USAID/ZIMBABWE

HIV/AIDS STRATEGY

FY2003 – FY2007

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TABLE OF CONTENTS

		Page Number
Acronyms		**iii**
Executive Summary		**4**
I.	**USAID/Zimbabwe's Philosophy and Approach**	**7**
II.	**Country Situation**	**7**
	A. Background	**7**
	B. Current Status of the HIV/AIDS Pandemic	**9**
	C. Zimbabwe's Response to the Pandemic	**10**
	D. USAID/Zimbabwe Program 1994 to 2002	**14**
	E. Partner Assistance	**16**
	F. Challenges	**19**
	G. Opportunities	**23**
III.	**USAID/Zimbabwe's HIV/AIDS Strategy for 2003 – 2007**	**24**
	A. Rationale and methodology for updating the strategy	**24**
	B. Summary of the Strategy	**25**
	C. Critical Assumptions	**27**
	D. Cross-cutting Themes	**27**
IV.	**Program Description**	**30**
	IR1: Reduced High-Risk Sexual Behaviors	**30**
	A. Behavior Change Communication	**31**
	B. Social Marketing	**33**
	1. Voluntary Counseling and Testing	**33**
	2. Condoms	**36**
	3. Contraceptives	**36**
	C. Commodity Logistics	**37**
	D. Community-based Distribution	**37**
	E. Prevention of Mother-to-Child Transmission	**39**
	F. Management of Sexually Transmitted Infections	**40**
	IR2: Enhanced capacity to formulate, advocate and implement improved HIV policies	**41**
	A. Building Advocacy Capacity	**42**
	B. Improved Information and Data for Advocacy and Policy Development	**44**
	IR3: Increased care and support of orphans, vulnerable children and individuals infected with HIV	**45**
	A. Orphans and Vulnerable Children	**46**
	B. Pre- and Post-test Services	**48**

C. Legal Assistance 49
D. Create and Expand Economic Opportunities 49
E. Comprehensive Medical Care 50

V. Vulnerability to Conflict 51

VI. Results Reporting 53
A. Magnitude and Nature of Expected Results 53
B. Country Reporting and Performance Indicators and Targets 53
C. Contribution to International and Expanded Response Goals 54

VII. Resources 55
A. Funding 55
B. Staffing 56
C. Procurement 56

Annexes

Annex I Map of Zimbabwe
Annex II Results Framework
Annex III USAID/Zimbabwe's Implementing Partners
Annex IV Partner Faith-Based Organizations
Annex V Social and Gender Analysis
Annex VI Performance Monitoring Plan (DRAFT)
Annex VII List of Persons Contacted
Annex VIII USAID/Zimbabwe and USAID/Washington HIV/AIDS Team Members

ACRONYMS

AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral
CBD	Community-based distributor
CBO	Community-based organization
CDC	Centers for Disease Control and Prevention
DHS	Demographic and health survey
FBO	Faith-based organization
GOZ	Government of Zimbabwe
HIV	Human immunodeficiency virus
HSV2	Herpes simplex virus 2
IR	Intermediate result
MOH	Ministry of Health
NGO	Non-government organization
NAC	National AIDS Council
NACP	National AIDS Control Program
NETA	National Emergency Task Force on AIDS
NIH	National Institutes of Health
OVC	Orphans and vulnerable children
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PSI	Population Services International
SO	Strategic objective
STI	Sexually transmitted infection
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNESCO	United Nations Economic and Scientific Organization
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID/Washington	United States Agency for International Development in Washington
USAID/Zimbabwe	United States Agency for International Development in Zimbabwe
VCT	Voluntary counseling and testing
YAS	Young Adult Survey
ZNFPC	Zimbabwe National Family Planning Council

USAID/ZIMBABWE

HIV/AIDS STRATEGIC PLAN, 2003-2007

Executive Summary

In 2002 UNAIDS estimated that 34% of Zimbabwe's sexually active population was HIV positive. With a total of 2.3 million Zimbabweans living with HIV, Zimbabwe has one of the highest HIV prevalence rates in the world. Over 600,000 Zimbabweans are estimated to have AIDS, while an average of 4,000 die each week due to AIDS. Zimbabwe also has one of the largest and fastest growing groups of orphans and vulnerable children in sub-Saharan Africa. It is estimated by that 2005 one third of all Zimbabwean children under 15 will have lost one or both parents.

Since the early 1990s, the Government of Zimbabwe has responded to the AIDS crisis in numerous ways. Key accomplishments include the adoption of a national policy on HIV/AIDS, the development of a strategic framework to guide a national response to HIV/AIDS, the establishment of a ministerial-level National AIDS Council to facilitate a multi-sectoral response to the epidemic and the introduction of a national "AIDS levy" payroll tax to improve AIDS services. At the same time, the level of commitment from the Government has been uneven and fragmented. Lack of leadership to spearhead AIDS efforts is of particular concern.

USAID's efforts to combat AIDS in Zimbabwe have expanded rapidly since its first AIDS prevention programs were initiated in 1986. In June 2000, USAID/Zimbabwe developed a detailed, comprehensive HIV/AIDS strategy to address the crisis for the period between 2000-2005. That strategy, which covered the same years as the approved Country Strategic Plan, has now been under successful implementation for almost three years. While the mission was convinced that the strategic approach outlined in that document continued to be valid, four key events required that it be reviewed and updated. First, in April 2002, USAID initiated a "Stepping Up the War against AIDS" plan that required that all missions carrying out HIV/AIDS activities at a level of $1.0 million or more submit to USAID/Washington a strategy for technical approval. With a budget of approximately $7.0 million per year, Zimbabwe clearly fell into that category. Second, as part of USAID's Expanded Response to HIV/AIDS, in 2002 Zimbabwe was reclassified as an intensive focus country, indicating that additional resources may become available. There was a need to determine how those resources could most effectively be programmed. Third, the humanitarian, economic and political crises currently confronting Zimbabwe have significantly altered the environment in which USAID's HIV/AIDS program is being implemented. A review of the impact of these crises, particularly the food shortage, on the strategy seemed prudent. Fourth, knowledge of the epidemic has improved in both a programmatic sense (lessons learned both in Zimbabwe and throughout the world) and in terms of the epidemiology of the epidemic in Zimbabwe (through improved surveillance data). There was a need to integrate this new knowledge into the strategy.

Of these events, determining appropriate strategies for responding to the changes in the operating environment presented, perhaps, the greatest challenges. Due to the crises facing the country, Zimbabwe's once excellent public health system is disintegrating, leaving the country bereft of

quality health services, particularly in rural areas. In addition, the political and economic crises have resulted in hyperinflation, high unemployment, shortages of essential goods and widespread hunger. Compounding the problem, many international donors have discontinued their development programs, leaving significant elements of the national HIV/AIDS programs unfunded. Furthermore, due to the restrictions of the Brooke-Alexander Amendment and in response to the flawed Presidential election of March 2002, USAID/Zimbabwe is restricted in its assistance to the Government of Zimbabwe (GOZ). Strategically responding to a national crisis under such circumstances is difficult, particularly when full collaboration with the GOZ is critical to having a significant impact on the pandemic.

In spite of the challenges, a review of USAID/Zimbabwe's June 2000 strategy confirmed that the strategic approach presented in that document is still valid. At the same time, several recommendations emerged for expanding and scaling up successful programs, introducing new program elements, strengthening technical approaches, developing stronger geographic and programmatic linkages between the elements of the strategy and improving targeting. Under this strategy update, therefore, USAID/Zimbabwe's approved strategic objective, "HIV/AIDS Crisis Mitigated," has not been changed, nor was the intent of the three approved intermediate results altered. The wording of the intermediate results, however, was modified slightly to more accurately reflect program emphases and anticipated results. The revised intermediate results presented in this strategy update are:

- IR1: Reduced high-risk sexual behaviors
- IR2: Enhanced capacity to formulate, advocate and implement improved HIV policies
- IR3: Increased care and support for orphans and vulnerable children and others infected with HIV

The first intermediate result, "reduced high-risk sexual behaviors," continues to focus on reducing the rate of new HIV infections through an integrated package of behavior change interventions and preventive and supportive health care services. Under this intermediate result, USAID/Zimbabwe will strengthen its support for the delivery of behavior change messages through a wide array of media. Increased emphasis will be placed on targeting and providing a balance of messages. In addition, USAID will expand its support for health care services that assist Zimbabweans to reduce risk, make informed decisions, protect partners and otherwise engage in safe sexual behaviors. Social marketing programs, commodity logistics, community-based distribution of HIV awareness, balanced behavior change messages and management of sexually transmitted infections will be continued and expanded, while a new program in prevention of mother-to-child transmission will be introduced. Because almost all antenatal care takes place in public health care facilities, the strategy update argues that working with the public sector is essential if USAID is to play a significant role in prevention of mother-to-child transmission.

Under intermediate result 2, "enhanced capacity to formulate, advocate and implement improved HIV policies," USAID/Zimbabwe will expand its support for building advocacy capacity in the public sector, civil society, faith-based organizations, private sector employers and the media to address issues related to women's empowerment, youth, stigma reduction, reproductive health and children infected and affected by AIDS. Increased resources will also be allocated to collaborate with the Centers for Disease Control and Prevention to increase the availability and accuracy of epidemiological data on HIV.

The third intermediate result, "increased care and support for orphans and vulnerable children and others infected with HIV" responds to the need to reach both children and adults affected by the HIV/AIDS crisis with appropriate care and support. Key elements under this intermediate result include an expanded program of support for orphans and vulnerable children, increased emphasis on assisting HIV affected adults with legal services, employment opportunities and post test services, and exploring the feasibility of supporting models of comprehensive medical care and support.

Because USAID/Zimbabwe views the three intermediate results as inexorably linked, several common themes weave their way through all activities implemented under the strategic objective. Addressing gender imbalances, focusing on youth, presenting balanced messages through the A-B-C's of safe sex and reducing stigma are integral parts of all elements of the strategy. Zimbabwe's extensive network of faith-based organizations, private sector organizations, community-based structures and traditional leaders will play key roles in service delivery. Furthermore, USAID/Zimbabwe will continue to engage in transparent and participatory practices, involving communities, people living with HIV/AIDS, orphans and vulnerable children and others infected and affected by the HIV/AIDS epidemic. This strategy will outline areas where increasing involvement with the GOZ would help to achieve a more comprehensive approach to combating AIDS. Since this is a generalized epidemic, USAID/Zimbabwe will closely collaborate and coordinate its efforts with the GOZ. Without collaboration and coordination within a national framework, mitigation and significant impact on the epidemic will not occur.

In response to the severe political, economic, humanitarian and HIV/AIDS crises concurrently confronting Zimbabwe, USAID/Zimbabwe hosted a contingency planning retreat in January 2003 that developed three scenarios of how the situation in Zimbabwe may evolve over the next twelve to sixteen months. This strategy update includes a discussion of the implications of each scenario for USAID/Zimbabwe's HIV/AIDS strategy.

This strategy update is one component of a larger USG response to the epidemic in Zimbabwe. The U.S. Ambassador to Zimbabwe, has taken an active leadership role in the coordination of the combined USG response. The U S Embassy provides policy direction and guidance while the United States Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH) and the Public Affairs Section (PAS) directly implement HIV/AIDS programs. Together, these organizations are working collaboratively toward a common goal**:**

> ***Mitigate a national HIV/AIDS crisis by instituting proven prevention strategies while developing and implementing new interventions to assist HIV-infected persons, orphans, and others affected by HIV/AIDS***

The programs outlined in this strategy update, in coordination with other U.S. government, donor and national efforts, are expected to assist Zimbabwe in meeting the goals of the United Nations General Assembly Special Session on HIV/AIDS. Achievements at the country level will be tracked through HIV seroprevalence levels, changes in sexual risk-reduction behaviors and progress on USAID-funded program implementation and coverage.

I. USAID/Zimbabwe's Philosophy and Approach

To meet the challenge of a rapidly deteriorating Zimbabwe environment, the Mission believes that it is imperative to implement a *strategic* and *focused* program that builds on USAID's comparative advantages and utilizes opportunities to complement and build synergies with other national and donor-supported HIV/AIDS programs. To this end, the Mission has adopted a strategy that is closely coordinated with other USG agencies and donor programs and fits into and forms an integral part of the Government of Zimbabwe's (GOZ's) national approach to HIV/AIDS.

USAID/Zimbabwe believes that Zimbabwe's HIV/AIDS crisis cannot be viewed as only a health issue, but instead is a long-term development issue that is inextricably linked to the current food and economic crisis. Program implementation therefore requires a multi-sectoral approach carried out in close coordination both with other Mission programs and other strategic partner programs in other sectors. The team foresees that the need for an integrated, concerted attack on HIV/AIDS will last through at least the next two generations. The short-term strategy presented in this document will, in coordination with other USG agencies, donor and national efforts, assist Zimbabwe in meeting the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) goals. Continued, significant investments in HIV/AIDS will be required, however, before the epidemic will be under control.

To have an impact on the HIV/AIDS crisis, USAID/Zimbabwe is committed to using best practices, such as the ABC approach to safe sex. To complement these best practices, USAID/Zimbabwe will learn and try new approaches. The team will use lessons learned to improve its programs, will adopt innovations when there are clear indications that new approaches are needed, and will continue to be creative and take risks. To this end, the team believes that operations research, in conjunction with program implementation, monitoring and evaluation, is essential.

The strategy update presented in this document reflects these commitments. It presents a technical approach to the HIV/AIDS crisis that is based on almost eighteen years of experience with HIV/AIDS in Zimbabwe as well as the results of recent HIV/AIDS research findings throughout the world, while also taking into account the effects of the current crisis situation in Zimbabwe. It is the Mission's belief that implementation of this strategy will directly affect the lives of many Zimbabweans and will contribute to the development of a long-term solution to the HIV/AIDS crisis.

II. Country Situation

A. Background

Four interrelated crises are currently exacting a heavy toll on the people of Zimbabwe. Once considered a showpiece of Africa, the concurrent political, economic, HIV/AIDS and humanitarian crises have reduced Zimbabwe to a country that is home to an increasingly poor, malnourished, HIV-positive, politically disenfranchised and desperate population.

Political Crisis: The Government of Zimbabwe's (GOZ's) actions over the last few years have caused immense damage to the nation's economy, democratic institutions and social cohesion as well as to the welfare of the population. As a result, the political situation has become highly polarized, unpredictable and volatile. The Presidential election held in March 2002 was neither free nor fair according to most international observers, including the United States. Since the election, human rights groups have catalogued continued government-sponsored violence against opposition party members and perceived supporters of the opposition. Corruption and intimidation are widely reported and the distribution of relief food is becoming increasingly politicized. While there is no solution to the political impasse in sight, it is also clear that the long and difficult task of repairing the damage cannot effectively begin until the underlying political crisis is resolved.

Economic Crisis: Zimbabwe's economic crisis can be starkly illustrated with a few statistics: The economy has contracted by 34% in the last five years. It is estimated that it would take some sixteen years of moderate growth for the economy to recover to its original level. Instead, "growth" of real gross domestic product is currently forecast at between *negative* 12 and 17%. Inflation for 2002 was calculated at 198% and is rising. Unemployment climbed to an estimated 70% in 2002. Price controls have been extended to almost all basic commodities, decreasing production and resulting in acute shortages of staples and fuel. The rapidly shrinking economy and restrictions on foreign currency have resulted in a parallel exchange rate of over Z$1400 to the U.S. Dollar compared to 55:1 on the official market. The lack of foreign exchange is evident in the severe shortages of essential commodities, drugs, spare parts, food, fuel and agricultural inputs throughout the country. "Queuing" for these items is commonplace. Locally produced foodstuffs, including the staple food, mealie meal, are also in short supply, causing prices to increase beyond the reach of the majority of Zimbabweans.

