PSI ZIMBABWE ASSESSMENT REPORT

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I. INTRODUCTION

PSI/Zimbabwe (PSI/Z) is currently implementing Phase II of a social marketing and behaviour change communication programme with joint funding from USAID and DFID. USAID has a five-year $17.5 million cooperative agreement with PSI/Z that ends 31 July 2005. DFID has a separate four-year £8.5 million agreement with PSI/Z that ends 31 December 2005. In 2004, DFID agreed to provide a further £2.77 million to enable PSI/Z to increase its reach and intensify its behaviour change communication.

The programme goal is to improve sexual and reproductive health in Zimbabwe. The purpose is to increase safer sexual behaviour. The outputs are: sustained high access to affordable male and female condoms; increased knowledge and improved attitudes conducive to safer sexual practices; demand increasing and regularly met for ProFam reproductive health services and products among low-income Zimbabweans; increased access and informed demand for affordable, quality VCT services and follow up; increased capacity among PSI/Z staff. Programme components are: VCT; post-test clubs; integrated private sector medical programme (ProFam); male and female condom social marketing; targeted communications initiatives.

USAID and DFID commissioned a team of four consultants – Kathy Attawell, independent consultant, UK; David Hales, independent consultant and team leader, USA; Janet Hayman, REDSO/USAID, Kenya; Naira Khan, Save Alliance, Zimbabwe – with experience in HIV/AIDS policy and programming, private sector strategies, social marketing and behaviour change communication to conduct a review in August 2004. The two main objectives of the review were to assess the PSI/Z-managed programme, including an output to purpose review (see *Annex 1*), and make recommendations for the remaining months of the programme; and to identify broader recommendations for future USAID and DFID support for HIV/AIDS initiatives in Zimbabwe. Findings and recommendations in this report are based on programme briefings, review of background documents, meetings with PSI/Z staff, interviews with a range of stakeholders and field visits; see *Annex 2* for a list of organisations that were met by the assessment team.

The assessment team presented its findings to DFID and USAID in a debriefing on 31 August 2004. The primary focus on this debriefing was the PSI/Z review; however, it included an overview of the team's perspective on future HIV/AIDS initiatives in Zimbabwe. Two additional briefings – one for the Permanent Secretary of the Ministry of Health and Child Welfare (MoHCW) and a separate one for PSI/Z staff – focused exclusively on the review of the PSI/Z-managed programme.

II. KEY STRENGTHS

1. PSI/Zimbabwe has established a constructive partnership with the Ministry of Health and Child Welfare.

The Government of Zimbabwe – specifically, the Ministry of Health and Child Welfare (MoHCW) – sees PSI/Z as an important partner in voluntary counselling and testing (VCT). The positive nature of the working relationship between MoHCW and PSI/Z has enabled the Government to embrace the network of New Start centres as the cornerstone of the country's VCT strategy. The partnership has also led to the co-location of New Start sites in government facilities.

In addition, the secondment of a senior staff person into the AIDS and TB Unit of the Ministry has strengthened the partnership with government while simultaneously contributing to improved capacity, coordination and transparency within the Ministry. Overall, the relationship with the Government has enabled PSI/Z to expand the New Start network and provide high-quality VCT to increasing numbers of Zimbabweans at a very challenging time in the country. Without this relationship with the Government, it is likely that much less would have been accomplished during this phase of the programme.

2. High-quality voluntary counselling and testing is well established and well regarded in Zimbabwe because of the network of New Start Centres in the country.

The programme has made a significant contribution to expanding access to VCT services through the establishment of 19 New Start centres. As of June 2004, New Start centres had provided VCT to 270,871 clients. PSI/Z has also made a significant contribution to creating awareness and demand for VCT. The New Start "brand" is well known in Zimbabwe and PSI/Z has used a range of innovative methods to promote VCT, including campaigns linked to Mother's Day, Valentine's Day and the World Cup.

New Start centres have set the standard for high quality services, with confidential and rapid testing provided by well-trained counsellors. The centres also have quality assurance and supervision measures in place to ensure consistent quality at direct and indirect sites. PSI/Z training for partners managing indirect centres, and the development of training and operational manuals, have played an important role in setting and maintaining standards. Other countries in the region have used the New Start approach as a basic model.

PSI/Z has developed multiple models for delivery of VCT services – stand alone or direct sites managed by PSI/Z, integrated or indirect sites managed by partners including government health facilities and NGOs, and outreach services provided by 11 sites – making VCT accessible to a wider population. Direct sites tend to serve younger (and often more affluent) urban populations, whereas outreach is an effective way to reach rural populations, women in particular. While an equal proportion of men and women use New Start centres (52% male and 48% female), 62% of outreach clients in the first two months of 2004 were women. Outreach accounts for an increasing proportion of VCT clients – 25.8% in April-June 2004 – and PSI/Z plans to expand outreach services from additional sites.

3. The Protector Plus and *care* condom brands are performing well in the market.

Brand awareness of Protector Plus and *care* is high in Zimbabwe and sales continue to grow steadily. PSI/Z has achieved the highest per capita condom distribution of any social marketing programme in Africa, for both male and female condoms. Sales increases of Protector Plus in 2003 suggest that socially marketed condoms may be an important safety net during public sector stock outs; public sector distribution fell from 40 million in 2002 to 29 million in 2003.

PSI/Z has achieved good coverage in urban and peri-urban areas and in growth points; large population centres account for the major proportion of Protector Plus distribution with Harare itself representing approximately 40% of total sales. A good start has been made on expanding distribution to rural areas through partnership with private sector channels such as Coca-Cola and with NGOs such as the Farming Community Trust of Zimbabwe, although coverage remains limited. Efforts to increase rural reach through food distribution points ended with the curtailment of World Food Programme activities in the country.

PSI/Z has made effective use of Zimbabwe's wholesale infrastructure for both consumer goods and pharmaceutical products. It has also tapped a full range of distribution channels; in addition to supermarkets, tuck shops and other retail outlets, Protector Plus is distributed through bottle shops, bars, guesthouses and service stations to ensure that condoms are available to people when and where they are needed. Both Protector Plus and *care* have been distributed through private sector health providers and pharmacies. PSI/Z has also made efforts to increase condom sales through alternative distribution channels. For example, hair salons account for 60% of *care* sales.

PSI/Z has not conducted a comprehensive distribution survey since 2001 but has recently begun using geographic information system (GIS) software to map distribution points. Initial mapping of Protector Plus outlets and availability at district level is complete and is already providing valuable information about the relationship between coverage, population and prevalence rate.

4. Across the organization, the calibre of the PSI/Z local staff is extremely high.

The programme has clearly benefited from the experience and expertise of its local staff. Although there has been a significant "brain drain" in Zimbabwe in recent years, the calibre of the local staff indicates that there are many well-trained and experienced professionals still living and working in the country. The assessment team was consistently impressed with the commitment of local staff and the innovative ideas they shared with respect to future programme strategies and interventions.

The support staff within the organisation is also very strong. They appear to be very committed to their work and their dedication and enthusiasm – even under difficult and demanding conditions – is obvious.

Tensions between local staff and expatriate managers have increased in recent months. Much of this stems from the ongoing economic problems in Zimbabwe. Local salaries have not kept pace with inflation and the steady erosion in real earnings is causing increasing hardships for staff and many of them appear de-motivated. Although PSI/Z is working hard to address economic issues, it is important to recognise that one of the programme's greatest strengths – its local staff – is currently at risk.

