention behaviour change work plan 2008.

UNICEF. Procurement work plan April 2008-March 2009.

WHO. Treatment and care (excluding procurement) work plan April-December 2008.

Midlands AIDS Service Organisation. First Quarter Work Plan January-March 2008

Reports

ESP annual report April 2007-March 2008.

IOM, mobile and vulnerable populations quarterly report: July-September 2008.

UNAIDS, management and coordination (including M&E) quarterly reports: April-June 2008; July-September 2008; October-December 2008.

UNFPA, HIV prevention behaviour change quarterly reports: April-June 2008; July-September 2008; October-December 2008.

UNICEF, procurement quarterly reports: April-June 2008; July-September 2008; October-December 2008.

WHO, treatment and care quarterly reports: July-September 2008; October-December 2008.

NAC, ESP AIR I, February 2008.

NAC, Evidence based district HIV and AIDS management toolkit, November 2007.

Report on the national behaviour change strategy baseline survey. February 2009

Concept paper for proposed research around collecting baseline data for the ESP and EC supported components of the national behaviour change strategy for NAC and UNFPA

New Dimension Consulting. Rapid assessments of 31 districts in preparation for the development of district behavioural HIV prevention responses. November 2007

Monitoring and evaluation plan for ESP and EC supported behavioural HIV prevention programmes in support of Zimbabwe's national behavioural change strategy

IOM. Assessment study on mobile and migrant populations access to HIV prevention and treatment and care services in Zimbabwe. Draft report.

IOM. Scaling up access to HIV and AIDS services for migrant/mobile and vulnerable populations in Zimbabwe. First quarterly progress report to ESP. August-October 2007.

MOHCW and WHO. ESP HIV/AIDS treatment and care component. First report April-June 2007. Planning phase.

MOHCW and WHO. ESP HIV/AIDS treatment and care component. April-September 2007 Report.

UNAIDS. Management and coordination component. Half yearly report. April-September 2007.

UNFPA. Behaviour change component. Quarterly report on the ESP on HIV and AIDS in Zimbabwe. April-June 2007.

UNFPA. First semi-annual report on the ESP HIV prevention/behaviour change component. April-September 2007.

UNFPA. Summary of progress made on ESP behaviour change component. Presentation to ESP Working Group. 7 November 2007.

UNICEF. Procurement component: Quarterly report on implementation of procurement activities.

UNICEF. Semi-annual report on the ESP on HIV/AIDS in Zimbabwe. Procurement for treatment and care work plan. April-September 2007.

Meeting minutes

Minutes of the ESP Working Group: 13th meeting 23 January 2008; 14th meeting 3 February 2008; 15th meeting 22 February 2008; 16th meeting 26 March 2008; 17th meeting 2 April 2008; 18th meeting 29 April 2008; 19th meeting 4 June 2008; 20th meeting 2 July 2008; 21st meeting 6 August 2008; 22nd meeting 10 September 2008; 23rd meeting 8 October 2008; 24th meeting 6 November 2008; 25th meeting 9 December 2008; 26th meeting 16 December 2008.

Other

HRH scheme. Lead implementation agency for 2009 retention scheme.

GF. Programme to support the scale up of ART and HIV testing and counselling services in 22 districts in Zimbabwe. Programme Grant Agreement.

Integrated District Plans 2009: Gutu, Masvingo Rural, Chiredzi districts.

Gutu District Consolidated Plan. National AIDS Strategy Framework for 2008-2010. NAC.

ZNNP+. Consolidated activity report: Provincial strengthening programme 2008.

ANNEX 4 TIMELINE OF POLITICAL AND ECONOMIC EVENTS

2008	
February	• NGOs start to experience difficulties in accessing US$ from RBZ • Z$ cash shortages and cash withdrawal limits (which continued for the rest of the year)
March	• Presidential and Parliamentary elections
April	• Severe restrictions on NGO, PVO (and UN agency) activities, e.g. holding meetings, travel, outreach, at community level
May	• Official election results released; date for Presidential run off announced
June	• Official ban on all NGO, PVO field operations (4 June) • Presidential run off election; MDC pull out due to concerns about escalating violence and intimidation • NGO ban clarified to not include NGOs working on HIV treatment (although some NGOs continued to experience problems in conducting field operations) (18 June)
August	• Ban on NGO, PVO activities lifted, but required to adhere to new reporting requirements (29 August) • 10 zeros removed from Z$ • Continued political violence in some districts
September	• ZANU PF, MDC and MDC-M sign MOY on unity government • NGO ban lifted and gradual increase in access allowed • First cholera case in Chitinguiza • Banking transfers prohibited, making payments in Z$ near impossible
October	• Cholera outbreak in Budidiro, Harare • UN and authorised NGOs able to make payments in US$ (although unclear if all service providers can accept US$) • Launch of forex-based retailers by RBZ, which allowed some providers to sell in US$ • US$ prices at all time high • Industrial action by health workers
November	• High levels of cholera in parts of Harare, spreading to other areas of the country
December	• Cholera in most districts, although Matabeleland North and South and Bulawayo less affected
2009	
January	• 12 zeros removed from Z$ • Widening of legality of selling in US$; de facto all products and services in US$ (or Rand) • General fall in US$ costs
February	• Government of National Unity formally in place (13 February)