HIV/AIDS Crisis: The HIV/AIDS crisis touches virtually every family and every institution in Zimbabwe. An estimated 2.3 million Zimbabweans[1] are HIV positive, with approximately ninety percent of those unaware of their HIV status. An estimated 600,000 Zimbabweans have AIDS and approximately 3,846 die each week due to AIDS. With access to antiretroviral (ARV) treatment very limited (both in terms of availability and cost), less than 1% of those who are HIV positive are currently being treated. In 2001 it was estimated that some 782,000 children had been orphaned due to HIV/AIDS, representing 76.8% of the nation's orphans. That number is expected to increase to 1.1 million by 2005. Due in large part to HIV/AIDS, life expectancy has fallen from 61 years in the mid 1980s to 39 years.[2]

The impact of the HIV/AIDS crisis is felt most acutely at the household level, where it is driving Zimbabwe's poor deeper into poverty. HIV-infected breadwinners become unable to work precisely when the costs of their care increase. Furthermore, other family members are frequently forced to stop working to care for the ill. The major burden for care falls on women and girls, reinforcing existing gender inequalities. Traditional coping mechanisms through

[1] Unless otherwise indicated, epidemiologic data in this strategy are from the UNAIDS' Report on the global HIV/AIDS epidemic, 2002. USAID/Zimbabwe acknowledges that there is some concern that UNAIDS may overestimate prevalence in the general population and realizes that this will be a topic under review. However, for Zimbabwe, the UNAIDS figures represent the most comprehensive, reliable source of data available.
[2] U.S. Bureau of Census

extended families and communities have become overextended as the number of AIDS patients and children affected by HIV/AIDS has increased.

The Humanitarian Crisis: The humanitarian crisis in Zimbabwe has been caused in large part by the politics of land and food, with some three million people having been displaced from fertile farm land because of aggressive land reform policies. Drought, crop failures and shortages of agricultural inputs (related to the economic crisis) have exacerbated the situation. The humanitarian situation in Zimbabwe remains precarious despite an enormous effort by the international community and unexpectedly large off shore purchases of maize by the GOZ. Well over one half of the population, or some 7.2 million people, required emergency food and other humanitarian assistance to survive at the start of 2003.

As part of USAID's humanitarian assistance strategy for Zimbabwe, three possible scenarios were developed: decline in the current situation, collapse, and improved situation. These scenarios and their pertinence to the context under which the activities detailed in this strategy will be implemented are discussed in Section V of this strategy.

B. Current status of the HIV/AIDS Pandemic

The antenatal surveillance system in Zimbabwe did not function well for several years, meaning that accurate national epidemiological data on HIV was unavailable during the period in which the HIV/AIDS crisis began to grow. In early 2000, the United State's Centers for Disease Control and Prevention (CDC) began working with the GOZ to improve surveillance. As a result, quality data are now becoming available that will allow for better understanding of the epidemiology of AIDS in Zimbabwe.

In 2002 UNAIDS estimated that 34% of the sexually active population was HIV positive. With a total of 2.3 million Zimbabweans living with HIV, Zimbabwe is thought to have the second or third highest HIV/AIDS prevalence in the world. Virtually the entire population is at risk in this generalized epidemic. There appears to be very little difference in prevalence among rural and urban populations, but there is some variation among men and women in different age groups.

According to antenatal surveillance carried out between October and December 2000, HIV prevalence among pregnant women was 35%. Prevalence was highest among women aged 30-34 years (43.5%), while prevalence among women aged 15-19 was 27.8%. There is some concern, however, that the 2000 survey was flawed and that the data is skewed. Antenatal survey data from 2001 found a 29% prevalence. Preliminary data from the 2002 antenatal survey, which is still being analyzed, also indicate a prevalence of under 30%. CDC's recently conducted Young Adult Reproductive Health and HIV/AIDS Survey (YAS), which collected HIV prevalence and behavioral data on a representative sample of males and females aged 15-29 years, found HIV prevalence of 22% among women and 11% among men. The highest prevalence was found in the 25-29 year age group for both women (35%) and men (25%).

The YAS found similarities in HIV prevalence between women aged 15-19 year (11%) and men aged 20-24 years (9%) and between women aged 20-24 years (26%) and men aged 25-29 years (25%). These similarities are possibly due to women having a younger age at first intercourse

and marriage compared to men and to the high incidence of cross-generational sex (younger women having sex with older and infected men).

Since the first case of AIDS was diagnosed in Zimbabwe in 1985, the country has experienced exponential increases in the number of people infected. By 1990, nearly 6,000 cumulative AIDS cases had been reported, 4,000 of which were reported in 1990. By late 1999, a cumulative total of 80,759 AIDS cases had been reported. The most recent cumulative total now stands at over 600,000. These numbers, while shocking enough, grossly understate the actual number of Zimbabweans living with AIDS. Factors such as the inaccessibility of HIV testing, the social stigma that stops many from seeking a diagnosis and the number of people who die before an official diagnosis of AIDS is made contribute to this underreporting. In addition, health workers frequently do not report deaths as AIDS-related due to both stigma and insurance-related issues.

According to the July 1990 AIDS Impact Model, approximately 92% of HIV transmission in Zimbabwe occurs through heterosexual sexual contact, with mother-to-child transmission accounting for 7% of all transmissions. The remaining 1% is primarily the result of contact with contaminated blood. Although poor medical practices have been cited as an important factor in HIV transmission in many African countries, World Health Organization research indicates that this is not true in Zimbabwe.

While Zimbabwe is experiencing a generalized epidemic and all Zimbabweans are considered "at-risk," there are still discernable groups within the general population that are at even higher risk. The 2000 HIV sentinel surveillance data indicates that HIV prevalence is higher among women living in commercial farming areas and in growth points within rural areas. Other studies, including extensive studies carried out at border sites in preparation for a regional AIDS program,[3] indicate that uniformed services, miners, commercial sex workers, border populations, truck drivers, those living along transport corridors and youth (especially girls) are population groups with particularly high risk. Given the crisis situation in Zimbabwe, it is believed that other high-risk groups may also be emerging, possibly including displaced commercial farm workers and older orphans and children affected by AIDS. Anecdotal evidence suggests, and most social scientists agree, that as a result of the economic crisis and food shortage, more women may be engaging in transactional sex, raising their risk of infection.

C. Zimbabwe's response to the pandemic

1. The Public Sector

Since 1992, when the GOZ obtained a World Bank loan for AIDS prevention and set up the National AIDS Control Program within the Ministry of Health, the GOZ has played a role in mitigating the HIV/AIDS epidemic. Key public sector players and programs are discussed below.

Ministry of Health (MOH)/National AIDS Control Program (NACP): The National AIDS Coordination Program was the initial leader of Zimbabwe's national response to HIV/AIDS. The NACP was responsible for the development and provision of voluntary

[3] See *Corridors of Hope Border Site Reports,* David Wilson

counseling and testing services, HIV/AIDS policy development, comprehensive training and treatment related to sexually transmitted infections (STIs), HIV surveillance activities and overall HIV/AIDS co-ordination. The NACP's annual budget allocation, however, was not adequate to cover its costs. The GOZ supported only about one third of NACP staff salaries, with donors funding the rest. Moreover, the NACP suffered from attrition as donors and NGOs offered better salaries and working conditions and as significant out-migration from Zimbabwe took place following aggressive recruitment by the United Kingdom and other countries.

In spite of these challenges, in 1999 the NACP, with USAID support, finalized two important policy documents to guide the national response to the AIDS epidemic: the *National Policy on HIV/AIDS for Zimbabwe* and the *Strategic Framework for a National Response to HIV/AIDS*. The *National Policy* is a comprehensive document that addresses all critical issues in the fight against AIDS. It has been widely disseminated throughout Zimbabwe and most of those working in the field are familiar with it. For the most part, however, the policy has not been operationalized.

The role and the name of the NACP were redefined in January 2000, when Parliament approved an act to establish a ministerial-level National AIDS Council to facilitate a more multi-sectoral government approach to HIV/AIDS. The newly formed NAC then assumed responsibility for HIV/AIDS resource mobilization, policy development, and overall coordination of HIV/AIDS programs while a new National AIDS and Tuberculosis (TB) Unit was established within the MOH and tasked with all health sector technical and medical functions related to HIV, sexually transmitted infections and tuberculosis.

National AIDS Council (NAC): Established in 2000, the National AIDS Council began to actively set up operational structures with the appointment of a secretariat in January 2001. Since then, the focus of the NAC has been on decentralization and the distribution of funds raised through the AIDS levy[4] payroll tax to the district-level District AIDS Action Committees. In carrying out these responsibilities, the NAC faces enormous obstacles. While the scope of the epidemic requires a rapid, coordinated response, quickly becoming operational within the large GOZ bureaucracy has been difficult. Recruiting and maintaining qualified staff has also been a problem, as is true in all public sector institutions. With its ability to offer competitive salaries constrained, the NAC has suffered from high staff turnover. To compound this problem, growing tensions between the donor community and the GOZ have made coordination difficult. Increasingly the donors are pulling away from having direct relations with the GOZ and reorienting assistance toward civil society groups.

The NAC was designated as the implementing partner for funds received by Zimbabwe under the Global Fund to Fight AIDS, Tuberculosis and Malaria (discussed below), giving it responsibility for substantial resources in addition to those raised through the AIDS levy. Under the Global Fund, resources will be allocated to help develop the capacity of the NAC. It is

[4] In early 2002 the GOZ introduced an "AIDS levy" payroll tax to improve AIDS services (excluding antiretroviral therapy). Funds from the levy are deposited into the National AIDS Trust Fund and distributed by the NAC. There have been allegations, particularly in the press, concerning abuse and misuse of AIDS levy funding. While many of the funds have been constructively used by the District AIDS Action Committees, other funds cannot adequately be accounted for.

envisioned that the Director and other key NAC staff will be funded by the Global Fund, thus mitigating the salary and staffing issue.

National Emergency Task Force on AIDS (NETA): In May 2002, Zimbabwe declared HIV/AIDS a national emergency, setting the stage for the country to import low-cost generic antiretroviral drugs. The National Emergency Task Force on AIDS was formed to coordinate comprehensive care for AIDS patients. NETA consists of leading University of Zimbabwe professors and the heads of the departments of clinical and preventive medicine and of pharmacy, the HIV/AIDS and TB Unit, the World Health Organization, CDC, Medicines Control Authority of Zimbabwe, NatPharm, physicians from central hospitals and others.

Drafts of national guidelines for HIV/AIDS care have been developed, including protocols for routine baseline labs for entry, ARV eligibility screening, and recommendations for patient monitoring. Standard treatment guidelines for antiretroviral therapy have been drafted as part of the HIV/AIDS Quality of Care Initiative. The guidelines are under review by the MOH. Until they are approved, there are no national guidelines to govern ARV use.

The Zimbabwe National Family Planning Council (ZNFPC): The ZNFPC, a parastatal, is responsible for coordinating Zimbabwe's national family planning program. Its mandate, defined by an act of Parliament, includes STI prevention. One major task of the ZNFPC is the procurement and distribution of condoms and family planning methods. In 2002, the ZNFPC managed 44 million condoms, 10 million cycles of oral contraceptives, 1,016,050 doses of Depo-Provera, 1,600 IUDs and 8,100 units of Norplant. The ZNFPC also plays a role in advocacy. It has conducted information, education and communication campaigns targeted at males and youth that include messages about STI and HIV prevention as well as family planning. Although favorably evaluated, the impact of these campaigns has been restricted by the lack of funding for long-term, follow-up programs. The ZNFPC trains a variety of cadres of family planning service providers, including family planning community-based distributors (CBDs). Zimbabwe has been noted for having an extremely strong and productive CBD program where over 580 CBD agents reach every district within the country. Although CBD agents are trained in both family planning and STI prevention, a 1994 situation analysis reported that CBDs rarely provide information about STIs to their clients.

Districts: Each district in Zimbabwe has formed a multi-sectoral District AIDS Action Committee. These committees were originally formed to coordinate the development of participatory, community-based district AIDS action plans, but once distribution of the AIDS levy began, they took on an implementing role. The committees now receive the AIDS levy funds distributed by the NAC and use these funds to provide services to AIDS infected and affected families, including children, according to the district action plan. Most people in the HIV/AIDS field who have visited District AIDS Action Committees say that they are functioning at different levels, with some working effectively and others being less successful.

Municipalities: Some municipalities have established (often through local non-government organizations) effective HIV/AIDS peer education, prevention programs, home-based care programs, voluntary counseling and testing centers, and STI treatment training centers. However, within the health facilities administered by rural district councils and the MOH, there are few ongoing, established community-wide prevention or care initiatives.

Other Government Departments: Among others, the Ministries of Education; Industry and Commerce; Public Service, Labor and Social Welfare; and Mines have had limited involvement in HIV/AIDS issues. The Department of Social Welfare, within the Ministry of Public Service, Labor, and Social Welfare, is responsible for child welfare. As such it is playing an extensive and increasingly active role in the provision of services for children affected by HIV/AIDS. Social workers, posted in every district, are expected to support and provide guidance to child welfare programs. However, like the MOH staff, the social workers are overwhelmed by the pressing load of work and do not have the time necessary to address this growing problem adequately. As with the health services, a significant number of Department of Social Welfare staff have left government service or have been recruited by other countries.

Uniformed Services: Zimbabwe's uniformed services carry out AIDS information and prevention activities, however, due to issues of national security, little is known about these programs. In the past, USAID has tried to work with the military. However, because of the secrecy and the military's inability to release data, it has been difficult to establish a working relationship with the uniformed services.

2. Non-government organizations

As the public sector collapses, Zimbabwe's non-government organizations (NGOs) are playing an increasingly vital role in meeting the health needs of the population, including orphans and vulnerable children (OVC).[5] In particular, NGOs operating community-oriented care, prevention and capacity-building initiatives have proliferated since the 1990s. The Zimbabwe AIDS Network lists 123 member organizations, most with full-time employees (up to 40 staff) involved in HIV/AIDS initiatives. Organizations are predominantly mission hospitals and clinics, AIDS and HIV-related service organizations, non-governmental organizations and private sector organizations.

Most NGOs involved with the Zimbabwe AIDS Network provide home care services and support for children affected by HIV/AIDS through volunteers; most also provide HIV/AIDS information and counseling; and over half provide pastoral support, nursing care, medical supplies and patient referrals. Many of the NGOs supply training for caregivers and support to self-help activities. Most directly implement care rather than establish partnerships with community groups. As a result, home care coverage is low. Although most of the NGOs are involved in awareness raising, few are involved in best-practice prevention activities which combine peer education, behavioral approaches and condom provision.

3. People Living with HIV/AIDS Support Groups

The number of support groups for people living with HIV/AIDS is growing rapidly. The most frequently reported support group activities include income generation (the main motivation for joining the group), home care, education about HIV/AIDS and counseling. However, only a few

[5] Throughout this document the term "orphans and vulnerable children" or OVC will be used inclusively to encompass *all* vulnerable children, including both those affected and infected by HIV/AIDS.

groups have received training in counseling and the failure rate of income generation activities is high.

Most support groups are members of the Zimbabwe National Network for People Living With HIV/AIDS, an umbrella groups which actively advocates for people living with HIV/AIDS. Unfortunately, in spite of external technical assistance and funding, the capacity of the Network remains weak, limiting its success in carrying out its mandate.