5. Studio 263: The top-rated television show in Zimbabwe!

Audience tracking surveys show that Studio 263 is rated the best television programme in Zimbabwe and, with over 2.8 million viewers, it is also the country's most watched programme. Although Studio 263, which airs five nights per week on ZTV, is primarily an entertainment vehicle, it includes valuable social messages on a regular basis.

The presentation of messages about HIV/AIDS on Studio 263 is widely considered by viewers to be both acceptable and effective. While impact on actual behaviour is difficult to evaluate, multi-round surveys indicate high levels of audience intentions to change behaviour in response to messages communicated by the programme. Anecdotally, New Start centre staff report that any mention of VCT on the show is immediately followed by an increase in clients. Other anecdotal information suggests that Studio 263 has stimulated viewer discussion of HIV/AIDS issues and lead to greater personalisation of these issues.

From a sustainability perspective, Studio 263 is an interesting case study because responsibility for getting the show on the air rests with Afro-Eye, an independent production company. Although the funding for the show comes through PSI/Z and some of its staff members are involved in script development, the bulk of the production is managed by Afro-Eye. Given the high ratings of the show and the commitment of ZBC/ZTV to continue airing it, there is a possibility that Studio 263 could become a self-sustaining enterprise.

The success of Studio 263 is also a testament to the commitment and passion of the producers, writers, actors and technical staff of Afro-Eye. They work extremely hard to produce the show, despite having very limited resources.

III. KEY WEAKNESSES

1. PSI/Zimbabwe does not appear to have a strategic approach to the programme.

There is no indication that the organisation has engaged in strategic planning based on an assessment of its comparative advantage vis-à-vis the needs in Zimbabwe or the activities of other organisations working on similar or compatible issues. Without a clear overall strategy, activities appear to be have been added to work plans in a rather *ad hoc* fashion.

The programme comprises a range of separate components and diverse initiatives with, in some cases, little coherence or linkage between them. For example, VCT was promoted in some Corridors of Hope areas before VCT services were available, the New Life campaign was launched before New Life centres were able to provide all of the services advertised and more effective linkages could have ensured that messages in Studio 263 better complement interpersonal communications initiatives.

There are also no identified strategies for specific programme components such as male and female condom promotion and distribution, provision of follow-up care and support or behaviour change communication. With regard to the latter, it would have been useful to have a clearly articulated strategy setting out overall objectives, intended audiences, communication channels and methods to reach these audiences as well as ways in which the programme would measure success. Similarly, it might have been useful for the programme to have developed a rural strategy encompassing condom promotion and distribution, provision of VCT and follow up services, and supportive media and interpersonal communication, rather than pursuing these components separately.

It is possible – even likely – that the lack of a strategic approach in the PSI programme is a reflection of the fact that the overall response to the epidemic in Zimbabwe is not particularly strategic. Although there is a wide range of tactical initiatives in place in Zimbabwe, each initiative appears to reflect the particular priorities of the implementing and/or funding organization. They do not appear to be part of a strategic framework coordinated by the government or any other institution in the country.

2. The availability of post-test services for clients of New Start centres – either at a New Life centre or by referral to other organisations with post-test programmes – is seriously limited.

People with HIV require a wide range of post-test services, including ongoing psychosocial support, nutritional counselling, medical treatment for opportunistic infections and palliative care. Unfortunately, ensuring that New Start clients who test positive have access to post-test services – either through a New Life centre or through referral to other service providers – has been one of the weakest areas of the programme. Historically, the programme has not had an overall strategy or systematic approach to post-test services. Efforts to develop direct links with other local organisations that do provide these services or to establish referral networks have only been moderately successful and the investment of time and energy required to develop links and establish networks has not been sustained.

At the request of USAID, PSI/Z took over five post-test clubs – formerly known as Moving On Clubs – from PACT in March 2003; these post-test clubs were subsequently re-branded New Life centres. Unfortunately, since the management of the clubs was transferred to PSI/Z, it appears that the quality of service has declined. In general, there is a sense that the New Life centres are under-resourced. For example, despite increasing demand, fewer services are available now than were provided by the Moving On Clubs. There are not enough trained counsellors to cope with the number of clients and staff are grappling with serious burnout issues but receive little support to help them cope.

Overall, the assessment team had very serious concerns about providing VCT without adequate plans for short and long-term post-test services. This was reinforced during a meeting with NGOs, where one stakeholder said, *'I think it is unconscionable for us to urge people to go for VCT and then have no support for them."*

3. **The programme has failed to actively engage with people living with HIV/AIDS or to involve them in its work.**

The fact that people living with HIV/AIDS (PHA) have little or no role in any of the programme's core activities is a significant weakness and represents a major missed opportunity. People living with HIV/AIDS can and should have integral roles across the programme, including VCT, post-test support, mass communications and interpersonal communication. There is no question that this programme would benefit from the knowledge and first-hand experiences of the PHA community.

4. **ProFam's contribution to programme purpose, in terms of services provided and clients served, is debatable.**

The most recent assessment (2002) of the impact of training on ProFam providers concluded that training made little difference to the extent to which providers discussed issues such as HIV/AIDS or VCT, and referral between providers and VCT services remains weak. Although ProFam has been repositioned as a network of reproductive health service rather than family planning providers, there is little evidence to indicate that providers are addressing wider reproductive health issues. In fact, the latest PSI/Z quarterly report cites increased sales of injectable contraceptives as a measure of the success of repositioning.

ProFam providers do account for 9% of total hormonal couple years of protection (CYPs) in Zimbabwe. However, the network is largely serving the better off rather than the LSM 3-5 target group identified by the donors. PSI/Z reports that 30% of network members reach LSM 3-5, but this is based on the geographical location of providers rather than on client analysis; there has been no client profile survey since 2001. Anecdotal reports indicate that even the middle classes are shifting to the public sector as private health care becomes increasingly unaffordable. If current proposals to increase private consultation fees from Z$50,000 to Z$80,000 are implemented and the economic environment continues to deteriorate, the proportion of LSM 3-5 served by private providers is likely to be further reduced, raising questions about whether creating demand for the services of private providers is the most appropriate use of donor resources.

5. **Prices for products and services provided by the programme appear to be unnecessarily low. Consequently, substantial resources are allocated to product and service subsidies, cost recovery is limited and the profit incentive for wholesalers and retailers on key products is very low.**

PSI/Z conducted a willingness to pay study of male condoms in early 2004, resulting in an increase in the price of Protector Plus from Z$5 to Z$100. Even with this increase, Protector Plus remains extremely cheap relative to the price of other products. While a further price increase is not recommended (since ensuring that condoms are affordable is a higher priority than cost recovery), pricing needs to be kept under careful review as the low profit margin – the wholesale price is Z$50 – offers little incentive for smaller retailers to carry male condoms.

The programme provides a significant subsidy on ProFam hormonal contraceptive products. For example, the wholesale prices of the Duofem oral contraceptive and the Depo Provera injectable are Z$100 and Z$350 while the retail prices are Z$650 and Z$3,350 respectively. The use of donor funding to subsidise these products when the benefit is going to private physicians and better-off clients should be re-examined.

Reproductive health training for ProFam providers is also heavily subsidised. The four-day course, including accommodation and meals, costs only Z$275,000. While some physicians work in both the private and public sectors, and in some cases the MoHCW has paid for public sector physicians to participate in the course, the use of donor funding to subsidise training for private

providers also requires re-examination. (Note: Due to budget constraints, PSI/Z has conducted fewer ProFam trainings in 2004 compared with previous years.)

There is also a significant subsidy for services provided to the private sector through the workplace initiative. PSI/Z has acknowledged that many private sector clients could be charged more for these services.