ANNEX 5 WORKING GROUP ESP AIR INTRODUCTORY MEETING

Participants

Name	Organisation	Contact details
Coumba Toure Kane	UNICEF	ctourekane@yahoo.co.uk
Chenydanai Mangevo	UNICEF	cmangevo@unicef.org
Sonja McLeod	Norwegian Embassy	smc@mfa.no
	SIDA	
Gugu Mahlangu	Medicines Control Authority of Zimbabwe	mcaz@africaonline.co.zw
Naume Tavengwa	Zvitambo	tavengwa@zvitambo.co.zw
Batsirai Mutasa	Zvitambo	bmutasa@zvitambo.co.zw
Albertina Chingono	UNDP	albertin.chingono@undp.org
Judith Chitando	ZAN	jchitando@zan.co.zw
Farai Gwenzi	MOHCW	gwenzif@yahoo.com
Tsitsi Apollo	MOHCW	tapollo2001@yahoo.co.uk
Beatrice Dupwa	MOHCW	beatricedupwa@yahoo.com
Leocadia Mangwanya	MOHCW	mangwanyaleo@yahoo.com
R Mugwagwa	MOHCW	rumbi@ecoweb.co.zw
Colly Masuku	ILO	masuku@ilo.org
Amon Mpofu	NAC	ampofu@nac.org.zw
Raymond Yekeye	NAC	ryekeye@nac.org.zw
Muchaneta Kardemiiri	Crown Agents	muchanetam@zw.crownagents.com
Christine Chakanyuka	WHO	chakanyukac@zw.afro.who.int
	WHO	
C Mwaramba	NatPharm	cmwaramba@natpharm.co.zw
Clemens Benedikt	UNFPA	benedikt@unfpa.org
Priscilla Mujuru	UNFPA	mujuru@unfpa.org
Dr T Magure	NAC	tmagure@nac.org.zw
Patricia Darikwa	ESP	pdarikwa@nac.org.zw
Marie Nyiramana	CIDA	marie.nyiramana@international.gc.ca
Lovemore Tinarwo	CIDA	lovemore.tinarwo@international.gc.ca

ESP Self Assessment

What is ESP?

- Support for the national HIV/AIDS response in Zimbabwe
- Pooled mechanism to provide funding for HIV and AIDS programmes in Zimbabwe in 16 districts
- Pool of funding from donors to expand or scale up HIV and AIDS initiatives in Zimbabwe; it should not be perceived as a stand alone project
- Programme intended to support MOHCW to fight HIV, TB
- District led and focused programme to support the roll out of ART services in Zimbabwe; works in line with ZNASP and the Three Ones
- Forum that brings together all the stakeholders working on HIV and health
- Group comprising NAC and donor partners using a common funding mechanism to support implementation of ZNASP
- Flexible multi-donor funding mechanism in support of the national HIV strategy
- Multi-donor basket funding approach to help in the fight against HIV and AIDS

- An initiative by donors to make available basic essential drugs and other commodities e.g. HIV testing kits, CD4 machines, and related skills to better manage HIV issues at district level
- Coordinated effort between donors, IPs and the government to respond to HIV and AIDS in line with the ZNASP

What are the main achievements of ESP?

- Significant contribution to scaling up HIV programmes in a challenging context and contribution to strengthening health system
- Improved coordination of HIV activities
- Brought together donors, UN agencies, government structures and civil society to respond to the epidemic in line with national priorities
- Rolling out prevention and scaling up behaviour change activities; leadership involvement and greater awareness at community level; anecdotal evidence of behaviour change
- Increased uptake HCT services
- Increased provision of ART services; scale up of ART coverage and uptake of treatment; support to the national ART programme for site assessments
- Improved management of TB
- ARV supply chain to 16 districts
- Provision of drugs (especially ARVs), commodities (including consumables and laboratory reagents), equipment (including CD4 machines, laboratory equipment and vehicles to improve outreach) and logistics support
- Improved laboratory services
- Support for human resources and stabilising human resources environment i.e. staff retention
- Support for capacity development through training e.g. on PMTCT, OI, ART and capacity building of nurses and PCCs
- Support for and improved M&E

What are the main challenges for ESP?

- Challenging economic and political environment e.g. hyperinflation, political instability
- Flow of funds from IPs to implementers e.g. from WHO to MOHCW and its collaborating partners; bureaucratic process of getting resources deployed for programme implementation and time spent on financial administrative issues to ensure funds are received; policies and systems of some IPs too rigid for a dynamic environment like Zimbabwe
- Transport; logistics of payment for workshops, per diems and health workers in foreign currency
- Coordination at district level due to shortage of staff
- General decline in the health and social service delivery systems
- High staff turnover, HRH challenges in the health sector; industrial action by health workers; lack of district level staff e.g. DMOs; demotivated staff at the grass roots
- Poor progress with CHBC component; funds not forthcoming for this from WHO
- Ensuring a continuous supply of drugs
- Retention of ESP-supported staff due to lengthy process of getting approval from MOHCW
- NGO ban March-September 2008 and political violence preventing activities in the districts
- No ESP focal persons at district or provincial level
- Measuring impact; monitoring based on indicators very limited; reporting not linked to financial expenditure

Where should ESP go from here?

- Continue support
- Consolidate the programme
- Address funds flow constraints
- Increase support for improved MOHCW service provision and integration with the national programme
- Evaluate activities in ESP-supported districts to identify best practices, gaps and the way forward
- Expand the scope to focus beyond HIV and AIDS on the whole health system
- Scale up to additional districts to ensure universal coverage and equitable distribution of services
- Increase drug supplies
- Sustain staff incentives and retention package