4. Faith-based Organizations

A large number of faith-based organizations (FBOs) are involved in HIV care delivery, more out of compassion than as a link to HIV. As is true of community initiatives (see below), these groups are predominantly female, rely on voluntarism and, for the most part, receive little external assistance.

5. Community Initiatives

Community response initiatives, which are widespread, are characterized by involvement in care and support of those affected by HIV/AIDS, including orphans, or income generation activities, rather than the prevention activities more common to organizations. Community organizations are also characterized by predominately female involvement, self-sufficiency and, in many cases, church-motivated voluntarism. Most initiatives are spontaneous. Few initiatives receive external financial or capacity-building support. Some responses have been facilitated by NGOs, which often provide technical and material support.

6. The Private Sector

Many initiatives have been established in the private sector, mostly in the area of HIV/AIDS prevention. Some of the more effective interventions have been established through collaboration with other organizations, such as commercial farm unions, mines and the transport sector. These initiatives often utilize peer education and behavior change technologies. Many smaller businesses have initiated awareness-raising activities and provide condoms to their employees. In 1998, the government passed a statutory instrument requiring employers to provide HIV/AIDS education to their employees, spurring the development of prevention activities in the private sector.

D. USAID/Zimbabwe Program 1994 to 2002

With its first HIV/AIDS programs starting in 1986, USAID has been a long-term, consistent supporter of HIV/AIDS interventions in Zimbabwe. Some of Africa's earliest targeted HIV/AIDS interventions, such as work with commercial sex workers, were initiated in Zimbabwe.

In 1994, USAID's HIV/AIDS strategy began to focus on behavior change. A comprehensive range of communications activities targeted high-risk populations in the commercial farms, the transport industry, the military, the private sector and the commercial sex industry. Mass media

campaigns targeted the general population, while youth were targeted via an HIV/AIDS education course that was added to the school curriculum. This strategy contributed to near-universal awareness of HIV/AIDS, with the Zimbabwe 1999 Demographic Health Survey (DHS) as well as other studies reporting that at least 98 percent of the general population is aware of HIV/AIDS. This approach, however, met with limited success in slowing HIV transmission because high awareness did not lead to behavior change.

In 1997, after analyzing HIV/AIDS prevention "best practices" from other African contexts, USAID/Zimbabwe refocused its behavior change efforts around a new voluntary counseling and testing (VCT) initiative, complemented by a vigorous condom social marketing program and targeted behavior change communication programs.

In April 1999, USAID Washington approved a new Country Strategic Plan for Zimbabwe for the years 2000-2005. "HIV/AIDS Crisis Mitigated" was approved as one of the mission's three strategic objectives. Accomplishment of the HIV/AIDS strategic objective was to be achieved through three intermediate results that centered on (a) behavior change that would slow or reverse the increase in the HIV/AIDS prevalence rate, (b) advocacy and policy development to increase Zimbabwean's control over the progress of the epidemic and (c) capacity building to assist orphans and children affected by AIDS.

Utilizing Zimbabwe's National Sport for HIV/AIDS Awareness

Recognizing the potential for using the international World Cup soccer tournament to reach Zimbabwean men with HIV/AIDS messages, USAID, in partnership with two local media companies, aired HIV/AIDS messages during the games. To complement messages encouraging men to go for an HIV test, the TV sports commentators wore "New Start" T-shirts (the brand name for the Zimbabwean VCT centers). Research after the games showed that the number of men seeking an HIV test increased by 34% compared to the previous 12 months.

During the three years that this strategy has been under implementation, USAID/Zimbabwe has achieved some notable accomplishments:

- Fourteen voluntary counseling and testing centers reached over 60,000 clients in calendar year 2002, while mobile VCT services reached an additional 3,796 clients in remote and hard to reach areas. With 49% of the VCT clients being female, it is clear that the VCT program is reaching both men and women.
- A television soap opera targeting youth was launched in September 2002. The program is aired three times a week and emphasizes abstinence, delayed sexual debut and other behavior change messages. Within only a few months, the soap opera became Zimbabwe's most popular television program, with over two million viewers.
- Socially marketed condom sales increased rapidly during this period, from nine million in 2000 to 20 million in 2002; sales of socially marketed oral contraceptives and female condoms increased by 95% and 32%, respectively, in the last year alone.
- Five pre-and post-test clubs were piloted to provide counseling, support and referrals, reaching over 3,000 clients in 2002.
- An innovative community-based prevention and mitigation program was initiated to support children affected by AIDS through education assistance, food security, psychosocial support and economic strengthening activities.
- Church leaders were increasingly mobilized to speak out against AIDS and help to break the stigma of the disease.

These accomplishments clearly indicate that USAID/Zimbabwe's relatively new programs are reaching their target audiences. Under this strategy update, USAID/Zimbabwe will enter a phase in which increased emphasis will be placed on analyzing the impact of interventions through operations research. For example, a study is currently underway to determine the impact of VCT and post-test clubs on clients' long-term behavior and stigma. Furthermore, the 2004 DHS will include questions to determine the impact of USAID's approach. In addition, USAID is updating the AIDS Impact Model using recent high quality epidemiological data to determine the impact of the national response to HIV/AIDS.

Regional Programs

In February 2000, USAID launched a southern Africa regional HIV/AIDS program, "Corridors of Hope," to work with high-risk border populations. In Zimbabwe, the program is supporting condom social marketing; STI prevention and treatment; and peer educators to increase awareness of HIV/AIDS among truckers, commercial sex workers and border uniformed services (customs officials, police) at key border sites and along major transport routes throughout Zimbabwe. *Miss Hope* competitions further increase awareness of HIV/AIDS through entertainment, helping to break the silence around sex and HIV/AIDS. The regional program has been integrated into USAID/Zimbabwe's national program through the co-location of targeted social marketing activities (supported under the national program) in the same geographic regions served by the regional program. USAID/Zimbabwe supplements regional funds with its own funds to implement the "Corridors of Hope" program.

USAID views the regional program as a very successful activity which has played an important role not only for its technical impact, but also for the way in which it has increased collaboration among health officers throughout the region by fostering dialog, information sharing, dissemination of lessons learned and increased coordination. Under this updated strategy, USAID will apply lessons learned from the regional program to internal hotspots throughout the country.

E. Partner Assistance

1. Other United States Government Programs

United States Embassy**:** The United States Ambassador to Zimbabwe, who is engaged in and committed to U.S. government-supported HIV/AIDS activities, has taken an active leadership role in coordinating the United States government's combined response to HIV/AIDS. Given that USAID and CDC have the largest HIV/AIDS programs, the Ambassador convenes monthly meetings with these two agencies to coordinate efforts. Furthermore, CDC and USAID communicate on a regular basis to ensure cohesion of activities.

Centers for Disease Control and Prevention (CDC): The arrival of CDC in 2000 significantly increased the level and importance of United States government support for HIV/AIDS in Zimbabwe. CDC has adopted a government-focused approach, working directly with the Ministry of Health. CDC supports GOZ programs to strengthen national surveillance; HIV prevention through the prevention of mother-to-child transmission (PMTCT) and behavior

change communication; care, including general and palliative care, opportunistic infections and ARV therapy; and monitoring and evaluation. In addition, CDC is strengthening laboratory capacity in Zimbabwe, upgrading Internet technology equipment and supporting HIV/AIDS-related training. CDC is also supporting the GOZ in the development of policies and guidelines in a number of areas, including PMTCT, and supporting a number of technical working groups. CDC has taken the lead role for coordination with the National Institutes of Health's in-county interventions.

National Institutes of Health (NIH): NIH currently supports several clinical and operational research projects in Zimbabwe, primarily focusing on HIV/AIDS, HIV-related conditions, and herpes simplex virus. By far the largest NIH project in Zimbabwe is the "HIV Prevention Trials Network," a joint collaboration of the University of Zimbabwe and the University of California, San Francisco to conduct and participate in Phase I, II and/or III prevention intervention clinical trials. Under the HIV Prevention Trials Network umbrella, studies are being conducted in the following areas: condom promotion and counseling, efficacy of vaginal microbicides in prevention of HIV, efficacy of extended PMTCT regimens to prevent HIV transmission during breastfeeding and effectiveness of ARVs to reduce transmission of HIV in discordant couples. In addition, NIH-funded research is being implemented to investigate HIV prevention in Harare beerhalls, the feasibility of community-based and mobile counseling and testing and hormonal contraception and the risk of HIV acquisition. Lastly, several NIH-funded activities focus on youth and adolescents. The Adolescent Livelihood Project consists of a two-phased study to 1) collect qualitative data from in-school and out-of school adolescent girls, boys and older men, and 2) a cross sectional survey of urban and rural adolescent girls with collection of behavioral and biological data. The Randomized Trial of HIV/STI Prevention in Zimbabwean Youth consists of the implementation and evaluation of an innovative HIV/STI prevention program involving students, professional peer educators, teachers, parents, rural health clinics and the wider community by means of a community randomized trial. The project will measure the effectiveness of the HIV prevention intervention in reducing incidence of HIV, herpes simplex virus and unintended pregnancy.

Public Affairs Office: The Public Affairs Office sponsors public diplomacy and exchange programs to increase the recognition and prominence of the HIV/AIDS crisis among Zimbabwean leadership, the media and civil society.

A document is currently being prepared that highlights the collaborative efforts between the various United States government agencies involved in HIV/AIDS prevention and care in Zimbabwe. This document will provide an overview of the combined United States government's response to Zimbabwe's HIV/AIDS crisis.

2. Global Fund to Fight AIDS, Tuberculosis and Malaria

Zimbabwe applied for $25 million from the Global Fund to Fight AIDS, TB and Malaria, including $15 million for HIV/AIDS and $10 million for tuberculosis and malaria. The funds were approved but not dispersed. One of the reasons for the delay in dispersement concerns how Global Funds will be at what rate funds will be transferred to Zimbabwe. At this writing the GOZ's official rate is Z$824 to US $1 while the majority of businesses and most other transactions are made at the parallel or market rate of Z$ 4,250 to US$1. There is much concern

that if the Global Fund monies were brought in at the GOZ official rate there would be a substantial loss in value.

A Country Coordinating Mechanism (CCM), chaired by the Minister of Health and staffed by representatives from several government ministries, NGOs, FBOs, United Nations agencies, USAID, other bilateral donors and private sector entities, was formed to prepare and submit Zimbabwe's proposal to the Global Fund. CDC provided significant technical input to the proposal for tuberculosis and HIV; the World Health Organization provided technical input for the malaria proposal. Both CDC and USAID are members of the CCM. CDC has the lead role in representing the USG on the Global fund in Zimbabwe.

As chair of the committee, the Minister of Health selected the National AIDS Council as the principal recipient of Global Funds. The USG (The Embassy, USAID and CDC) have been working collaboratively with the CCM and the Global Fund to ensure that funds will be dispersed to ensure program viability. The Global Fund will be an essential source of funding for HIV/AIDS activities since other sources of donor funding are no longer available to the GOZ.

Global Funds will be used for:

- Prevention of HIV transmission among young people with a focus on sexual and reproductive health services
- Expansion of VCT to rural areas
- Scaling up prevention of mother to child transmission
- Providing a holistic continuum of care, including ARV therapy

3. Other donors

The current political, economic and humanitarian crises have dramatically altered the donor landscape in Zimbabwe. Because the GOZ is in arrears on its multilateral obligations, both the World Bank and the International Monetary Fund, have suspended and/or terminated their activities in Zimbabwe. In the case of the World Bank, this includes the Social Investment Program that had a large HIV/AIDS component.

Several bilateral donors have also closed or suspended their development assistance programs in Zimbabwe, in some cases including their HIV/AIDS assistance. Germany and Denmark closed their development assistance programs in 2002, while Norway and Sweden relocated their regional offices to neighboring countries. Australia closed their program in 2003. The European Union continues to provide essential drug support and funds for blood safety and Japan provides limited HIV/AIDS funding. Bilateral donors that continue to work in Zimbabwe, like the United States and Great Britain, have significantly altered the nature of their assistance, limiting direct assistance to government and instead strengthening civil society organizations, in particular faith-based and community groups.

While *development* assistance has been curtailed, in response to the food crisis, the international donor community has significantly increased *humanitarian* assistance in Zimbabwe. Australia, Austria, Denmark, Finland, Germany, Norway, South Africa, South Korea, and Switzerland have

all provided humanitarian assistance. The United Nations has increased both its HIV/AIDS and humanitarian assistance to Zimbabwe through UNICEF, the World Health Organization, the United Nations Development Program, UNESCO and the UNAIDS secretariat. As part of the response to the food crisis, the United Nations has carried out a vulnerability assessment that specifically looked at the impact of food shortages on HIV/AIDS, increased its support to vulnerable groups and, wherever possible, has targeted HIV/AIDS affected communities with food relief.

Zimbabwe also receives funds for HIV/AIDS interventions from a number of foundations. The Turner Foundation provided funds to UNAIDS to strengthen the formation and effectiveness of District AIDS Action Committees. The Rockefeller Foundation is funding ARV research that is providing treatment to approximately one thousand six hundred Zimbabweans in an effort to determine the minimum laboratory services required for follow-up of ARV patients and the response of patients on continuous versus interrupted ARV treatment.

There are also a large number of international NGOs that continue to support HIV/AIDS activities in Zimbabwe, including Save the Children Fund, Doctors Without Borders, Oxfam, Action Aid, and others. These organizations support and compliment the large number of Zimbabwean civil society and faith-based groups that fund and implement HIV/AIDS programs.

F. Challenges

As described above, Zimbabwe is a country in deep turmoil. While addressing the HIV/AIDS epidemic presents a significant challenge under the best circumstances, in the Zimbabwe context the task is even more daunting. Some of the more significant challenges are discussed below.

1. Inconsistent Leadership

Zimbabwe's generalized epidemic requires a comprehensive, well-coordinated response under the leadership and commitment of the host country government. Without this, Zimbabwe's response to the HIV/AIDS crisis remains fragmented and piecemeal, with no overarching vision or uniform approach. Despite public announcements to the contrary, the GOZ has not made HIV/AIDS a priority that is commensurate with the significance of the national epidemic. Furthermore, the human and organizational capacity of the public sector to coordinate, mobilize and set directions for both national players and international partners in a united response to HIV/AIDS is becoming increasingly limited. The political crisis, the dire economic situation in the country, deteriorating salaries and poor working conditions have decimated the public sector. Tragically, deaths related to HIV/AIDS have also significantly contributed to the erosion of public sector capacity.

To compound this general lack of leadership within the government, there have been no leaders from any sector (including churches, trade unions, communities or traditional structures) willing to publicly display personal commitment to the fight against AIDS. In other countries, personal commitment has paved the way for more open dialogue about transmission, prevention and care, helping to reduce stigma and denial, reach new audiences and generate new approaches to prevention. Rapid advances have been made when presidents, prime ministers and other influential individuals take control of the AIDS response. In Zimbabwe, no such national leaders

have yet come forward. Instead, Zimbabwe's leaders continue to hide the illness among them with stories and excuses that perpetuate the shame and stigma associated with AIDS. This lack of leadership and commitment impairs all efforts to mitigate this tragedy.

2. Stigma

The HIV/AIDS epidemic in Zimbabwe is hidden behind a veil of denial kept firmly in place by the stigma attached to AIDS. Those openly acknowledging their illness risk social alienation, discrimination and other violations of human rights. Stigma facilitates the spread of HIV/AIDS, while undermining ongoing efforts to stem disease transmission. Stigma within families is often the most devastating, making disclosure to loved ones very difficult. Stigma also persists in the health care sector, media, religious and many other sectors, making it difficult for people living with HIV/AIDS to speak openly about their experiences. As long as silence, shame, guilt and ostracism are associated with AIDS, prevention and behavior change will be difficult.