6. The lack of a behaviour change communication strategy resulted in a fragmented communications campaign, which has not been responsive to changing epidemiology and patterns of vulnerability.

Despite specific recommendations made by the 2003 OPR, the programme is still not sufficiently responsive to changing epidemiology and patterns of vulnerability in Zimbabwe. Targeted communications approaches do not appear to have been revised to reflect the risks faced by married women or the impact of poverty on sexual risk behaviour. Male condom campaigns are largely targeting youth despite evidence indicating that older married men also need to be addressed. The rural initiative focuses on targeted promotion of the female condom to women and of abstinence messages to young people, ignoring evidence suggesting that men's attitudes towards the female condom will need to change if women are to be able to use *care*, and the needs of young people who may already be sexually active.

As noted earlier, the programme has no overall behaviour change communication strategy. PSI/Z implements or plans to implement a rather disparate range of interpersonal communications initiatives – in hair salons, workplaces and rural areas, and with commercial sex workers and youth – and campaigns – on delayed sexual debut and abstinence, stigma and discrimination, cross-generational sex, condom efficacy, and personal risk perception. Neither media nor interpersonal communications activities appear to be mapped out by target group or geographical area, or designed to ensure that delivery of messages is coherent and that media and interpersonal approaches are mutually reinforcing.

7. Available information about distribution and sales of the female condom is somewhat contradictory, and the programme lacks good data about the uptake of this product.

The recent hair salon impact assessment (2004) reported that some salons had insufficient quantities of the *care* female condom to meet the demand created. However, anecdotal feedback from a range of sources indicates that the female condom is a slow moving product, and hair salons and pharmacies visited by the team reported few sales. Low demand is attributed in part to limited media promotion and marketing of the product. The 2004 hair salon assessment also raises questions about the extent to which hairdressers are actively promoting *care*; the majority of women who knew of *care* had heard about it through television or radio rather than from their hairdresser, and they were more likely to purchase from a pharmacy or store than from the salon.

There is also a lack of information about the sustained use of *care*, and about barriers to uptake and use. The 2004 hair salon assessment found that, while 22% of women interviewed had purchased *care* at some point, over half had tried it once and not used it again, either because their partner did not like it (60%) or because they found it difficult to use (32%). PSI/Z needs to rethink the way in which *care* is promoted, revisiting media approaches and giving higher priority to tackling negative male attitudes, and to strengthening efforts to ensure that women feel confident about using the product.

8. There are several weaknesses in the current programme management, including the hierarchical nature of the management structure, an over-reliance on senior-level expatriate staff, the use of the programme budget as a management tool and relationships with key partner organizations.

The management structure is very hierarchical. There are, for example, five levels of management between the Country Director and a site manager at a New Start centre. Decision-making is also highly centralised. Even within the senior management team, expatriate managers are reported to take key decisions without the involvement of local managers. Mid-level managers are not included in strategic planning or decision-making despite their potential to make an important contribution.

Programme management is over-reliant on expatriates at senior level. In addition to the Country Director, the programme has three expatriate staff at senior management level, all of whom were recruited in early 2004. While recognising that human resources is a problem in Zimbabwe, the team would have expected PSI/Z to have local staff in these senior management positions after operating in the country for nine years. Although PSI/Z has a staff development plan, there is no system in place for monitoring increased staff capacity.

The budget is not being used as a tool for efficient and effective programme management. The programme has an overall budget, broken down into broad categories, such as communications and commodities, and two separate and extremely detailed budget breakdowns, used for reporting to USAID and to DFID. However, it appears that there is no operating budget. The assessment team experienced difficulties in obtaining detailed information about resource allocation and expenditures; for example, specific information from the commodities budget line on the subsidy of hormonal contraceptives distributed to the ProFam network or on female condoms was not readily accessible, nor were specific figures from the communications budget line on the expenditures for Studio 263 or the workplace initiative.

Management of relationships with donors, suppliers and collaborators is another area of weakness. While PSI/Z is credited with producing timely and comprehensive quarterly reports, it has failed to respond to many of the recommendations of the DFID 2003 OPR and some of these were outstanding from the 2002 OPR; see *Annex 1*. In addition, several organisations met by the team perceive PSI/Z as demanding and unreasonable rather than as a partner or collaborator. Relations appear to have worsened in the past six months, and several organisations complained of serious problems in receiving payments from PSI/Z.

9. With a few notable exceptions, PSI/Zimbabwe does not have an institutional commitment to actively collaborating with other organizations.

There is a general perception among non-governmental organisations in Zimbabwe that PSI/Z gives limited priority to working with other organisations and prefers to work largely on its own. (Exceptions include specific partnerships with Batsirai in Chinoyi and FACT in Mutare.) This perception is reinforced by the weaknesses of the referral system for clients of the New Start and New Life centres, apparent gaps in PSI/Z's knowledge of the work of other organisations addressing common issues, concerns about management of key relationships, the lack of an advisory board for Studio 263 and limited commitment to broad-based sharing of information.

Weaknesses in the referral system at the New Start and New Life centres are discussed above. PSI/Z has not reached out to the Zimbabwe AIDS Network (ZAN) for assistance with referrals, even though ZAN publishes the most comprehensive directory of HIV/AIDS-related services in the country. Based on discussions with key PSI/Z staff, it is clear that they have not invested sufficient time or energy in understanding what other NGOs and FBOs are doing on HIV/AIDS; for example, PSI/Z has been discussing a new youth initiative but is not aware of the youth programme operated by JSI-UK and funded by DFID. In general, a failure to exploit partnerships has isolated PSI/Z from the wider HIV/AIDS community.

Both PSI/Z and Afro-Eye are now talking about the value of having an advisory board for Studio 263 to provide expert insight on how difficult or sensitive issues can be handled on the show. While this is a very positive development, it is unfortunate that it has taken until the third season of the show to begin this discussion, particularly given the number of qualified individuals and organisations that could have been advising the show during its first two seasons.

In general, research findings are not shared with other partners working in the field or with other researchers. For example, information from KAP studies has not been made available to organisations contracted to collect data about distribution or to develop media campaigns, and information about behaviour change has not been widely shared, either with UN agencies or with other organisations involved in behaviour change communication such as CDC and JSI-UK. While these other organisations bear some responsibility for the limited exchange of data, as the largest HIV/AIDS programme in the country, PSI/Z can and should be more proactive about sharing information and encouraging others to do the same.

10. PSI/Zimbabwe generates copious amounts of data but much of it is not useful for effective programme management.

There are weaknesses with both information management and knowledge management. PSI/Z does not appear to collect, analyse and use information productively and has not effectively leveraged knowledge generated from experience to improve programme impact.

For example, the most recent quarterly report highlighted a significant decrease in sales of Protector Plus in border districts and through all types of outlets, although rural sales remained steady. While a brief discussion attributes this to vacant sales staff positions, the April 2004 price increase and overstocking at the end of 2003, it would have been useful to analyse the reasons for the decrease in border areas in more depth.

The team noted that PSI/Z has not used monitoring and evaluation data to inform or adapt programming approaches. For example, the 2002 assessment of the hair salon initiative suggested that hairdressers might not be a credible information source, but the programme decided to expand this approach. At the same time, the programme lacks information in critical areas. For example, there is no retail sales data, which means PSI/Z has no information about how many condoms have been sold or who has bought them, and data about uptake and sustained use of the female condom is limited.