3. Disintegration of the Public Health System

The MOH supervises the entire health sector and is responsible for administering provincial and district health teams, some rural clinics and most secondary and tertiary level hospitals.[6] Once hailed as the strongest in Africa, Zimbabwe's public health delivery system has been weakened severely by the combined impact of political events, economic recession and the HIV/AIDS epidemic. Quality of care in most public sector facilities has deteriorated dramatically. Based on the U.S. government's parallel market rate, per capita public health expenditures have declined from $2.59 in 1999 to $2.22 in 2000, to $0.32 in 2001 and to $0.10 in 2002. Virtually all public health facilities are now severely understaffed, while staff who continue to work within the system are both overwhelmed and demoralized. Remuneration is inadequate and staff have few supplies to be able to effectively discharge their responsibilities. Increasing numbers of employees are being recruited to work overseas, further contributing to staff depletion. Between the economic crisis (which has resulted in a severe shortage of foreign exchange), the political crisis (which has caused the international financial institutions to withdraw their support), the depletion of their fleet of vehicles and the absence of fuel, the GOZ is unable to either purchase or deliver desperately needed medical commodities. As a result, essential drugs, including those related to HIV/AIDS, are in short supply, especially in the most peripheral level health facilities. Virtually all essential drugs found in the country are currently funded by the European Union.

4. Absorptive Capacity

The same forces decimating Zimbabwe's public health sector affect all other public sector entities, increasingly limiting the capacity of the GOZ to receive, manage and utilize funds. Similarly, Zimbabwe's civil society organizations have limited management and operational capacity, largely due to out migration. As a result, donors tend to channel their support through

[6] Primary health care in cities and towns is administered by municipal health services, while rural health clinics are administered by rural district councils (Ministry of Local Government). Over half of rural health hospitals and clinics are administered by churches. A large, mostly urban, private sector of doctors and hospitals exists to cater for individual patient care. All health providers administer treatment for STIs and HIV-related conditions.

the same few strong NGOs. The ability of these groups to absorb more funds and to maintain the same quality of programming on a larger scale is questionable. This lack of absorptive capacity within both the public and NGO sector constrains both the scaling up successful initiatives and the initiation of new activities.

5. Restrictions on USAID's Ability to Work with the Government of Zimbabwe

Since January 2002, USAID/Zimbabwe's program has been subject to the restrictions of the Brooke-Alexander Amendment. In addition, in response to the flawed Presidential election of March 2002, U.S. government policy has further restricted USAID's assistance to or through the GOZ. These constraints not only limit USAID's ability implement a HIV/AIDS crisis mitigation program, but also negatively affect the sustainability of HIV/AIDS investments in the country for several key reasons:

- A strong, functioning public health sector is critical to addressing a generalized epidemic such as that found in Zimbabwe. Whereas non-government, faith-based and private sector-operated programs are effectively reaching certain target populations, they do not have national coverage and, in the absence of strong leadership, are not coordinated in a way that ensures national coverage. Supporting the public health system, with its widespread infrastructure, is the most effective means of reaching Zimbabwe's people.

- Both the economic decline and the loss of human capacity have left Zimbabwe's public health infrastructure unable to cope with the escalating numbers of HIV infected patients. Yet, at some point, the crises in Zimbabwe will end and recovery will begin. Maintenance of key investments in the public sector health system is essential to ensuring that the public sector will be positioned to take on the task of recovery.

- Zimbabwe's social safety net/social welfare system, while lacking the resources to adequately cope with the ongoing crises, continues to have a means of targeting the vulnerable and mechanisms in place for actually reaching them. Rather than create a parallel system that undermines the GOZ, support for the growing numbers of orphans and vulnerable children should build on and reinforce the system that is already in place.

Balancing these factors presents a continuous challenge for USAID's activity managers, demanding creative approaches and skilled diplomacy. USAID has been able to coordinate with and complement CDC programs with the GOZ. This strategy will outline areas where increasing involvement with the GOZ would help to achieve a more comprehensive approach to combating AIDS.

6. Food Issues

The interrelationship between, food, nutrition and HIV/AIDS is poorly understood, especially in peri-urban and urban areas. The general targeting strategy currently utilized by the humanitarian relief efforts in Zimbabwe is to identify vulnerable groups, including orphans and vulnerable children and people living with AIDS, and provide them with general food relief rations. Using

this methodology, a number of HIV/AIDS infected and affected groups receive assistance. However, the efficacy of this approach needs to be monitored, documented and validated.

Zimbabwe's humanitarian crisis will remain unpredictable, given its complex political, social and economic structural nature and will require constant monitoring and regular assessments. Contingency planning efforts, already underway, will need to be regularly updated. To further develop linkages between humanitarian efforts and HIV/AIDS, USAID/Zimbabwe will continue to engage the humanitarian relief and recovery community to take into account the specific and particular vulnerabilities and needs of HIV/AIDS affected individuals and communities. The mission will also support a number of small studies to strengthen the targeting of relief assistance to HIV/AIDS vulnerable groups. It will also review the appropriateness and effectiveness of the food basket being provided and examine how households and communities in HIV/AIDS affected areas utilize food relief within the household. In particular USAID/Zimbabwe will look at further integrating food aid to support and strengthen its on going orphan and vulnerable children project, utilizing the extensive OVC network to more specifically target food aid distribution. In addition USAID will consider the potential for developing community food mixes that may be more appropriate, palatable and effective for HIV/AIDS infected children and adults and that can be prepared at the community level.

7. Changing donor landscape

The rapidly changing donor landscape in Zimbabwe has challenging implications for USAID assistance. First, with the withdrawal of a number of donors, significant and critical elements of the national HIV/AIDS programs continue to be unfunded. Second, as central government capacity declines due to funding, staffing and logistic constraints, the international community is being forced to assume a greater responsibility for program implementation. Third, there has been a marked switch among donors from long-term development assistance to emergency relief and humanitarian assistance. Finally, for political reasons, many donors are increasingly supporting civil society organizations and funding district-level activities, rather than the public sector at the central level. For USAID HIV/AIDS programs, these changes demand greater flexibility, increased emphasis on donor coordination and improved linkages with humanitarian and food assistance programs. The U.S. Ambassador is very supportive of USAID efforts to continue to provide critical HIV/AIDS assistance in the deteriorating and changing landscape.

8. Targeting in a generalized epidemic

As discussed previously, Zimbabwe is experiencing a generalized epidemic that places all Zimbabweans at risk. At the same time, there are discernable groups at higher risk. Targeting in such a situation requires multiple approaches. Different interventions are needed in different areas to reach different population groups. Furthermore, given the crisis situation and constantly changing dynamics in Zimbabwe, it is anticipated that high-risk populations will also be in flux. New high-risk groups will emerge that have not yet been identified by studies or observation. Throughout the period of this strategy, USAID/Zimbabwe will continually need to ask, “Who are we missing?” “Are there new groups at risk?” “How can we reach them?" "With what interventions?”

USAID/W will provide assistance to the Mission (within the next six months) on at risk groups i.e, size, geographic distribution, behavioral characteristics and seroprevalence.

9. Scaling up during a period of crisis

In the past, USAID/Zimbabwe adopted the successful strategy of initiating small, innovative programs and then scaling them up to national level, where national level impact could be expected, once feasibility was proved. Condom social marketing, as one of USAID's first HIV/AIDS interventions, went national some time ago. Other programs, such as VCT and certain care and support activities, have been tested and refined over the past few years and are now ready for scale up to reach greater numbers of HIV infected adults and children.

While this approach makes sense, allowing USAID to pilot new models, make adaptations and learn from mistakes before large scale implementation takes place, the rapidly evolving political, economic and humanitarian situation in the country constantly changes the environment in which programs are being implemented and scaled up. The implications of those changes for scaling up and out are not always clear. For example, the impact of food shortages on people living with AIDS is not known, making it difficult for USAID to respond appropriately. Similarly, the overall impact of the crisis situation on behavior change is not understood, with some questioning whether it is realistic to expect people to change their sexual behavior when access to food and employment are of more immediate concern for most.

G. Opportunities

In spite of the many challenges described above, there are reasons for optimism and numerous strengths and opportunities in Zimbabwe that can be built upon and utilized by those implementing programs to address Zimbabwe's HIV/AIDS crisis. First, preliminary data from CDC's Young Adult Survey indicate that there may have been a slight decrease in HIV prevalence among young people in some parts of Zimbabwe. While it is too early to draw conclusions, this may be an indication that the impact of USAID and other donor/GOZ consistent efforts over the past twenty years are beginning to be statistically noticeable. Second, levels of knowledge about HIV infection are almost universal throughout Zimbabwe, providing a solid base on which to build behavior change initiatives and to change people's perception of risk. Third, demand for HIV-related services is growing, as evidenced by the increasing numbers of clients at VCT centers, the increasing sales of condoms, and the growing interest in prevention of mother-to-child transmission. Fourth, 93% of Zimbabwean women seek antenatal care, offering a target of opportunity for PMTCT interventions. Fifth, Zimbabwe's family planning program has been highly successful, demonstrating that multi-faceted, long-term efforts pay off. Sixth, although public sector services are failing, Zimbabwe has strong faith-based and community-based organizations that are already being mobilized to provide HIV prevention and care. Seventh, the high level of education and trained personnel throughout Zimbabwe facilitate program implementation. Finally, Zimbabwe's infrastructure, although rapidly deteriorating, remains better than that found in many African countries, increasing access to the majority of the population.

USAID has had a strong program in place to capitalize on these opportunities to reduce HIV prevalence and offer increased care and support for HIV infected and affected individuals. The

refinements offered in this revised strategy will further help USAID/Zimbabwe meet the challenge.

III. USAID/Zimbabwe's HIV/AIDS Strategy for 2003 – 2007

A. Rationale and methodology for updating the strategy

In April 1999, USAID/Washington approved a new Country Strategic Plan for Zimbabwe for the fiscal years 2000-2005. At this time, the strategic objective "HIV/AIDS Crisis Mitigated" was approved. To operationalize this strategic objective, in June 2000 the mission completed a design document that more fully articulated the mission's HIV/AIDS strategy and described implementation modalities for achieving the strategic objective. The design document covered the same period as the Country Strategic Plan.

While the strategy presented in the June 2000 design document remains solid, a series of events over the past two years required that it be reviewed and updated. First, in April 2002, USAID initiated a "Stepping Up the War against AIDS" plan that required that all missions carrying out HIV/AIDS activities at a level of $1 million or more submit to USAID/Washington a strategy for technical approval. With a budget of approximately $7 million per year, Zimbabwe clearly fell into that category. Second, as part of USAID's Expanded Response to HIV/AIDS, in 2002 Zimbabwe was reclassified as an intensive focus country, indicating that additional resources may become available. There was a need to determine how those resources could most effectively be programmed. Third, the four crises described in the background section, above, have significantly altered the environment in which USAID's HIV/AIDS program is being implemented. A review of the impact of these crises, particularly the food shortage, on the strategy seemed prudent. Fourth, knowledge of the epidemic has improved in both a programmatic sense (lessons learned both in Zimbabwe and throughout the world) and in terms of the epidemiology of the epidemic in Zimbabwe (through improved surveillance data). There was a need to integrate this new knowledge into the strategy.

Building on the continuous dialog between USAID/Zimbabwe and USAID/Washington's HIV/AIDS Office, a team of six people from Washington[7] visited Zimbabwe in February 2003 to participate in a strategy review and lend their expertise to the process. Over a two-week period, a series of intense discussions was held with implementing partners, other donor organizations, groups providing humanitarian assistance and other relevant partners.[8] In addition, field visits were made and literature consulted. Based on their consultations, the combined USAID/Washington and USAID/Zimbabwe team revalidated the priorities and directions of the original strategy, but also agreed on "mid-course corrections" that could strengthen program impact in light of the contextual changes outlined above.

The strategy set forth in this document is therefore not a new strategy, but rather an *update* of a strategy that is being successfully implemented within the context of an approved Country Strategic Plan. It is anticipated that this HIV/AIDS strategy will be valid through 2007, but with another verification/update exercise taking place simultaneously with the development of a new

[7] See Annex __ for a list of team members.
[8] See Annex --- for a list of people consulted.

Country Strategic Plan. While this update has been reformatted to respond to requirements of USAID's Expanded Response to HIV/AIDS and therefore, in appearance, is different from the June 2000 design document, in fact the priorities and emphases remain constant. The strategic objective has not been modified and the intent of the three intermediate results remains unchanged. Key modifications include:

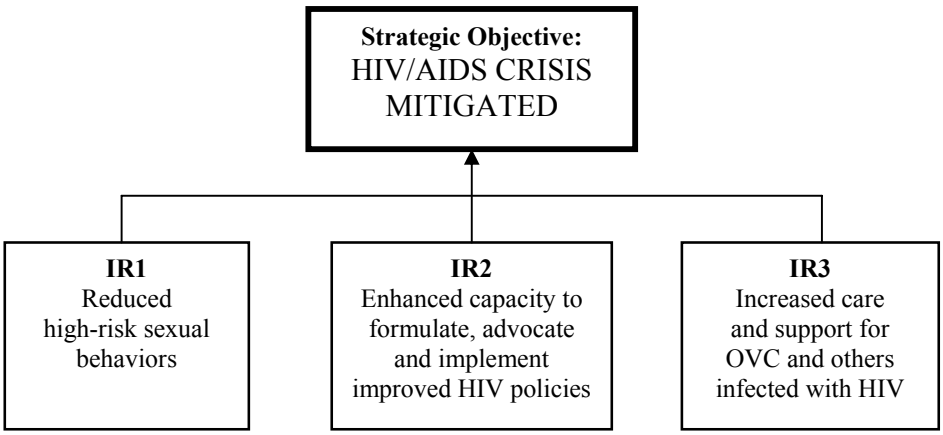
- The wording of the intermediate results has been modified to more accurately reflect program emphases and anticipated results
- There is greater emphasis on integrating programs and interventions to ensure synergies and impact--both geographically and within key populations
- Successful programs are being scaled up to reach a broader audience
- There is increased focus on reaching high-risk populations, including an increased focus on behavior change strategies targeted to specific, higher-risk subgroups of youth
- New activities in support of a continuum of care, including the prevention of mother-to-child transmission and antiretroviral drugs, are included
- The target group of care and support activities has been expanded to include adults as well as orphans and vulnerable children
- Ongoing efforts to provide services to OVCs and to link ongoing work with humanitarian efforts in the country are significantly increased
- There is increased emphasis on piloting different models of service delivery
- Operations research has been integrated into additional activities

The rationale for these changes will be discussed in the relevant sections of this document.

B. Summary of the Strategy

As illustrated in the results framework below[9], USAID/Zimbabwe will achieve its "HIV/AIDS Crisis Mitigated" strategic objective through three interrelated intermediate results (IRs). The first IR focuses on behavior change to reduce the rate of new HIV infections. The second IR supports the development of an improved policy environment, informed by the collection of high quality data and information. The third IR responds to the need to reach orphans and vulnerable children and others infected and affected by HIV/AIDS with appropriate care, treatment and support.

[9] See Annex II for a more detailed Results Framework that includes activities to be implemented under each IR.



This results framework has been slightly modified from the results framework presented in USAID/Zimbabwe's June 2000 design document. The strategic objective, "HIV/AIDS Crisis Mitigated," which was approved in USAID/Zimbabwe's Country Strategic Plan, remains unchanged. The word "crisis" in the strategic objective statement reflects the fact that USAID/Zimbabwe's efforts to combat HIV/AIDS are taking place in a crisis environment. The word "mitigated" highlights the fact that USAID is striving not simply to reduce HIV prevalence, but to support the full prevention-to-care continuum of interventions that is needed to reduce the crisis.

The wording of Intermediate Result 1 was changed from "behavior change through increased use of effective quality services for HIV prevention" to "reduced high-risk sexual behaviors." The revised wording is not only methodologically more sound than the previous IR statement, but, more importantly, also better reflects the result that USAID is striving to achieve. With 92% of HIV in Zimbabwe transmitted through heterosexual sexual contact, reducing high-risk sexual behaviors is clearly key to decreasing HIV prevalence and thus to mitigating the HIV/AIDS crisis.

Two changes have been made to IR2, "enhanced capacity to formulate, advocate and implement improved HIV policies." First, the words "of institutions" were removed from the IR statement (the original read "enhanced capacity *of institutions* to formulate and advocate for improved HIV policies"). It was felt that these words were too limiting. Second, the words "and implement" were added to the statement, as it was agreed that formulating and advocating improved policies is not adequate -- implementation of those policies is the real key. By supporting advocacy, policy formulation and implementation, stigma reduction and breaking the code of silence, activities under this IR help strengthen indigenous capacity, so that Zimbabwe, itself, is better able to respond to and mitigate the HIV/AIDS crisis in a strategic and sustainable manner.

IR3, was expanded from "improved care and support for vulnerable children" to "increased care and support for orphans and vulnerable children and others infected with HIV." The revised wording encompasses a larger target audience, not only reflecting USAID's position that infected adults and children are clear and equally important target groups, but also more accurately

reflecting USAID's commitment to international goals.[10] This intermediate result directly contributes to mitigation of the HIV/AIDS crisis by reaching out to those already infected and affected by HIV, helping ensure that they receive the care, support and treatment they require.

While each intermediate result is discussed separately below, USAID/Zimbabwe's strategy relies on the interrelated nature of the intermediate results for achieving maximum impact. Activities already under implementation as well as proposed new activities were identified, in part, for their ability to enhance and reinforce other activities. Strengthening linkages, both geographically and programmatically, and achieving program synergies to maximize impact is a crosscutting key theme that is woven throughout this strategy.

The financial and human resources required to achieve the specified results are discussed in Section VII of this document.

C. Critical assumptions

A series of critical assumptions were articulated during the development of this strategy update, including:

- USAID will continue to operate in Zimbabwe
- The government of Zimbabwe will continue to support the CBD program
- The ZNFPC will continue to function and maintain its role as the major family planning service provider for Zimbabwe
- Civil society will remain vibrant and committed
- There will continue to be NGOs with the capacity to absorb additional assistance
- CDC will continue to work with the Ministry of Health to support and strengthen its efforts to build a national PMTCT program
- USAID will be allowed to work with the GOZ to implement PMTCT within the public sector

D. Cross-Cutting Themes

In addition to the "linkages/integration of activities" theme mentioned above, several other common themes thread their way throughout USAID/Zimbabwe's updated strategy and all USAID/Zimbabwe-supported activities.

Gender: USAID/Zimbabwe recognizes the important role that gender and gender imbalances play in the HIV/AIDS epidemic. Empowering women and promoting male responsibility are themes that will continue to be integrated into all behavior change interventions. An extensive Social and Gender Analysis was carried out for the January 2000 design document which helped to ensure that the strategy presented in that document was responsive to gender issues in Zimbabwe (see USAID/Zimbabwe HIV/AIDS Strategy

[10] In 2001, USAID developed an expanded response to the Global HIV/AIDS pandemic and, with other donors and host country partners, is working to help local institutions provide basic care and psychosocial support services to at least 25% of HIV infected persons and to provide community support services to at least 25% of children affected by AIDS in high prevalence countries by 2007. (2002 update of the *Guidance on the Definition and Use of the Child Survival and Disease Programs Fund*).

Document, 2000). This analysis remains valid and relevant to Zimbabwe today and has continued to guide this strategy update. With minor changes, the Social and Gender Analysis is attached to this strategy as Annex V. However, because there have been both significant changes in Zimbabwe and lessons learned in program implementation since 2000, a few additional gender-related considerations that have been incorporated into this strategy update are highlighted below.

With the current food crisis, women may not be primary target beneficiaries for food distribution programs, may not receive rations first and are more likely to give/share their rations with their children. For all women, this affects their ability to care for their families. For those who are HIV positive, lack of food may increase their vulnerability to developing AIDS and render them less capable of caring for others in the family infected and affected by AIDS. As USAID/Zimbabwe coordinates with humanitarian programs, it will help ensure that food programs consider gender dynamics.

It is believed that Zimbabwe's poor economic conditions and lack of food security my result in more women, particularly young women who have not been commercial sex workers, engaging in transactional sex as a survival technique. It is very difficult for both women such as these, who may not see themselves as sex workers, and commercial sex workers to negotiate safer sex. Options for targeting and empowering such women will be identified. To complement these initiatives, activities that promote condom use with non-regular sexual partners will expand outreach to men, recognizing that it is difficult for women to negotiate condom use.

Violence against women continues to be a concern in Zimbabwe, as elsewhere in the region. Options for reducing such violence and reaching out to rape victims need to be explored, including working with faith-based organizations and traditional healers. As USAID continues to build on its prevention efforts targeted to youth to promote delay of sexual debut, gender considerations will guide program interventions, as many young women's first sexual encounters are coerced.

Gender does not just equal targeting women, but should also focus on the socialization of men and the construct of gender among both sexes. Programs to promote "be faithful" will target men, addressing social constructs with masculinity. The role of men as responsible partners will be expanded in behavior change messages.

Youth: Increasing the age of first sex, reducing the number of partners and increasing condom use among youth have tremendous potential to alter HIV disease transmission. As such, young people have been identified as a high-risk group that will specifically be targeted by the USAID/Zimbabwe program. However, because there is considerable variation within the "youth" category, some youth are at higher risk than others. To reach the many subcategories of youth, a variety of interventions will be required. For example, young unmarried youth, especially those who are not yet sexually active, will targeted with delay/abstinence programs, while intensive condom promotion campaigns may be more appropriate for youth who engage in transactional sex. At the same time, all sexually active youth need to have access to contraception methods, including condoms.

Under this strategy, USAID will continue to explore new means of reaching youth. Strong television and radio programs are already targeting this group, but grass roots communication strategies to promote HIV prevention behavior change need to be developed. Innovative ideas such as using internet cafes to disseminate messages will be explored. Furthermore, the need for special youth-friendly approaches (i.e. different counseling strategies) within VCT and post-test services will be evaluated. Mobilizing youth to engage more actively in care and support services will also be considered.

Working with Faith-based Organizations: Given that 90% of Zimbabweans are Christian, with most of those belonging to a church and actively religious, working with church organizations offers a unique opportunity to reach a large segment of the population with prevention and counseling. To date, churches and FBOs have mainly been involved in HIV care delivery. They therefore represent a huge, relatively untapped resource that could effectively be used for not only care of HIV affected groups, but also for channeling messages, launching motivational campaigns, promoting behavior change, stimulating discussion, advocating for policy change and reducing stigma. Because religious leaders are highly respected, messages delivered through them have the potential to be highly influential.

USAID has already begun substantial work to cultivate a closer relationship with faith-based organizations. Eight FBOs receive sub-grants under USAID's cooperative agreement with Catholic Relief Services to support community responses to orphans as well as other vulnerable children affected by HIV/AIDS. Similarly, World Pentecostal Evangelism Ministries, Kadoma Ministers' Fraternal and the Seventh Day Adventists are partners in USAID's advocacy and policy activities. In addition, 247 church leaders from eighteen different churches have participated in USAID-funded workshops for church leaders throughout Zimbabwe that aim to break the silence on the HIV/AIDS epidemic. (See Annex IV for more detail.) Under this strategy update, additional effort will be made to work with this influential and powerful group in all USAID-supported interventions.

Utilizing the A-B-C Approach: USAID/Zimbabwe will integrate the A-B-C's of safe sex into its behavior change messages, presenting a balance among and an explanation of a variety of different strategies for protecting oneself from HIV. Different messages will be used for different target audiences.

Involving traditional leaders: As the guardians of Zimbabwean culture, traditional leaders also play an important role in combating HIV/AIDS. USAID/Zimbabwe will involve traditional leaders in the planning and development of activities and will seek to use their influence as a positive force.

Reducing stigma**:** Until the stigma surrounding HIV/AIDS can be broken, HIV/AIDS will continue to be hidden, impeding all efforts to mitigate the crisis. Reducing stigma will be an integral part of all USAID/Zimbabwe-supported activities and a major focus of the advocacy program.

Strengthening community capacity to care and cope: It is anticipated that communities will continue to be the backbone of Zimbabwe's response to the HIV/AIDS crisis. USAID will increase its commitment to strengthening the ability of communities to assume this role, while

seeking innovate means to promote greater involvement of traditional leaders, trade unions, school children, women's groups, micro-finance and credit schemes and other traditional networks. Leaders will be trained to provide information, counseling and referrals.

Involving people living with HIV/AIDS (PLWHA): The important role that PLWHA can play in prevention, care, support, treatment and mitigation is well recognized. USAID has consistently tried to involve PLWHA in all its interventions, but will constantly look for additional ways to involve them in a significant and substantive manner, in particular in policy development and program design and implementation.

Working with the private sector: With the current decline in public sector institutions, private sector involvement in HIV/AIDS activities takes on increasing importance. USAID/Zimbabwe will strive to adopt a more systematic and strategic approach to involving this critical group. Activities supported under IR2 will specifically target the private sector and explore ways to leverage resources (including Global Development Alliance activities) within the private sector to expand access to comprehensive care and support services, including antiretroviral and palliative therapies for employees. USAID will also continue to increase the engagement of the private sector in providing integrated reproductive health services through training and support programs that enable health care providers to update their knowledge and encourage them to offer workplace services or refer clients for HIV-related services such as VCT and PMTCT.

Donor collaboration and coherence: USAID/Zimbabwe will actively seek to strengthen its collaboration with other United States government agencies and other donors to maximize the coherence, comprehensiveness and coverage of HIV/AIDS programs throughout Zimbabwe.

Operations research: In order to better understand program implications and impact, USAID/Zimbabwe will incorporate operations research into its programs, testing models and recording results so that both the mission and others can benefit from lessons learned.

IV. Program Description

IR1: Reduced high-risk sexual behaviors

Experience has demonstrated that, to achieve behavior change goals, behavior change interventions must occur in the context of quality complementary services such as effective programs that promote primary prevention; voluntary counseling and testing; post-test support services; condom distribution, including intensive promotion targeted to high risk groups; prevention of mother-to-child transmission; treatment of opportunistic infections; infection prevention; and blood safety. With this lesson in mind, under this IR, USAID will support an integrated program that includes:

(1) Behavior change interventions: USAID will continue its primary[11] behavior change and communication strategies, disseminating behavior change messages and mobilizing individuals and communities through community-based distributors, mass communication messages, faith-based organizations and community-based organizations. To reach as many of those at high risk as possible, a wide variety of communication approaches and channels will be exploited. Greater focus will be placed on inter-personal communication, segmenting the target groups more precisely, refining messages for each group, and addressing the balance between the various components. The emphasis will be on reaching those segments of the population that are not being reached, on targeting those with the highest risk, and on motivating people to both change their sexual behaviors and make use of HIV-preventive health care services. Because of the complex nature of the issue, innovative communication tools will be tested and used.

(2) Preventive and supportive health care services**:** Lack of quality support services, which are essential for risk reduction, making informed decisions, protecting partners and otherwise engaging in "safe" sexual behaviors, constrains Zimbabwean's ability to maintain or change behavior. Rural populations are particularly underserved. To overcome this barrier, USAID will increase the availability of quality voluntary counseling and testing, support the distribution of essential HIV-related commodities, enhance prevention of mother-to-child transmission services, and provide STI treatment. The GOZ, with European Union support, already has in place a strong blood safety program to prevent HIV transmission through blood transfusions. Intravenous drug use is uncommon in Zimbabwe and demands no specific interventions. CDC is working with the GOZ on improving universal precautions and supports HIV surveillance systems.

VCT, commodity distribution and STI treatment are activities included in USAID's June 2000 strategy. Under this update they will be both continued and expanded. PMTCT is a new and important area for USAID/Zimbabwe. The decision to become involved in PMTCT grew out of a desire to respond to the United States' President's PMTCT Initiative, the key role that PMTCT plays in interrupting transmission, the recognition that PMTCT is an important complement to preventive health care services already being supported by USAID and other donors, and the identification of several potential areas of comparative advantage for USAID.

Specifically, USAID/Zimbabwe will support interventions in behavior change communication; social marketing of voluntary counseling and testing, condoms and contraceptives; the distributio of commodities that support the USAID program; community-based distribution; prevention of mother-to-child transmission; and the management of sexually transmitted infections. Implementation of these activities is expected to result in reduced transmission of HIV.

A. Behavior Change Communication (Primary stakeholders/partners: PSI, MOH, NAC)

[11] *Primary* behavior change refers to a change in actual sexual behavior through abstinence, monogamy, delaying sexual debut, etc., as opposed to increased condom use, which indicates behavior change around condoms, but doesn't truly indicate a change in actual sexual behavior.

Expanding the ABCs of Safe Sex

USAID/Zimbabwe is expanding on, the original A-B-Cs of safe sex by including D-E-F and G. D = Delay early sexual activity, thus increasing the median age for first sexual contact. E = Early treatment of STIs, a major risk factor for HIV transmission. F = Frank discussions of protection and sensitive sexual issues with your partner. G = "Get Real" by learning your serostatus. "Frank discussions" is an important message in Zimbabwe not only for negotiating safer sexual behavior at the individual level, but also for the impact it can have on breaking the stigma of AIDS and the silence that surrounds the disease. "Get real" is the slogan under a new USAID-funded campaign aimed at challenging youth to learn their HIV status by visiting a "New Start" VCT center. This new area will be implemented on a small scale at first, to test the impact on sexual behavior change. While this new approach appears to be promising, lack of evidence will require assessment of activities for better understanding of this comprehensive approach.

Because people are diverse, with equally diverse preferences for risk reduction strategies when it comes to their reproductive health, USAID-funded behavior change communications messages will provide a balance among and an explanation of a variety of different strategies for how to protect oneself from HIV. The content of USAID-supported messages will revolve around the A-B-Cs of safe sex (**a**bstinence, **b**e faithful and **c**orrect and **c**onsistent use of condoms if one cannot abstain or stay faithful). Abstain and delay messages will specifically be targeted at youth, while "be faithful" messages promoting the reduction of sexual partners will be targeted at the sexually active population, including youth. Within the ABC approach, partner reduction probably has had the most impact in programs that have reduced HIV transmission, as demonstrated in countries such as Uganda. Based on this evidence, USAID/Zimbabwe will explore specific interventions which actively promote reduction in the number of sexual partners. The "B" message will therefore serve as the cornerstone of the prevention activities, while at the same time promotion of delay or abstinence will be included as well as the availability of condoms. Increased understanding of how young Zimbabweans perceive and respond to sexual risk has led USAID/Zimbabwe to also explore the possibility of expanding on the ABC model [see box] to reach young people with Zimbabwe-specific messages. However, it is understood that this expanded version of ABC has not yet been studied in terms of its impact on behavior change and therefore will be implemented on a small scale basis and evaluated thoroughly, while not replacing the proven and effective components of ABC as described above. As appropriate, these expanded messages will also be used to target specific audiences.