There are also weaknesses in the way that information is presented. For example, quarterly reports include indicators from the logical framework but do report against these indicators, only providing cumulative figures for product sales and including percentages and figures that are not related to each other or to denominators. Programme reports give no indication of the proportion of the overall condom market represented by Protector Plus or of unmet need, and the basis for PSI/Z's male condom distribution targets is not clear; the same applies to VCT clients.

The programme has a narrow research agenda, which focuses largely on certain marketing, sales and distribution figures, formative research for campaigns and the assessment of media impact. Multi-round surveys, which are the most frequently used research method, assess media audience figures, adverting and message recall and intended or reported behavioural outcomes, but evaluation of interpersonal communications activities has been limited. KAP surveys, which are the main source of information for several purpose and output level OVIs, are only conducted every 2 years and the results of the next survey will only be available towards the end of 2005.

PSI/Z has carried out very little qualitative research and has not followed up the DFID recommendation regarding poverty and vulnerability analysis. Opportunities to conduct research to gather longitudinal data, for example, on the impact of high-quality counselling on risk behaviour have unfortunately been missed.

IV. RISKS

The review identified a number of political, economic and organisational risks to the programme. In addition, there are constraints posed by the donors that need to be considered. All of these risks and constraints need to be monitored carefully and responded to appropriately, which will require improvements in the rigour and frequency of strategic planning.

1. Political Risks

The political environment continues to be challenging and, with the upcoming parliamentary elections in March 2005, is likely to become more so. Access to rural areas may become more difficult, with implications for product distribution and interpersonal communications activities. For example, deploying PSI/Z's newly acquired mobile video units may be problematic between now and the elections because they generally attract crowds of people. The use of mass media may also become more difficult, with possible implications for both the content and review process of Studio 263.

The proposed NGO Bill, which will more closely regulate NGOs, could be a major risk but it is not clear how it will affect PSI/Z. PSI/Z should consider its options, including seeking legal advice immediately, so that work is not disrupted should the legislation be enacted.

2. Economic Risks

The economic environment in Zimbabwe also continues to be a major challenge. PSI/Z has already experienced the effects of hyperinflation, diminishing salaries and changes in the availability of foreign currency. This situation is not likely to improve in the immediate future and increasing oil prices may worsen inflation. Lessons learned during the past year should be used to determine implementation and budget priorities for the remaining months of the programme.

The economic impact on the programme's clients and customers should not be overlooked. For example, it appears that fewer people are going to private clinics for health care because of the higher cost. However, it appears that the Z$5,000 consultation fee at public health facilities is too high for many people to pay, so they are instead opting for over-the-counter drugs and advice from pharmacists. Across all of the programme's activities, it is likely that financial pressures will have an impact on their reach and effectiveness.

3. Organisational Risks

The ongoing management transition is a significant risk to the programme. The current PSI/Z Country Director is scheduled to leave Zimbabwe in late September 2004. PSI proposes to recruit an interim Country Director to cover the period from October 2004 to January 2005, and appoint a permanent replacement starting in January 2005. The lack of consistent leadership could have an adverse impact on staff motivation, the implementation of core activities and external relations.

Another risk is the departure of senior local staff. The two most senior Zimbabweans in the programme – the Director of Technical Services and Deputy Director of HIV Services – are leaving shortly, one to take up a post with PSI in another country. PSI/Z has no plans to replace them and their responsibilities will be passed to other current staff. This will heighten the imbalance between expatriate and Zimbabwean staff at the senior management level, and could further "de-motivate" the remaining local staff. Continued staff attrition is also a potential risk that will need to be carefully managed.

4. Donor issues

At present, there are limitations on the extent to which DFID and USAID can directly fund government health and social welfare services. In an environment of increasing attrition of human resources and shortages of essential drugs, this is a major constraint to strengthening the capacity of public services to provide treatment and care services for people who test positive at New Start centres. It should be noted that DFID and USAID are providing funding for the supply and distribution of public-sector reproductive health commodities.

Donor expectations of social marketing, mass communications and private sector approaches may be unrealistic. Both DFID and USAID have encouraged PSI/Z to make greater efforts to reach the poorest and most vulnerable population groups and to extend rural coverage. However, it may not be feasible for social marketing and mass communications approaches to achieve this in Zimbabwe. For example, PSI/Z charges Z$500 for VCT but feedback in Chinoyi indicates that outreach services are largely provided free of charge since people in rural areas have little or no money; fewer than 10% are able to pay.

Similarly, donor reviews have recommended that PSI/Z increase the proportion of clients from LSM 1-6, specifically LSM 3-5, reached by the ProFam network. Again, it may not be realistic to expect private sector providers to serve the less affluent, and this is increasingly less likely to be case given the deteriorating economic environment in Zimbabwe.

Shortages of commodities and deterioration in distribution systems are a potential risk. USAID and DFID support has improved the supply and distribution of reproductive health commodities and it is likely that ongoing support will be required assure continued supply and to sustain the operation of the system. At present, different donors are supporting parallel logistics and distribution systems; the JSI-DELIVER programme is working with ZNFPC to strengthen distribution of reproductive health commodities, while the EU is supporting NATPHARM to strengthen distribution of essential drugs. There may be opportunities to streamline efforts and maximise use of limited donor resources.

V. RECOMMENDATIONS

The overarching recommendation for the remaining months of the programme is for PSI/Z to consolidate and strengthen existing programme components (male and female condoms, New Start and New Life, mass media and interpersonal communications initiatives, and Corridors of Hope) and linkages between them. PSI/Z should build on success to date rather than expanding into provision of additional products and services or developing additional campaigns and initiatives. The primary focus on prevention should continue, with the exception of greater efforts to ensure that VCT clients who test positive for HIV receive follow-up support services.

More specific recommendations to be addressed during the remaining months of the programme are as follows:

1. Voluntary Counselling and Testing

Evaluate under-performing sites and either close or improve them. PSI/Z has already closed some under-performing sites and it may be difficult to close sites that were established for political reasons. Steps should be taken to *improve* the operations of any under-performing site.

Limit the development of new sites. PSI/Z has limited capacity and time to establish new direct sites in the remaining months of the programme. Additional sites should be limited and should only be established in high prevalence locations where VCT services are not available.

Expand outreach services from existing sites. This should include both geographical outreach to peri-urban, rural and high prevalence areas (e.g., commercial farm estates, resettlement and

border areas) and *in situ* outreach within health facilities, using New Start counsellors in indirect sites to provide providing HIV counselling for STI and TB patients.

Document different models of VCT service delivery including direct and indirect sites and outreach services. This should include documenting effective approaches to reaching different population groups, strategies for ensuring quality, different models of partnership, the cost and potential for replicability and scaling up of alternative approaches to service delivery including provision of counselling by more and less qualified counsellors and the effectiveness of involving PHA as counsellors, drawing on lessons from the pilot programme with MSF in Bulawayo.

Support other organisations to expand coverage in under-served high prevalence areas using a range of models. There is likely to be increased demand for VCT services in Zimbabwe, even if the government expands access to ART on only a limited scale. The team recommends that PSI/Z focus on using programme experience and expertise to support expansion of VCT coverage through indirect sites managed by government and non-government partners, concentrating on training and quality control rather than on direct management of additional sites. Consideration could be given to using New Africa House as a training centre. Lessons should be learned from the approach that has been taken to expanding provision of PMTCT services.