USAID will continue to make use of a wide array of media to disseminate HIV-related messages and encourage the use of HIV-related support services. To date, USAID has launched several nationwide information, education and communication campaigns ("Make a New Start Today," "Let's Talk," and "Get Real") to provide both the general public and targeted populations with information about HIV transmission and HIV prevention, including the availability of HIV-related services. These messages are helping to mobilize people, especially youth, to learn their HIV status, to use VCT services and to openly discuss HIV along with also maintaining a primary focus on promoting behavior change. The various media channels provide a good forum to promote protective behaviors, such as the reducing the number of sexual partners. The media campaigns will be segmented to target specific high risk groups as appropriate. The USAID-funded television soap serial, *Studio 263,* is Zimbabwe's most widely viewed local television program [see box], while a USAID-funded TV talk show (*This is Life*) provides a forum for open discussions of HIV issues. To complement these popular television programs and to reach those who do not have access to television, CDC recently launched a radio serial drama, *Mopani Junction,* that provides HIV prevention messages and USAID funds a radio talk show (*From Me to You*) and a youth reproductive health hot line (*Youth Chat-line*). In addition, USAID has funded several commercials using well known singers who deliver HIV/AIDS prevention messages.

Under this strategy update, USAID will continue and expand its behavior change communication efforts, constantly reaching out to new target groups and developing new messages that will update information and keep people engaged in the HIV/AIDS issue. New approaches include refocusing *Studio 263* to select key behavior change messages that focus on reaching young adolescents with messages to delay sexual debut and to reduce the number of sexual partners, with special attention to serial monogamy and cross-generational sex. The messages will be reinforced through other communication strategies. Linkages with faith-based organizations, the media, radio programming (such as CDC's *Mopani Junction*) and key leaders and decision-makers will be emphasized. In addition, a wider campaign targeted to the general population about the benefits of reducing the number of sexual partners will be introduced. Messages in this campaign will be reinforced through interpersonal communication channels within religious groups, communities, schools and with orphans. Intensive condom promotion will focus on higher risk populations and will be positioned to reach different high-risk segments of the population.

Studio 263

Launched in September 2002, *Studio 263* is a TV soap opera that airs half-hour episodes three times a week. Targeted at youth, the show deals with real, day-to-day issues confronting young Zimbabweans. Stories are designed to help youth understand the risks associated with sexual activity, especially HIV/AIDS and unwanted pregnancy, to understand the choices available to them in overcoming such risks and to create social support to for making their environment clean and healthy. By providing role models that young people can emulate, the series helps youth build their future according to who they are.

Studio 263, which opened with a viewership of 1.6 million, now has over 2 million regular viewers and is the most widely watched show on Zimbabwean TV. As one person said, "*Studio 263* has become a cult and [the main characters] are all household names today."

USAID's behavior change communication programs are expected to result in increased risk-reducing behaviors, particularly increased age of sexual debut, decreased number of sexual partners and increased condom use with non-regular partners, especially among high-risk populations.

B. Social Marketing

1. Voluntary Counseling and Testing (Primary stakeholders/partners: PSI, MOH, NAC)

A key component of infection control is the identification of those infected with the disease, followed by efforts to interrupt transmission. VCT is uniquely placed to serve as an entry point for both prevention of disease transmission and HIV care and support. Evidence is accumulating that VCT helps individuals to reduce sexual behaviors that put them at high risk for HIV infection. The weight of this evidence is strongest for HIV positive persons and sero-discordant couples.[12] In those who are HIV positive, the counseling provided through VCT and post-test support services is intended to influence the clients' sexual risk behavior to limit further transmission of HIV and to facilitate medical and social support. VCT also provides a critical

[12] Lancet 2000, July 8; 356(9224): 103-12; Kamenga, M. et al, AIDS, 1991 January; 5(1): 67-7.

> ***It's not the test results that are important. It's what we do with the results, how we conduct ourselves—to avoid infection or to spread infection.***
> Noerine Kaleeba, founder
> The AIDS Support Organization

entry point to other services for HIV positive persons, including preventive therapy for tuberculosis and opportunistic infections, PMTCT, STI and family planning services, home-based care services, legal services, ongoing counseling services and PLWHA and other support groups. Ready availability of VCT is also thought to be a factor in reducing stigma surrounding HIV. As stigma lessens, awareness, dialogue, problem-solving, and preventive action generally increase. Similarly, through its links and partnerships with community organizations, VCT also encourages community support and care for those infected with HIV.

Given that evidence suggests that VCT is most effective at reducing high-risk behaviors for HIV positive persons and couples, there is a strong argument for focusing VCT efforts in a way that will reach those at highest risk of being HIV positive. However, the studies that looked at VCT were not conducted in settings with prevalence as high as in Zimbabwe, where experience shows that there is a high self-perception of risk among the majority of VCT clients that test negative. This suggests that VCT may also play an important role in reducing high-risk behaviors among single persons who are HIV negative in high-risk prevalence settings such as Zimbabwe.

Since 1999, when the first five USAID-funded VCT centers opened, VCT has been the cornerstone of USAID's HIV/AIDS prevention program. USAID now funds 14 "New Start" VCT centers which provided services to more than 60,000 clients in CY2002 (up 40% from CY2001). To date, the vast majority of these clients have been from urban areas, where there is still a significant unmet demand. At the same time, the 65% of Zimbabwe's population that live in rural areas are also at risk and are not well reached by VCT. In 2001, USAID initiated mobile VCT services targeting hard-to-reach rural communities. These mobile services were scaled up in 2002 to reach 3,796 mainly rural clients.

In February 2003, a VCT stakeholders meeting was held involving the GOZ, local and national NGOs, researchers, USAID and CDC. At this meeting, participants began working on a united approach to VCT expansion. As part of this united approach, under this updated strategy, USAID's priority for VCT will be to increase access to VCT services for both urban and rural at-risk populations by (a) opening additional urban sites where there is still significant unmet demand; (b) building the capacity of the VCT programs to reach hard-to-reach populations through mobile VCT services; and (c) expanding VCT services to mission hospitals, which provide 65% of rural health care. This expansion of VCT services in rural areas will respond in part to the demand generated by the relatively new PMTCT programs being offered throughout Zimbabwe. Increasing numbers of male partners of the pregnant women tested at PMTCT sites are requesting testing at USAID sites. In addition, many of the women tested at PMTCT sites are requesting counseling through USAID's VCT centers, where staff are highly trained and are full time counselors. (Personnel in public sector PMTCT sites have numerous duties in addition to counseling and are unable to devote as much time to counseling as counselors in New Start centers).

Within these efforts to reach a greater percentage of Zimbabwe's high risk population, USAID will increase its efforts to target groups with high risk and high prevalence. The USAID VCT program is successfully targeting youth (60% of VCT clients are between 15-24 years of age). Data from the Zimbabwe Young Adult Survey (YAS) and antenatal surveillance data suggest

that men and women between the ages of 25 and 34 have a much higher prevalence of HIV, particularly women with a lower socioeconomic status. In order to further increase the impact of existing and future VCT programs, USAID may need to explore innovative community-based approaches to targeting and reaching groups such as these.

To improve its targeting, USAID will (a) explore demographics/epidemiology and disaggregate data from existing VCT sites so as to be able to direct programmatic efforts to reach those not currently being reached through existing efforts and (b) explore geographic coverage and cross-check this information with demographic information so as to be able to direct programmatic expansion to reach populations of high HIV prevalence that are not currently being reached through existing efforts. These efforts will help answer questions such as: Are urban, middle-aged persons likely to go to VCT centers? If not, how can they be reached? Should media efforts target them, or would community-based approaches be better?

As part of this targeting effort, USAID will also explore ways to further sensitize VCT services and outreach to stigma issues faced by hard-to-reach populations and will consider options for supplementing media-based VCT promotion/social marketing with community-based outreach to hard-to-reach populations, possibly through partnering with networks of traditional healers, churches and other groups.

To further improve VCT services and increase their impact, USAID will explore other options for strengthening the linkages between and integration of VCT with the existing health infrastructure and other USAID-supported prevention, care and support programs, including:

- Continue the VCT-STI treatment integration pilot that is already underway in selected New Start centers and through the regional program
- Explore the active case-finding and screening for TB within VCT services and/or strengthen referral networks between VCT and TB services. TB is a leading cause of death for Zimbabweans, particularly those living with HIV/AIDS, and VCT provides an opportunity to interrupt the lethal interplay between HIV and TB.
- Explore additional ways to integrate or more strongly link the opportunity provided by HIV diagnosis through VCT to comprehensive preventative and care services, including prophylaxis against TB, opportunistic infections, and antiretroviral and palliative treatment.
- Explore additional ways to integrate or more strongly link PMTCT and VCT to programs providing services for families affected by HIV/AIDS, particularly those providing services to HIV positive children and other vulnerable children
- Pilot a program to integrate family planning into VCT and VCT into family planning sites. This pilot will provide an opportunity to investigate whether those seeking family planning services are also at high risk for HIV and to investigate up-take of family planning services when family planning is added to VCT services. Given the limited data on FP-VCT integration, key operational research questions, including feasibility issues, will be explored. In addition, a tool or job aide to help counselors provide referral to family planning services (either within or close-to) the VCT sites will be developed. The feasibility of training VCT counselors in family planning settings will also be reviewed. In the future, the comparative feasibility and appropriateness of family planning within

VCT versus family planning within post-test care and support services should be explored depending on the results of the initial pilot program.

- Establish VCT centers at qualifying PMTCT/PMTCT Plus sites to provide access to VCT for partners/family members of pregnant women and other community members and to provide supplemental counseling to women receiving PMTCT services.

As a result of these activities, USAID expects to achieve the following results:

- Increased efficacy of VCT in achieving behavior change through reaching more HIV + persons with further targeting
- Increased access to VCT through the expansion of services to fill geographic gaps
- Reduced stigma
- Increased access to medical care and social support services for HIV + persons through program integration and expansion

2. Condoms (Primary stakeholders/partners: PSI, ZNFPC, MOH, JSI/Deliver, NAC)

Condoms, both male and female, are barriers to the transmission of HIV/AIDS. Condom use at last risky sex is one of USAID's three key global indicators. As shown in Thailand, targeted condom distribution programs that focus on high risk groups and/or high risk locations can contribute to a decline in HIV prevalence. The general population should also have access to condoms.

Coca-Cola and Condoms

In June 2001, the Coca-Cola Company, with its unrivaled marketing and logistics expertise, joined the international effort to combat HIV/AIDS. In Zimbabwe, USAID's contractor, Population Services International (PSI), made an arrangement with Coca-Cola to distribute condoms to rural areas. Under the agreement, PSI delivers condoms to Coca-Cola depots throughout Zimbabwe, then Coca-Cola distributes them through its vast commercial network of outlets. Although the partnership is in its nascent stage, Coca-Cola has been able to distribute over 50,000 condoms per month—many to hard to reach areas—and the number is growing exponentially.

USAID/Zimbabwe's public sector and condom social marketing program will continue and expand, placing grater emphasis on reaching high-risk populations, but simultaneously ensuring that condoms are available to the general population in both rural and urban areas. Youth, i.e. Zimbabweans between the ages of 15 and 29, are the key target group for this program. The program is, and will continue, to conduct extensive research that will lead to more effective targeting on the various diverse youth subgroups, for example urban and rural youth, in-school and out-of-school youth, male and female. Another target groups will be high risk groups at border sites, including, but not limited to, sex workers and truck drivers. USAID will consider developing other focused targeted condom social marketing programs at other "hot spots" that are not cross border sites. Educational and entertaining promotional material on condom use and HIV prevention will be developed.

USAID's public sector and condom social marketing program is expected to result in increased condom use at last risky sex.

3. Contraceptives (Primary stakeholders/partners: PSI, ZNFPC, MOH)

Contraceptives and family planning mitigate the HIV crisis at the household level in a number of ways. First, family planning is one method of reducing perinatal HIV transmission and, because it helps HIV positive women prevent unintended pregnancies, is considered an essential component of PMTCT. Second, spacing births improves the health of women and children. Dependency ratio studies have shown that spacing children at least three years apart reduces infant and maternal mortality. DHS data show both indicators deteriorating in Zimbabwe. Family planning cannot change these trends, but may mitigate the decreasing trend. Third, limiting family size helps families in the face of worsening economic conditions because large families are expensive. Even in Zimbabwe, which has a contraceptive prevalence of over 50%, there is still an unmet need for family planning. Fourth, family planning empowers women to make critical choices about child bearing if they are HIV-infected and about the size of their family if they are burdened with the care of others who are infected. Family planning is needed to slow the growth in the number of orphans in coming years and to help women manage their energies and time to effectively respond to the AIDS crisis.

USAID/Zimbabwe's contraceptive social marketing activity "ProFam" has been folded into the condom social marketing effort to enhance effectiveness. The examination of recent data has led to increased targeting of the program on the lower socio-economic sectors, which will continue under this strategy. The module on STI prevention and treatment will be expanded. Private sector providers—physicians, nurses and pharmacists—will be trained in family planning, STI prevention and HIV counseling.

USAID support for the social marketing of contraceptives is expected to result in reduced transmission of HIV, fewer orphans and vulnerable children and improved care of those infected and affected by AIDS.

C. Commodity Logistics (Primary stakeholders/partners: ZNFPC, JSI/Deliver, MOH, DFID, JSI/UK)

Effective distribution programs are essential components of a comprehensive HIV/AIDS prevention program. Availability and easy access to good quality HIV-prevention products are prerequisites for their use. Contraceptive procurement and logistics were very successful in Zimbabwe in the 1980s and 1990s, with USAID support playing an important role in that success. In the current crisis environment, however, Zimbabwe's public sector commodity distribution system has unraveled. Many clinics, particularly in rural areas, suffer from almost permanent stock outs because delivery from the central warehouses to clinics is extremely problematic.

At present, the Brooke Amendment prohibits USAID from providing contraceptives or associated technical assistance to the GOZ because the Zimbabwe family planning program is managed by the Zimbabwe Family Planning Council, which is a government parastatal. The British Department for International Development has agreed to provide support for this critical intervention.

Under this strategy, therefore, USAID will focus on reestablishing a public sector distribution system and making certain that condoms, contraceptives, ARVs and other HIV/AIDS-related

pharmaceuticals that are necessary for successful implementation of USAID/Zimbabwe's program get to the end user. Specifically, as recommended in a July 2002 transport study,[13] USAID will fund a commodities advisor and provide transportation means for selected supplies within the public sector network. USAID acknowledges that this is not a sustainable solution, however it will keep the commodities required for successful program implementation flowing during the current period of almost chaos.

USAID's support for commodity logistics is expected to result in increased availability of commodities that are essential inputs into several USAID-funded programs, increased condom use at last sex and increased use of contraceptives.

D. Community-based Distribution (Primary stakeholders/partners: ZNFPC, Advance Africa)

One of the most difficult groups to reach in Zimbabwe with HIV/AIDS awareness and behavior change messages is women and men of reproductive age who live in rural areas. Community-based distributors (CBDs), who have been providing family planning methods, including condoms, for over a decade, provide a key opportunity to reach this group at a personal level with HIV/AIDS risk reduction information and support.