Limit the remit of New Start Plus. While staff are understandably keen to provide clients with comprehensive clinical services, this is not PSI/Z's core business. Uptake of family planning, STI and PMTCT services provided by New Start Plus centres is low, and the last quarter saw a decline in the number of clients seeking these services. PSI/Z pays private physicians to provide services such as STI diagnosis and treatment and this is a costly approach. There is no evidence to indicate that providing other services increases uptake of VCT. The team therefore recommends that the programme does not expand the number or remit of New Start Plus centres, and that existing New Start centres focus on counselling and referral – for HIV, PMTCT, TB, STI and family planning – rather than clinical service delivery. Priority should be given to strengthening referral to health facilities that provide treatment services and developing mechanisms to assess the experience of clients who are referred.

Resolve the issue of written results. At present, a lack of legal clarity with regard to confidentiality means that New Start centres cannot provide clients who test positive with written results, and in practice the centres provide anonymous rather than confidential testing. Without written results, it is difficult for clients to access treatment and care from other facilities, unless they take a further HIV test. PSI/Z and other organisations that participate in the MoHCW-coordinated VCT partnership forum are currently seeking clarification of the legal situation.

Promote and make VCT accessible to a wider audience. The current New Start client profile indicates that over 50% are aged 16-24 years. It will be important to ensure that older age groups, especially men, access VCT, and to build on efforts to date to expand couple and family counselling and testing.

2. Follow-Up Support

Link New Start centres to appropriate and effective follow-up support services. At a minimum, every New Start client should have access to a comprehensive list of local organisations that provide post-test support services. Rather than develop its own referral list, PSI/Z would be better served to collaborate with ZAN to use – and potentially expand – its directory of service providers. Before the end of the programme, individual New Start centres should develop more direct links with local organisations as well as with New Life Centres, to ensure a smooth transition from New Start to follow-up services. Improvements in referral mechanisms and direct links with support organisations would enable New Start clients who test positive to avoid the "hard landing" that many of them currently experience when they leave New Start with their results.

Strengthen New Start and New Life referral linkages with other service providers. Neither New Start nor New Life centres – individually or collaboratively – will be able to address all of the support needs of their clients. Consequently, the comprehensive referral mechanism mentioned above must be sufficiently robust to address the potential needs of all New Start and New Life clients.

Prioritise and provide adequate support to the New Life Centres, especially qualified counsellors. PSI/Z needs to urgently address under-resourcing of the New Life centres to meet the needs of staff and clients. Since adequate funding is not currently allocated for the five New Life centres, PSI/Z and the donors will need to prioritise funding for these centres against other programme activities.

3. Role of PHA

Consult with the PHA community on technical issues. Mechanisms should be established to enable members of the PHA community to provide inputs on a wide range of technical issues, including but not limited to counselling, post-test support, Studio 263 messages and appropriate interventions with FBOs.

Actively involve PHA in programme activities, including in paid and volunteer positions. People living with HIV/AIDS can and should be offered positions at New Start and New Life centres in both paid and volunteer capacities; their experience and expertise would be invaluable, as the initiative in Bulawayo has shown. As a high-profile HIV/AIDS organisation, PSI/Z should consider involving PHA in all of their activities.

4. ProFam

Increase cost recovery. The prices for hormonal contraceptives and ProFam training courses should be raised immediately to reduce funds spent on subsidies. In fact, an immediate end to donor subsidies of ProFam commodities should be seriously considered.

Consult with stakeholders, including donors, to identify a new institutional base for ProFam. With more than 1,100 members, including physicians, nurses and pharmacists, the ProFam network does have some value, although there is some question about the extent to which it functions as a "network." Possible institutions that could take responsibility for the network include SHE, an NGO established by the Zimbabwe Medical Association to provide training on ART and other aspects of HIV/AIDS clinical care, and the University of Zimbabwe and College of Obstetrics and Gynaecology, which already play a major role in conducting hands-on and on-line training for the ProFam network.

Cancel rural expansion plans for the network, since few private providers are based in rural areas.

5. Condoms

Develop an overview of the availability, access and uptake of public sector and socially marketed male condoms. This should inform efforts to clarify market segmentation with ZNFPC, and ensure that distribution of socially marketed condoms complements rather than substitutes for distribution of public sector condoms. ZNFPC and UNFPA can and should take the lead in gathering and analysing this information; however, the PSI/Z as the social marketing contractor should also play a major role in the process because of their knowledge of marketing and distribution male condoms largely through commercial sector mechanisms. In addition, to ensure that the overview is completed in a timely fashion, PSI/Z should consider facilitating the process.

Expand distribution of Protector Plus. There is scope for considerably higher per capita distribution of male condoms to ensure adequate coverage in high prevalence areas and higher

and more consistent rates of protected sex. PSI/Z should increase and intensify targeted distribution in resettlement areas, large-scale commercial farms, mines, national parks and army camps, which (according to the 2003 national HIV and AIDS estimates) have higher HIV prevalence rates (34.9%) than urban centres (28.1%) or rural areas (20.9%), rather than trying to increase new outlets in rural areas.

Analyse the performance of *care* in Zimbabwe. Despite relatively high distribution, it is not clear that this is translated into sales or sustained use of the product. PSI/Z should intensify promotion of the female condom through mass media and interpersonal communications in selected high-prevalence areas, and conduct relevant operational research to provide information about unanswered questions. At present, PSI/Z has no plans to expand promotion beyond an expanded network of hair salons and the rural initiative. However, opportunities for promotion through PMTCT, family planning and antenatal services could be explored; again, in the same selected high-prevalence areas.

6. Behaviour Change Communication

Develop an overall strategic approach. Within the limited time remaining, PSI/Z needs to re-examine and prioritise the current set of rather disparate activities within an overall strategic approach to its behaviour change communication. In addition, when and where possible, PSI/Z should also coordinate its activities with other communications initiatives in Zimbabwe (e.g., government, NGO, FBO, etc.) to encourage a strategic integration of activities.

Consolidate existing activities. Given current budget constraints, PSI/Z should consolidate existing activities rather than investing in a range of new campaigns in the last months of the programme. The assessment team believes now is not the most appropriate time to start a major new initiative such as the Youth Alert campaign and that it might be better, for example, to concentrate efforts on expanding Corridors of Hope interventions to target those most at-risk in transport hubs and along transit routes within Zimbabwe.

Launch one integrated and coordinated campaign to address stigma and peoples attitudes towards HIV/AIDS and PHA. Given the high levels of stigma and discrimination experienced by PHA in Zimbabwe and the adverse impact this has on demand for VCT, disclosure of status and uptake of follow-up care and support, the team recommends that priority be given to a campaign to promote a more supportive social environment for PHA rather to the other proposed campaigns. Such a campaign should be integrated, so that messages are included in both mass media and interpersonal communication initiatives. It should promote deeper public understanding of HIV/AIDS and it should actively involve PHA. PSI/Z should identify opportunities to collaborate with other organisations to ensure a wider strategic approach to addressing stigma that encompasses policy, leadership and community levels as well as efforts to change individual and social attitudes.

Implement as planned the Protector Plus marketing messages that emphasise condom efficacy and consistent use of condoms.

Provide adequate inputs to Studio 263 and consider the potential for spin-offs. PSI/Z should review and increase the budget allocated to Studio 263 and establish an advisory committee that includes NGO and PHA representatives to provide a wider range of inputs to programme content. Given the limitations on use of television and radio in Zimbabwe, PSI/Z could build on the success of Studio 263 by developing spin-offs such as videotapes, audiotapes and comic books targeted at young people and rural audiences. Consideration could be given to producing these in local languages as well as in English.

Establish linkages with other organisations working on behaviour change communication to strengthen approaches. This should include local groups as well as international

organisations such as CDC and JSI-UK, who have jointly developed a behaviour change training curriculum and tools for organisations working with communities.