Zimbabwe's 580 CBDs are a paid cadre of para-professionals who provide key family planning services door to door. CBD agents are highly respected and valued individuals within their community and villages. Many of the CBD agents have been providing family planning service delivery to the same communities for over fifteen years and have established a strong rapport with the communities. The CBDs also enjoy excellent access and rapport with local leaders.

The CBD program operates through the Zimbabwe National Family Planning Council (ZNFPC) and has been viewed as one of the strongest CBD programs in sub-Saharan Africa. Over the years, this program has contributed significantly to increasing contraceptive prevalence rates in the country. However, because of the current crises in Zimbabwe, the ZNFPC has not been able to maintain its previously high quality standards of family planning service delivery and, as a result, a significant portion of the CPR is now being attributed to private sector sales of commodities. Even with this shift, the CBD agents still provide an important link to rural populations.

By the early 1990s, it was clear that the CBD workers were involved at the household level in issues beyond family planning. Communities and villages were increasingly relying on CBDs for HIV care and support, requesting that they provide assistance for treatment of someone living with HIV/AIDS or that they informally discuss an HIV test result. In recognition of this community-based expression of need, a study was conducted in the late 1990s to assess the feasibility of adding a few AIDS-related activities to CBDs' scope of work, particularly the provision of information, referrals to VCT and the promotion of condoms. The study found that CBD agents had both the time and the interest to take on these additional responsibilities. A clear opportunity existed to build on the strengths of the CBD distribution networks to access rural households in the fight against AIDS.

[13] *Zimbabwe Commodity Transport Study,* Deliver, July 2003.

With the approval of its June 2000 design document, USAID began to intensively train CBDs in sixteen districts to increase their knowledge of HIV/AIDS and their ability to provide HIV prevention information to their communities. Specifically, CBD workers were trained to provide HIV risk reduction counseling, condom and contraceptive distribution, referrals to VCT (when applicable and appropriate), limited home-based supportive care, and referrals to additional services as the need arose.

Under this update, USAID will continue its work with CBDs. The HIV training for CBD workers will be refocused to increase HIV prevention education to the community at an individual level and link community members with a constellation of HIV-related care and support services. CBDs who have not yet received training trained; refresher training will be provided for those previously trained; a system for ongoing supervision will be established and implemented to ensure program quality and impact; an accurate referral system for CBDs will be developed after mapping out existing services within each district; and technical assistance and monitoring and evaluation will be funded, as needed. Increased emphasis will be placed on integration and coordination between the CBD and VCT programs, to ensure that VCT is available in a nearby vicinity at either a static or mobile testing site when CBDs are providing referral services.

Under this strategy update, USAID/Zimbabwe will also better capitalize on CBDs potential to play a strong advocacy role by drawing attention to the need to support HIV prevention efforts at the community level. Expanding their role will thereby contribute to all three intermediate results of the USAID strategy.

USAID support for the CBD program is expected to result in improved HIV prevention behavior among community members and increased linkages between rural communities and HIV-related services.

E. Prevention of Mother-to-Child Transmission (Primary stakeholders/partners: MOH, Elizabeth Glazer Foundation, CDC, CIDA)

With mother-to-child transmission is responsible for a significant 7% of transmissions and almost 100% of HIV infections in children, HIV/AIDS has become a critical child health problem in Zimbabwe, contributing to severe child morbidity and significant child mortality. As part of the expanded response to the global HIV/AIDS pandemic, USAID has committed, with other donors and host country partners, to ensuring that by 2005 at least 25% of HIV/AIDS-infected mothers in high prevalence countries have access to interventions to reduce HIV transmission to their infants.

Programs to prevent mother-to-child transmission of HIV have been shown to effectively reduce HIV transmission from 25% to around 13% (HIVNET 012). PMTCT programs build health care infrastructure to provide voluntary counseling and testing and short-course antiretroviral prophylaxis, deliver prevention messages to keep HIV negative pregnant women from becoming infected and counsel on family planning aimed at preventing unintended pregnancies in HIV positive women. They also provide a solid foundation for MTCT Plus/antiretroviral treatment programs for infected family members, including children.

In Zimbabwe, the Ministry of Health has taken the lead in developing a national PMTCT program, with efforts to expand the program only seriously beginning in early 2002 with the establishment of a national PMTCT team. CDC supports the MOH in coordinating the national program through a PMTCT forum and regular meetings with donors, government, NGOs, and other local stakeholders. According to the PMTCT 2002 Annual Report,[14] as of the end of 2002, a PMTCT training manual and a draft PMTCT curriculum guide had been produced, 233 provincial and district trainers had been trained and 1,119 health workers had been trained. Thirty two of the fifty nine district and central hospitals were registered for MPTCT by the end of 2002, with most of the non-registered hospitals referring their clients to the registered sites. Adequate supplies of nevirapine and HIV rapid test kits were available to the program throughout the year.[15] Uptake for PMTCT services was low, however, which, it is believed, indicates that VCT services need to be strengthened.

Under this strategy, USAID/Zimbabwe will collaborate with partners and stakeholders already involved in PMTCT in Zimbabwe to determine how USAID can best complement, support and enhance their efforts through areas of USAID's comparative advantage. Preliminary discussions indicate that USAID's most significant contribution(s) might be made in the areas of:

- Building critical linkages (in both directions) between PMTCT and VCT and between PMTCT and family planning
- Providing logistics management for PMTCT-related commodities, especially HIV test kits and nevirapine
- Engaging in communication/community mobilization efforts that provide information about PMTCT and encourage women to use PMTCT services
- Linking PMTCT with post-test clubs, home-based care and OVC projects

However, to confirm these initial impressions, a comprehensive, collaborative assessment of current PMTCT activities throughout the country will take place in mid-2003 to cover such topics as: GOZ plans for PMTCT, logistics management issues, the status of guidelines and protocols, etc. Based on this assessment, USAID will work with its partners to determine its way forward.

In the longer term, USAID/Zimbabwe sees its PMTCT program efforts as an important entry point to PMTCT Plus care and treatment programs—complementing and linking with potential USAID interventions in antiretroviral therapy (see IR3), including therapy for HIV/AIDS infected children. This could include working with existing partners to build capacity for implementing PMTCT Plus programs that will provide antiretroviral treatment and care and support (including treatment for opportunistic infections, nutrition, and psychosocial support) for mothers, infants, and family members within the PMTCT programs.

[14] *The Zimbabwe Prevention of Mother to Child Transmission of HIV Programme, 2002 Annual Report*, Ministry of Health and Child Welfare, AIDS and TB Unit, March 2003, p.5.

[15] Nevirapine is donated by the manufacturer, Boeringher Ingleham, under a five year agreement. HIV rapid test kits are donated by both CDC and Abbott Laboratories.

It should be noted, however, that USAID's ability to become more involved in PMTCT is constrained in part by restrictions on working with the GOZ. Given that almost all antenatal care in Zimbabwe takes place in public sector health care facilities, it is difficult to play a significant role in PMTCT without working with the public sector. PMTCT is an area where collaboration with the government is essential to successful national scale-up of PMTCT programs. Although the mission has no plans to fund government health centers directly, funds may be allocated to NGOs to work with government health centers in implementing PMTCT programs.

USAID support for PMTCT will compliment CDC efforts to provide antiretroviral prophylaxis to at least 25% of HIV positive pregnant women attending antenatal clinics by 2005.

F. **Management of Sexually Transmitted Infections** (Primary stakeholders/partners: PSI, MOH, NAC)

STIs are believed to increase HIV transmission by making both HIV positive persons more infectious and HIV negative persons more susceptible to HIV infection. Syndromic management of STIs has been an important approach to reducing this type of HIV transmission. The syndromic approach is effective in treating STIs when genital ulcers are present or when urethral discharge is present in men. In general, the syndromic approach is not effective for vaginal discharge, as most often cervical STIs are asymptomatic and most women with vaginal discharge do not have an STI. Data is accumulating that, particularly in settings with a mature AIDS epidemic, syndromic STI management may not lead to a reduction in HIV incidence, despite concurrent behavioral interventions and evidence of reduced incidence of STIs.[16]

Surveillance data indicates that the rates of gonorrhea, chlamydia, and syphilis are relatively low in Zimbabwe (2%, 1% and 2%, respectively, according to a study conducted by Community Medicine in the University of Zimbabwe). However 44% of study participants tested positive for herpes simplex virus 2 (HSV2), indicating very high levels of exposure to this virus. Because of the high prevalence of SHV2 infection, genital herpes probably accounts for a high proportion of HIV infections in Zimbabwe.[17] Genital herpes, however, is an incurable, lifelong infection that is not effectively controlled by existing measures. It is essential to find ways to reduce the effect of HSV2 on HIV transmission. Episodic treatment with antiviral drugs, like that described in the Zimbabwe syndromic approach to HSV2 is unlikely to have a significant effect on HIV transmission unless it is coupled with education about early HSV2 symptom detection and prompt treatment. Continuous suppressive drugs for HSV2 might be more effective in limiting HIV transmission, but cost and feasibility make this unlikely.[18]

Under this strategy update, USAID will review its current STI prevention and treatment programs in order to explore ways to increase their impact in interrupting HIV transmission. Options many include expanding counseling on early symptom detection and safer sex among HSV2-infected persons and exploring the feasibility of continuous suppressive therapy for HSV2. USAID/Zimbabwe will continue to support STI prevention and treatment in programs in

[16] Kamali, A. Lancet 2003; 261:645-52
[17] In one study, fifty two percent of sexually transmitted HIV infections among people who also had HSV2 could be attributed to infection with the herpes virus, Wald A., et al., *Journal of Infectious Diseases*, 2002; 185:45-52
[18] Corbett, E., *Lancet,* 2000, 359:2177-87.

high risk border areas (under the regional "Corridors of Hope" program) and the VCT-STI treatment integration pilot that is already underway at one USAID-funded VCT center. However, USAID/Zimbabwe will review the applicability to the Zimbabwe context of the literature on the effect of STI control on HIV prevention before further expanding its STI prevention and treatment programs, regardless of funding levels.

At a minimum, STI management activities are expected to result in reduced levels of STIs in border areas and the provision of input for making decisions on the integration of STI treatment into VCT services.

IR2: Enhanced capacity to formulate, advocate and implement improved HIV policies

Policy frameworks at national, regional, district, and local levels are some of the most powerful determinants of the social environment for the AIDS crisis. Good policies guide, facilitate, and empower people to respond to the crises they face. In Zimbabwe, responses to the AIDS crisis continue to be weakened by widespread denial of the problem, stigma attached to infection and illness, powerlessness of teenage girls and young women (the people most vulnerable to infection), reduced access to quality education and health services, and laws and regulations detrimental to the welfare of women and children. Policy adjustment at all levels of Zimbabwean society is urgently needed to encourage people to respond more effectively to the challenge of AIDS in a manner that is sustainable and broad-based. To encourage policy change, USAID is building advocacy capacity within a broad array public, private, civil society and faith-based of organizations and supporting improvements in the availability and quality of information and data for advocacy and policy development. These are ongoing activities that were included in the June 2000 strategy.

A. Building Advocacy Capacity (Primary stakeholders/partners: NAC, MOH, Futures Group)

The AIDS epidemic is one of many factors that have changed Zimbabwe dramatically over the last decade. Yet institutions, laws, policies, regulations and practices have not fully adapted to the new realities. While advocacy should be able to play an important role in heightening awareness of both HIV issues and how changes can be made, to date, actions in Zimbabwe for advocacy and communications for promoting behavior change related to HIV prevention have been somewhat fragmented and disorganized. Some of the drawbacks include a lack of sustained, targeted media/communications campaigns for specific audiences; ineffective efforts to deal with cultural, social, health, gender and legal contexts for risky behavior; lack of political commitment to, and community ownership of, national responses; and lack of understanding of the changing economic and social environment which may facilitate HIV transmission. The stigma associated with HIV/AIDS in Zimbabwe is a significant deterrent to the success of efforts to reduce the transmission of HIV, but stigma has not been effectively addressed at a scale that could have an impact on the epidemic.

To address these constraints, in February 2002 USAID/Zimbabwe launched a program to promote practical ways to help the nation find its collective voice and break the national code of silence and denial. This program will continue as designed under this update, with a focus on strengthening the advocacy capacity of five key segments of Zimbabwean society: the public

sector, civil society organizations, faith-based organizations, private sector employers and the media. These groups were specifically selected for their ability to raise awareness and influence large numbers of people. The public sector clearly sets the overall tone for HIV/AIDS policies in the country. Civil society and faith-based organizations, with their broad constituencies, can potentially play a much more important role in educating and informing their members, advocating on behalf of their constituents and monitoring actions that affect their members than they have to date. Private sector employers in Zimbabwe have been largely neglected in the fight against AIDS, yet are critically affected by the AIDS-related illnesses and deaths of their employees. Advocating for improved policies and response to the HIV/AIDS epidemic is clearly in their best interest. (Employers also play an important role in driving the AIDS epidemic underground, as employees with AIDS fear losing their jobs, so will not speak out about their illness. Working with private employers therefore has tremendous potential to help break the silence around AIDS.) Finally, the media wields significant power in its ability to inform and influence people, organizations and public policy, yet the quality of the media has limited its ability to play a more positive role in advocating for change.

Five themes will continue to serve as the focal areas for USAID's advocacy support. Changes related to these themes are expected to have a significant impact on the HIV/AIDS crisis.

- **Women's empowerment**: Women are more vulnerable than men to HIV, both physically and socially. The vulnerability of girls and women is directly linked to their lack of political, economic, and cultural power. At the national and sectoral levels, USAID's advocacy efforts will focus on such issues as legal reform of gender-biased laws (such as those related to inheritance), education and health care. At the grassroots level, women's advocacy groups will raise awareness of women's roles and needs related to care of HIV-infected individuals.
- **Speaking out and reducing stigma**: Transparency, honesty, responsible planning and active leadership in the public arena have preceded changes in private behavior in communities where the tide has turned against HIV transmission. Media exposure and local and national advocacy by civil and religious leaders are essential for public education and dialogue. People living with HIV/AIDS, including prominent figures, their children, and their caregivers, are particularly important to reducing stigma. They must have visibility and a voice to share their histories, their abilities, their contributions and their needs. USAID's advocacy program will continue to help these groups voice their messages. Opportunities for working with traditional healers and others with influence at the individual and community level will be explored. USAID will also continue to support the dissemination of the National AIDS Policy.
- **Reproductive health:** With the current economic crisis, health services are being severely curtailed in Zimbabwe. Women and children are the predominant users of these services, and, as such, the consequences of cutbacks will most likely affect them disproportionately. Identifying and eliminating policy obstacles to integration and rationalization of services, improving incentives for better services and addressing social norms and gender issues in reproductive health will continue to be topics supported by USAID to minimize negative impacts on reproductive health services.
- **Youth**: Youth audiences and youth issues will be integrated into every advocacy effort supported by USAID/Zimbabwe. Stigma among youth – the generation that is the majority of the population and will be the vanguard cohort that stops or proliferates HIV – will be a particular focus. Women's empowerment advocates will address gender issues specific to adolescence, such as the interaction of gender and youth that makes girls and young women

so susceptible to HIV transmission from older men and the most vulnerable groups for HIV infection. The burden of care and the loss of opportunity imposed on youth by infection of older cohorts will also be addressed in campaigns that take on children affected by AIDS.