7. Information and Knowledge Management

Improve collection and use of knowledge and information in programme management. Related to this, PSI/Z should widen the scope of its technical inputs; the current reliance on PSI-Washington and programme donors is inadequate.

Improve analysis, presentation and sharing of knowledge and information. Although this is a wide-ranging recommendation, there is sufficient reason – better programme decisions, improved relationships with partner organisations, stronger evidence base for specific activities, etc. – and time to improve these aspects of information and knowledge management.

Focus the research agenda on the quality, use and impact of products and services. There are a number of areas where PSI/Z could conduct research to contribute to the wider HIV/AIDS knowledge base in Zimbabwe. While the remaining programme timeframe is limited, there is scope, for example, to improve information about the number of new and repeat clients attending New Start and New Life centres, to analyse in greater depth the factors that motivate or inhibit people from seeking counselling and testing, to assess the efficacy of VCT on short-term behaviour of clients who test positive and those who test negative, to evaluate the effectiveness of different approaches to provision of post-test support services, to assess client perceptions of the value and quality of VCT and post-test services, to assess the impact of mass media versus interpersonal communications approaches on attitudes towards HIV/AIDS and PHA and to explore contradictions in attitudes towards condoms highlighted by the 2003 KAP.

8. Human Resources

Implement previous DFID recommendations to promote local staff to senior management positions.

Develop and implement a strategy to provide support to New Start and New Life staff to prevent burnout. The health of staff and the quality of service delivery could be compromised if immediate steps are not taken to prevent burnout. Given the importance of both New Start and New Life to Zimbabwe's response to HIV/AIDS, it would be a significant loss if qualified staff were to leave due to preventable burnout. It would be an equally significant loss if the high standards of service delivery at New Start centres suffered due to staff burnout.

Continue to work with staff regarding salaries and working environment. This is a difficult issue with no obvious solutions, particularly given the unpredictable nature of the economy in Zimbabwe. However, the programme is ultimately only as good as the staff who run it and it is in the best interests of PSI/Z to maintain an open and honest dialogue with the staff about salaries and working conditions. PSI/Z should also take specific and immediate steps to improve the working environment and re-motivate the staff; for example, the organization should also move to a more decentralised decision-making process and it should consider launching new staff development activities.

9. Corridors of Hope

Expand to key hubs inside Zimbabwe. A deficiency of the Corridors of Hope initiative is that it does not continue to reach at-risk populations connected to long-distance trucking in the interior of the country.

Link to VCT and other follow-up services. Wherever possible, Corridors of Hope interventions should be linked to other programme components, such as the New Start and New Life centres and services provided by other organisations.

10. Donors

Synchronise the end date of the programme.

Conduct a detailed review of the remaining budget to prioritise expenditures. PSI/Z is experiencing serious difficulties with the budget line for salaries and should explore with donors the potential to shift funding between budget lines to ensure adequate resources are allocated to address the recommendations of this assessment.

Establish a forum for donor-funded programmes. At present some programmes appear to be operating in parallel, resulting in duplication or overlap of activities. USAID-coordinated partner meetings are considered useful but insufficient to address technical aspects of programming or to promote collaboration. USAID and DFID should take the lead in promoting greater collaboration between donors, implementing agencies and multilateral organizations, and the objectives of the forum should be to improve coordination, harmonise technical approaches, share lessons learned and ensure more effective linkages between activities.

Annex 1.
Output to Purpose Review

PROGRESS IN IMPLEMENTING PREVIOUS OPR RECOMMENDATIONS

PSI/Z has followed up many of the 2002 and 2003 OPR recommendations. Those not yet taken up are as follows:

- **Recruitment of a social scientist to support poverty analysis.** This was a recommendation of the 2002 OPR. The 2003 OPR suggested use of consultants with qualitative research skills for analysis of poverty and gender issues as an alternative to employing a social scientist. With the exception of some formative research on cross-generational sex and for the trusted partner campaign, PSI/Z has conducted limited social science analysis and it was not clear to the review team that PSI/Z has specific plans to follow up on this issue.

- **Assessment of whether uptake of the female condom though hair salons is sustained.** This was a recommendation of the 2002 OPR. The 2003 OPR also recommended that PSI/Z conduct such an assessment and provide findings within 6 months. The July 2004 hair salon assessment does not provide this information, and the 2004 review recommends that PSI/Z conduct a wider assessment of uptake and sustained use of the female condom during the coming year. Consideration could be given to conducting this in partnership with ZNFPC.

- **Liaison with ZNFPC on targeting of the female condom to share lessons.** This was a recommendation of the 2002 OPR. The 2003 OPR recommended that this be revisited in the light of DFID decision on whether to continue working with ZNFPC on the female condom. The 2004 review found little evidence to indicate a proactive approach to sharing lessons with ZNFPC.

- **Monitor New Start Plus to ensure public sector health facilities are not undermined.** This was a recommendation of the 2002 OPR. The 2004 review recommends that New Start Plus centres focus on provision of counselling and referral services rather than expanding to include clinical services. If this approach is taken, New Start Plus centres are unlikely to undermine public sector health facilities.

- **Develop MOU with ZNFPC.** This was a recommendation of the 2002 OPR. The 2003 OPR proposed that this be revisited following the development of an overview of the availability, access and utilisation of public sector and socially marketed commodities. ZNFPC reports that it has a MOU with PSI/Z. PSI/Z reports that it has mapped distribution outlets and availability of Protector Plus at district level and is working with ZNFPC to map Protector Plus and *care* distribution outlets at ward level and public sector product distribution. However, it was not clear to the review team that there is clear agreement on market segmentation; discussions indicated competitiveness rather than complementarity between the two organisations.

- **Ensure that over time a greater number of senior management positions are filled by Zimbabweans and development of the capacity of Zimbabwean staff members.** This was implied in the 2002 OPR report and reinforced by the 2003 OPR. The 2003 OPR agreed that PSI/Z would provide at the 2004 review an overview of how its management and staffing structure had evolved since the inception of the programme, specifically a profile of how the balance between expatriate and Zimbabwean staff has shifted and how key responsibilities have changed as PSI/Z has developed its programme. This overview was not available. The 2004 review recommends that PSI/Z take steps to address the continuing imbalance between expatriate and Zimbabwean staffing at senior management level.

- **Expansion of provision of PSI/Z products and services to rural areas, including resettlement areas.** The 2003 OPR recommended that PSI/Z expand rural coverage and, specifically, exploit the reach of Protector Plus distribution into resettlement areas as a matter of urgency to meet existing unmet demand. Consideration was also to be given to achieving greater impact by working with FCTZ to create demand. PSI/Z has taken some steps to expand distribution in rural areas, through food distribution points and through collaboration with Coca-Cola and FCTZ. The former has ceased with the ending of food distribution activities, and rural reach through the latter remains limited. Protector Plus is still largely distributed in urban centres. The 2004 review recommends that PSI/Z prioritise expanding reach of Protector Plus to areas defined in the 2003 national HIV prevalence report as 'other' (growth points, resettlement areas, commercial farm estates, border towns, mines, national parks and army camps), since these have the highest prevalence rates in the country, and expanding VCT services in these areas through outreach, provided that clients can be linked to care and support services.

- **Explore other organisations' interest in taking on responsibility for managing post-test clubs.** This was agreed during the 2003 OPR. Although PSI/Z recognised that post-test clubs is not its core business, it decided to continue to manage these clubs. PSI/Z has re-branded these five Moving On Clubs as New Life centres.

- **Convene a meeting with JSI and ZAPA to explore opportunities for future work with pastors.** This was a recommendation of the 2003 OPR. The review team saw no evidence to indicate that a meeting had been convened. PSI/Z has provided support to train 25 pastors. The 2004 review recommends that PSI/Z explore the potential for other programmes such as ZAPA and JSI to work with pastors and FBOs to reinforce the proposed stigma campaign, rather than implementing training directly.

- **Disaggregation of ProFam clients by socio-economic class and socio-economic targeting of ProFam.** The 2003 OPR agreed that PSI/Z would continue to track the socio-economic profile of ProFam users and strive to improve focus on LSM 3-5. The 2004 review concludes that the expectation that ProFam providers will serve LSM 3-5 is unrealistic in the current economic environment.

- **Changing the programme completion date.** This possibility was discussed during the 2003 OPR, to bring the USAID (July 2005) and DFID (December 2005) end dates into line. PSI/Z has not submitted a formal request to DFID. The 2004 review recommends that consideration be given to synchronising the two donor end dates.

NOTE: Recommendations arising from the 2004 OPR are included in Section V of the review report.

PROGRESS TOWARDS OUTPUTS

The team reviewed progress towards outputs by assessing programme achievements against the indicators in the original DFID logframe (October 2001) and joint DFID and USAID revised logframes (June 2004), drawing on available information, including the PSI/Z briefing and latest quarterly report (Q12: April-June 2004).

Output 1: Sustained high access to affordable male and female condoms

Revised indicator	Original DFID indicator	Progress
150 million Protector Plus male condoms and 3 million *care*	50 million Protector Plus male condoms and 700,000 *care*	• Original target for Protector Plus sales already exceeded at the time of the 2003 OPR.

female condoms sold	female condoms sold	• Protector Plus sales (11.64 million in Q12 and cumulative sales to date of 95.44 million to date) are on track to meet the revised OVI target. • Original target for *care* sales already exceeded at the time of the 2003 OPR. • *care* sales (150,540 in Q12 and cumulative sales to date of 2.4 million) are also on track to meet the revised OVI target.
Protector Plus available in 80% of liquor related and other night outlets	Same as revised indicator	• Baseline in 2001 was 44%. • Information on the current status of this OVI was not available at the time of the review. • Most recent comprehensive PSI/Z distribution surveys conducted in 2001.
Protector Plus perceived as affordable by 84% of LSM 1-6	Same as revised indicator	• OVI target already exceeded at baseline in 2001 and at time of 2003 OPR. PSI/Z aims to maintain level of perceptions of affordability. • Information on the current status of this OVI was not available at the time of the review. PSI/Z conducts a KAP survey, the main source of information on this OVI, every 2 years. Data from the next survey will be available end 2005. • Price of Protector Plus was increased in April 2004 from Z$5 to Z$100, following willingness to pay study. • Comparison by OPR team with prices of other products (e.g. cooking oil Z$9,800; soap Z$4,200; Coke Z$2,200; beer Z$5,000; one cigarette Z$200) suggests that Z$100 is very affordable.
Proportion of Protector Plus sales that are rural increases from 29% to 40%	No indicator originally proposed; rural presence indicator for condoms suggested in 2002 OPR	• Rural sales accounted for 29% of all Protector Plus sales at the time of the 2003 OPR. • Information on the current status of this OVI was not available at the time of the review. • Rural sales through Coke (398,040) and the FCTZ (8,100) for Q12 represent 4% of total sales. • Review recommends focus expansion on areas where HIV prevalence is higher than the national average.
care perceived as affordable by 50% of urban single women	*care* perceived as affordable by 50% of urban single women	• OVI target already exceeded at baseline in 2001 and percentage increased to 59% at time of 2003

aged 15-34	aged 15-25	OPR. • Information on the current status of this OVI was not available at the time of the review. Data from the next PSI/Z KAP survey, the main source of information about this OVI, will be available end 2005. • *care* price increased in April 2004 to Z$300. No willingness to pay review conducted but comparison with prices of other products suggests that *care* is affordable.

Score: 2 (likely to be largely achieved)

Output 2: Increased knowledge and improved attitudes conducive to safer sexual practices

Revised indicator	**Original DFID indicator**	**Progress and comments**
Percentage who believe that condoms are effective against HIV is: - 74% among urban and rural male youth aged 15-24 - 83% among urban single women aged 15-34	Percentage who believe that condoms are effective against HIV is: - 86% among urban and rural male youth aged 15-25 - 83% among urban single women aged 15-25	• Data on perceived efficacy of condoms from PSI/Z 2003 KAP survey indicated a decline among male youth from 63% to 60% and an increase among urban single women from 54% to 55% since 2001. • Information on the current status of this OVI was not available at the time of the review. Data from next PSI/Z KAP survey, DHS and YAS will be available end 2005. • Review supports PSI/Z planned focus on condom efficacy in upcoming Protector Plus marketing.
Percentage of people who report that their peers approve of using a condom increased from: - 31% to 50% among urban male youth aged 15-24 - 22% to 45% among urban single women aged 15-34	Percentage of people who report that their peers approve of using a condom increased from: - 33% to 50% among urban male youth aged 15-25 - 22% to 45% among urban single women aged 15-25	• Data from PSI/Z 2003 KAP survey indicated an increase among urban male youth from 33% to 86% and among urban single women from 21% to 80% in peer approval of condom use since 2001, exceeding the OVI targets. PSI/Z aims to maintain these levels of approval. • Information on the current status of this OVI was not available at the time of the review. Data from the next PSI/Z KAP survey, DHS and YAS will be available end 2005.
Increase personal risk perception from x% to y% among youth aged 15-25	No indicator originally proposed	• Indicator introduced Q12. • PSI/Z plans to use secondary data sources (e.g. YAS, DHS) in addition to programme multi-round and KAP surveys to track this indicator.

Score: 3 (likely to be partially achieved)

Output 3: Demand increasing and regularly met for ProFam reproductive health services and products among low-income Zimbabweans

Revised indicator	Original DFID indicator	Progress and comments
Sales of socially marketed hormonal contraceptives provide 480,000 CYPs	Sales of ProFam supported contraceptives provide 160,000 CYPs, 40% to LSM 1-6	• Hormonal contraceptives sales are on track to meet the OVI target for CYPs (46,195 CYPs in Q12 and cumulative CYPs to date of 365,877).
Proportion of modern contraceptive method users from LSM 3-5 who choose ProFam as their source of contraceptives increases from 31% to 40%	Proportion of ProFam users from LSM 1-6 increased from x% to y%	• At time of 2003 OPR, proportion had declined slightly to 28%. No information on this OVI available at the time of the review but PSI/Z briefing to team reported that 30% of ProFam network members reach LSM 3-5. This figure is based on geographical location of providers rather than on analysis of socio-economic status of ProFam clients. • Proportion of contraceptive users from LSM 3-5 choosing ProFam as a source is likely to decline. Anecdotal evidence indicates that, due to the worsening economic situation in Zimbabwe, the middle classes are increasingly unable to afford private providers. At the time of the review a proposal to increase the cost of private sector consultation fees from Z$50,000 to Z$80,000-100,000 was under consideration. Such an increase would result in a further decline in the percentage of ProFam users from LSM 3-5. • Review recommends that PSI/Z cancel plans to reach LSM 3-5 through rural expansion of ProFam, since majority of private providers are in urban centres.

Score: 3 (likely to be partially achieved)

Output 4: Increased access and informed demand for affordable, quality VCT services and follow up

Revised indicator	Original DFID indicator	Progress and comments
93% of target group can cite correctly at least one place where s/he could obtain VCT services	Same as revised indicator	• Data from PSI/Z indicate that in 2001 93% knew where to obtain VCT services and 51% had knowledge of New Start; by 2003 this had increased to 96% and 62%

		respectively. • Information on the current status of this OVI was not available at the time of the review. Data from the next PSI/Z KAP survey, the main source of information about this indicator, will be available end 2005.
Increase from 46% to 65% of target group who report that they are likely to utilise VCT services	Increase from 46% to 86% of target group who report that they are likely to utilise VCT services	• Data from PSI/Z indicate an increase in percentage likely to use VCT services from 46% in 2001 to 69% in 2003. • Information on the current status of this OVI was not available at the time of the review. Data from the next PSI/Z KAP survey will be available end 2005.
12 New Start integrated and 7 New Start direct VCT centres operational at EOP	7 New Start integrated and 3 New Start direct VCT centres operational at EOP	• Original target already exceeded at the time of the 2003 OPR. • Revised target met. PSI/Z plans to add an additional New Start centre in 2004, taking total to 20, and a further 2-3 in 2005.
Rapid test kits introduced in all operational New Start centres	Same as revised indicator	• Original target already exceeded at the time of the 2003 OPR. • All New Start centres continue to use rapid test kits.
60% of clients are offered information on at least one community group to provide follow-up support	80% of positive clients are offered information on at least one community group to provide follow-up support	• Data available at the time of the 2003 OPR indicated that this percentage had declined from 60% in 2001 to 45%. The review team recommends that this indicator be revised to 100% of positive clients. • Information on the current status of this OVI was not available at the time of the review. PSI/Z plans to improve New Start and New Life data collection systems and to produce a referral directory. There are only 5 New Life centres; feedback from PSI/Z staff suggests only a quarter of the 19% of New Start clients who test positive go on to attend a New Life centre. • Post-test support is discussed in more detail in the main report.

Score: 2 (likely to be largely achieved)

Output 5: Increased capacity among PSI/Z staff

Revised indicator	Original DFID indicator	Progress and comments
70% of national PSI/Z line managers	70% of local PSI/Z staff line managers	• During 2003 OPR it was agreed that better way of measuring this

report that they are applying increased skills acquired in previous year	report that they are applying increased skills acquired in previous year	indicator was required and that the evolution of PSI business and composition of the management team over the programme lifetime would be considered by the 2004 review. • Indicator has not been revised and no information on management evolution was made available to the review team. • Management and human resources issues are discussed in more detail in the main body of this report.
Key GOZ officials consider PSI/Z critical collaborative partners for achievement of health objectives	No indicator originally proposed	• MoHCW and NAC consider that the PSI/Z programme plays a critical role in the response to HIV/AIDS in Zimbabwe and feedback to the review team regarding partnership with PSI/Z was very positive.
Continuing collaborative operations considered successful by PSI/Z and NGOs	No indicator originally proposed	• While PSI/Z has established good collaboration with some partners (e.g. FACT Mutare), there is scope for improved collaboration with NGO and private sector partners. Collaboration is discussed in more detail in the main report.

Score: 3 (likely to be partially achieved)

LIKELIHOOD OF ACHIEVING PURPOSE

Information was only available to the review team for three of the six purpose-level OVIs. Of these, PSI/Z is well on track to achieve the target for VCT clients and the proportion of clients tested through outreach, and has already reduced the cost per client to below US$36. However, without current data on the three OVIs related to sexual behaviour, it is difficult to comment on the likelihood of achieving the overall purpose.

Purpose: To increase safer sexual behaviour in Zimbabwe

Revised indicator	Original DFID indicator	Progress and comments
Male condom use in last risky (i.e. with non-spousal and non cohabiting partner) sex is: - 56% among male youth aged 15-24 - 49% among female youth aged 15-24	Male condom use in last sex act with non-spousal partner is: - 66% among rural male youth aged 15-25 - 72% among urban single women aged 15-25	• Figures available for 2003 were 75% and 67% respectively. • Information on the current status of this OVI was not available at the time of the review. Data from the next PSI/Z KAP survey will be available at end 2005. • PSI/Z will also draw on the findings of the 2005 DHS and YAS to assess progress towards these OVI targets.
Percentage of people having sex with more than one non-marital	Percentage of people having more than one partner in past	• Figures available for 2003 were 44% and 33% respectively. • Information on the current status of

and/or non-cohabiting partners in the past 12 months decreased from: - 52% to 41% among young makes aged 15-24 - 43% to 33% among young women aged 15-24	12 months decreased from: - 76% to 50% among rural male youth aged 15-25 - 66% to 50% among urban single women aged 15-25	this OVI was not available at the time of the review. Data from the next PSI/Z KAP survey will be available at end 2005. • PSI/Z will also draw on the findings of the 2005 DHS and YAS to assess progress towards these OVI targets.
Increase median age at first sex from 18 to 19 and from 19 to 20 years for female and male youth aged 15-24 respectively	No indicator originally proposed	• The 2001 baseline and 2003 aggregate figures were 19 and 18 years respectively, indicating a decrease in median age. However, the findings of smaller studies indicate that age of sexual debut is considerably younger. • Information on the current status of this OVI was not available at the time of the review. Data from the next PSI/Z KAP survey will be available at end 2005. • PSI/Z will also draw on the findings of the 2005 DHS and YAS to assess progress towards these OVI targets.
350,000 (revised upward from 298,000) clients requesting HIV tests and receiving results at New Start centres by January 2006, 86% from LSM 1-6	150,000 clients counselled at New Start centres by 2005, 86% from LSM 1-6	• Original target for VCT clients exceeded. With 38,560 clients in Q12 and total clients to date of 270,781, PSI/Z is on track to meet the revised OVI target. • Information on socio-economic status of New Start clients not available at the time of the review. Data from the next PSI/Z KAP study will be available at end 2005.
Proportion of total New Start clients that are tested through outreach increased from 21% to 27%	No indicator originally proposed	• 21% represents baseline figure for first quarter of 2004 when this indicator was introduced. • Outreach represented 25.8% of VCT clients seen in Q12 and 31% in July 2004.
Recurrent cost per client decreases to US$36 in final year	Same as revised indicator	• Baseline recurrent cost in 2001 was US$37. • Overall cost and recurrent cost per VCT client in 2003 calculated at US$33.4 and US$22.8 respectively. No figures available for 2004.

Score: 3 (likely to be partially achieved)

Annex 2.
List of Organisations Met

Government organisations:
- MoHCW
- NAC
- ZNFPC
- City Health Department

Donors and international NGOs:
- USAID
- DFID
- EU
- JSI (UK)
- JSI Deliver
- EGPAF
- US CDC
- Mildmay

Local NGOs:
- SAFAIDS
- PACT
- PPAAT
- Mrs Jambgwa (inter-faith organisation)
- ZAN
- The Centre
- HOSPAZ

Private stakeholders and partners:
- Barker McCormac
- Target Research
- Afro-Eye
- Zimbabwe Broadcasting Cooperation
- Coca-Cola
- University of Zimbabwe, Department of Obstetrics and Gynaecology
- GEDDES
- Shelley Pharmacy

UN agencies:
- UNFPA
- UNAIDS
- UNESCO
- UNICEF

PSI Sites visited:
- Harare New Africa House New Start direct site
- Harare Samora Machel New Life centre
- Chinhoyi and Chinoyi Hospital New Start indirect sites