- **Orphans and Vulnerable Children**: Children have no political voice. Estimates are that 200,000 Zimbabwean children each year suffer the death of a parent from AIDS and 240,000 children are living with HIV/AIDS. Many children now live in child-headed households or with elderly grandparents who may be more in need of care than they are able to give it. These children are subject to grief, stigma, isolation, dislocation, physical and sexual exploitation, economic deprivation, loss of educational opportunity, increased responsibility for care of siblings or a second ill parent, and increasing fear for their own future. Advocacy efforts will continue to center on issues of education, health care, inheritance, institutionalization of children, protection of rights, labor laws, birth registration/certificates and the finalization of the GOZ's draft orphan policy in order to (1) create an enabling environment that better facilitates the protection of and mitigation efforts for children infected and affected by AIDS by increasing the capacity of all institutions to assess and develop policies relevant to children affected by AIDS, and the full implementation of those policies ; (2) promote better communication among communities, districts and the government about what is happening to children, their families, and their communities; and (3) mobilize leadership and resources to scale up the provision of services, care, support and treatment, as well as to mitigate the impact of HIV/AIDS on children, families and communities

To date, USAID has provided twenty-three grants to a wide variety of organizations to assist them to develop and implement advocacy campaigns and to engage in policy activities which will help mitigate the transmission and impact of HIV/AIDS. Under this strategy update, several of these small grants will be extended and additional grants will be made. To complement the grants, technical assistance will be provided to the grantees to help build their institutional capacity to engage in HIV/AIDS advocacy activities. Separate training sessions and workshops on HIV/AIDS technical issues as well as topics such as policy content and formulation, advocacy skills, financial management and monitoring and evaluation as will be organized for leaders from civil society, churches, public sector organizations and private organizations. In addition, policy-making workshops will be held and research studies will be funded. Particular attention will be paid to responding to the momentum initiated by very successful workshops already held with journalists and church leaders. The Auxillia Chimusoro award will also continue to be awarded to outstanding HIV/AIDS advocates [see box].

Auxillia Chimusoro Award

To provide positive support for those fighting against the AIDS epidemic, USAID established the Auxillia Chimusoro Award, named after the first Zimbabwean to publicly announce her sero-positive status. In 2002, the award was given to Zimbabwe's most famous musician, Oliver Mutukudzi. Mr. Mutukudzi, who plays to enthusiastic audiences in even the most remote parts of Zimbabwe, is known to all Zimbabweans. The humor and optimism in his songs reach across generations. Most importantly, Mr. Mutukudzi has used his lyrics to address HIV as a terrible epidemic sweeping across the continent. What better proponent of HIV/AIDS awareness could Zimbabwe have than this man who reaches the majority of the population with his songs?

USAID's advocacy interventions are expected to

result in increased awareness of AIDS, a reduction in stigma, strengthened community capacity to care and support those affected by HIV/AIDS and the implementation of better AIDS policies related to gender, youth, stigma, reproductive health and children infected and affected by AIDS.

B. Improved Information and Data for Advocacy and Policy Development
(Primary stakeholders/partners: CDC, MOH, NAC, Futures Group)

The availability of accurate, high quality epidemiological data on HIV prevalence, the spread of the disease and the impact of interventions is essential for effective advocacy, policy development and program design. USAID and CDC will work collaboratively to collect, interpret and disseminate HIV-related data.

As discussed in Section I.B., Zimbabwe's antenatal surveillance system did not function well for several years, meaning that national epidemiological data on HIV were not available. Since 2000, CDC has been working with the MOH to re-establish the sentinel surveillance system. This system has now begun to provide information critical to determining the way forward.

In 2002, CDC also supported the MOH and ZNFPC in carrying out a Young Adult Survey of 8,000 males and females between the ages of 15-29. This survey has provided new insights into the disease among this age group and will be used to inform USAID's targeting efforts and results reporting. CDC plans to merge the Young Adult Survey into the 2004 Demographic Health Survey, which will be jointly funded by USAID and CDC. In 2003, CDC will update the data and presentations in the AIDS Impact Model for Zimbabwe, last done in 1996.

In an effort to continuously adapt to the changing needs of the HIV/AIDS epidemic, USAID will carry out operations research within the activities implemented under this strategy, including:

- An examination of the feasibility, acceptability and social outcomes of post-test services for VCT clients by developing and comparing high quality post test club services to VCT site-based ongoing counseling.
- The feasibility of providing VCT services within limited family planning clinics, including the efficacy of service, up-take of VCT and attitudes among providers.

USAID, along with UNICEF and others will undertake a number of studies to better quantify the situation of children affected by HIV/AIDS in Zimbabwe, building on previous situation analyses. USAID will also partner with other organizations to monitor the situation of children affected by HIV/AIDS, examine the potential to develop community identification mechanisms for OVCs, and develop indicators and measurement tools to establish coverage of services in line with the national and international goals and targets.

Surveillance, operations research and data gathering efforts are expected to result in improved knowledge of HIV and the impact of HIV interventions, which will lead to improved planning and program implementation.

IR3: Increased care and support of orphans, vulnerable children and individuals infected with HIV

> *"Although primary prevention of HIV is rightly the focus of many programmes, it cannot be separated from care and support for people living with HIV. Communities cannot take on the reality of HIV in their midst if there is nothing to offer for those who are sick.* Noerine Kaleeba, founder, Uganda's The AIDS Support Organization

Care and support of those affected by the HIV/AIDS pandemic is essential for achieving USAID/Zimbabwe's strategic objective. Not only are care and support an integral part of mitigating Zimbabwe's HIV/AIDS crisis, but they also reinforce and enhance other USAID efforts by reducing stigma, encouraging behavior change and stimulating greater family and community involvement in HIV/AIDS issues. In its June 2000 strategy, USAID/Zimbabwe outlined a plan for providing assistance to children affected by AIDS and subsequently initiated activities to support community responses to the needs of these children. In 2001, USAID developed an expanded response to the global pandemic and began working with other donors and host country partners to help local institutions provide basic care and psychosocial support services to at least 25% of HIV-infected persons and to provide community support services to at least 25% of children affected by AIDS in high prevalence countries by the year 2007. In 2001 USAID also declared its support for the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) 2001 Declaration of Commitment on HIV/AIDS, including the following concepts:

- Care and support are inseparable elements of an effective response
- "By 2003, ensure that comprehensive care strategies are developed to strengthen health care systems; provide access to affordable medicines and drugs for those who need time; support individuals, households and communities affected by HIV/AIDS; and address factors affecting the provision of essential drugs, including technical and system capacity, prices, international trade rules and intellectual property rights;
- "By 2003, ensure that national strategies are developed in close collaboration with the international community and the private sector to increase substantially the availability of essential medicines for HIV, including antiretroviral therapy for people with symptomatic HIV infection."

Under this strategy update, USAID/Zimbabwe has solidified its commitment to these global care and support goals by revising IR3 to include care and support for both HIV positive adults and children. To this end, USAID will continue and expand its support to OVC, continue and expand programs that provide pre- and post-test services and legal advice and continue to cooperate with other USAID activities to increase economic opportunities for people living with AIDS. To further strengthen its commitment to care and support, USAID/Zimbabwe has also decided that, with the increased funding it expects to receive under USAID's Expanded Response to HIV/AIDS, it will more explicitly identify its role and comparative advantage in "providing integrated care across the continuum of HIV/AIDS, including antiretroviral therapy, improving quality of life, treatment outcomes and end-of-life care for patients and families." [19]

A. Support to Children Affected by AIDS (Primary stakeholders/partners: CRS, UNICEF, MOH, Department of Social Welfare, SIDA)

[19] Selwyn, P., "The Challenge and Opportunity of Palliative Care for HIV/AIDS," 2/25/03, Presentation at the White House Conference on Palliative Care.

Zimbabwe has one of the largest and fastest growing groups of orphans and vulnerable children in sub-Saharan Africa. It is currently estimated that there are 782,000 orphans in Zimbabwe due to HIV/AIDS, with that number expected to reach 1.1 million by 2005 (33% of all children under 15) and likely to continue to increase for several years thereafter. These figures do not adequately reflect the magnitude of the problem, since they do not include children who are affected by HIV/AIDS because they are living with parents who are ill or those in families that have taken on the additional economic and psychosocial burden of caring for additional children.

The Department of Social Welfare has statutory authority and responsibility for children affected by AIDS, but it lacks the financial and human resources, as well as the vehicles, for supervision and field visits to make an impact. Social welfare officers are over burdened with public assistance, war veteran activities, drought relief, administration of the Social Safety-net fund, as well as child welfare, foster care, school and health fees exceptions.

Extended families and communities continue to be the first line of response in providing care and support to children and their families affected by HIV/AIDS. Zimbabwe has a large cadre of community volunteers, NGOs and faith-based organizations that have responded to the needs of children affected by HIV/AIDS.

However, much of the assistance provided by volunteers, NGOs and FBOs is limited, disjointed, welfare oriented, small-scale and not commensurate with the size and urgency of the problem. Furthermore, these efforts are based on historical practice rather than on any empirical evidence of effectiveness. Much of the assistance is also monofocal, concentrating on one intervention (education, psychosocial support, health, etc.), rather than on a comprehensive package of services. In addition, little detailed information is available as to the costs associated with the different interventions, or their cost effectiveness—a key consideration given limited resources within communities.

USAID began to provide assistance for orphans and vulnerable children in 2001 through an umbrella program of small grants and technical assistance for community-based organizations (CBOs) in order to strengthen their capacity to deliver and sustain current community efforts to help children affected by AIDS. As originally envisioned, the eight grants awarded to CBOs in 2001 were to be pilot programs, where different intervention strategies (community mobilization, participatory learning approaches, food security, economic strengthening, education assistance and psychosocial support) under different conditions would be tested and intensive operations research on the effectiveness of the interventions would be conducted.

Although the operations research in the pilot sites had not been completed, the increasing numbers of OVC, the long-term consequences of the OVC crisis on Zimbabwe's development, and the increased risk of HIV infection faced by OVC forced USAID to reassess its timetable. In 2002 USAID begin to scale up its assistance to OVC by awarding a second set of small grants to eight NGOs.

Under this strategy update, USAID plans to continue and conclude its operations research with the first "pilot eight" grantees to validate different scaling up strategies, their costs and the strengths and weaknesses of different combinations of intervention approaches. A collaborative assessment of the program, including both the original eight sub-grantees and the eight scale-up

sub-grantees, is planned for May 2003. The results of the assessment will be used to modify the ongoing program and guide the further scale up and expansion of the OVC program. USAID will also assist UNICEF and others in undertaking a participatory situation analysis of OVC in Zimbabwe, jointly supporting a national OVC consultation and a policy and legislation review.

As part of its focus on integration of activities, USAID will ensure that care and support of children affected by AIDS is addressed in its other HIV/AIDS activities, particularly its policy and advocacy activities. USAID will also ensure that the VCT, PMTCT and ARV programs take into account the special and specific needs of children affected by HIV/AIDS.

As a result of USAID's interventions with OVC, there will be an increased number of OVC receiving direct care and support (an estimated 250,000) and community capacity to respond to the needs of OVC will have been strengthened. These efforts will contribute to the USAID goal of assisting 25% of children infected and affected by HIV/AIDS in high prevalence areas by 2005 and will support the UNGASS goal related to orphans and vulnerable children.

B. Pre- and Post-test services (Primary stakeholders/partners: PSI, Advance Africa, NAC, MOH)

A September 2000 evaluation of the existing USAID/Zimbabwe VCT program revealed the lack of post-test services as a significant gap. It was observed that VCT centers were providing only short-term post-test counseling to clients, while most of these individuals had a need for longer-term support to both help them plan for their future and to strengthen their ability to maintain behavior change. It has also been noted that post-test services offer a venue for addressing gender dynamics, particularly around the high level of violence often found in the lives of HIV infected women around the world. Furthermore, post-test services can play an important role in helping to reduce stigma around HIV and AIDS given that many of those in post-test clubs are open about their status.

To respond to these observations, in 2001 USAID supported Pact to establish five pre- and post-test clubs (PTC) that provide VCT clients with long-term psychosocial support, counseling, information and education on HIV/AIDS, guidance on positive living, nutrition advice, condom distribution and legal, social and medical referral networks. PSI will assume responsibility for managing the post test clubs in July 2003 to bring closer synergy between VCT and post test services.

Under this updated strategy, USAID/Zimbabwe plans to expand its support for post-test services in parallel with expansion of VCT and PMTCT services. Links between post-test services and static and mobile VCT services will be strengthened, as well as links with other local initiatives including, home-based care, food aid, HIV-related research and legal support (see below). To help HIV positive parents plan for the future, links will be strengthened between post-test support services and programs for OVC. To this end, USAID will examine how it can link with CDC in supporting the establishment and expansion of the Mildmay Center in order to expand medical treatment for HIV positive children in Zimbabwe.

Concurrently, PSI, with support from the Horizons project, will determine the feasibility of scaling post test services through operations research. Many countries in the region are scaling

up PTC but little is known about the activities that would form the core components of PTC. In addition, the obstacles of PTC utilization and the ability of centers to cope with increased number are not known. Information on the process, uptake, short-term social support outcomes and cost effectives of different models of post-test services will managers to determine how to best link VCT services to post test services.

To improve services, USAID will analyze gaps in existing post-test support services and referrals and test innovative mechanisms to address these. USAID will also examine how post-test services can be made available and relevant to the increasing number of children and young people infected by HIV/AIDS.

USAID's post-test service interventions are expected to result in improved community care, increased referrals, reduced stigma and psychosocial support for both children and adults affected by HIV. It is also believed that high-quality ongoing post-test counseling and/or post-test clubs may help VCT clients to sustain reductions in high risk sexual behavior over the long-term.

C. Legal Assistance (Primary stakeholders/partners: PSI, Advance Africa, LEAD)

People learning that they are HIV+ are immediately confronted with the enormous burden of planning for the inevitable decline in their health status and eventual death. Of primary concern are issues related to inheritance and guardianship of children. Few individuals, however, have the financial resources to seek the legal assistance needed to ensure that their wishes will be documented and respected.

> *The absence of legal mechanisms can spell disaster for dependents. So this program will fill a critical gap in the fight against AIDS.*
> Marko Mavhurume, Zimbabwean lawyer

In mid-2002, USAID initiated a unique and innovative legal services voucher program that is helping less affluent HIV positive individuals access legal and estate planning services. The aim is to increase access to these services for a set of clients that has previously been marginalized by Zimbabwe's legal services delivery system.

The program connects law firms and HIV/AIDS service programs through a voucher system. AIDS service organizations, such as USAID-sponsored post-test clubs and OVC programs, make the vouchers available to members at a subsidized rate. Voucher can then be taken to participating legal centers for assistance with issues related to their HIV status, including guardianships, maintenance claims, transfers of property and wills. To date, 79% of those taking advantage of this program have been women.

Under this strategy update, USAID will assess the effectiveness of this program and use the results of the assessment to determine the scope and scale of future interventions in this area. Additional means of getting legal services to rural areas, such as training community leaders and/or clergy to assist with wills and other legal issues, will also be explored. This intervention is expected to result in a greater number of HIV-infected individuals receiving legal services and increased protection of the rights of orphans and vulnerable children.

D. Create and Expand Economic Opportunities (Primary stakeholders/partners: LEAD)

Families affected by HIV/AIDS become increasingly vulnerable as resources are used for health care, as infected individuals become less able to work, as those healthy enough to work are required to care for the ill, and as the number of family members expands when children are taken in upon the death a relative. Increasing poverty becomes both a stumbling block to mitigating the crisis and a factor that exacerbates the crisis. Indeed, most research in Zimbabwe shows that people and families living with HIV/AIDS list employment as their primary concern.

To help provide such vulnerable households with greater economic opportunity and food security, USAID will continue to collaborate with and support the mission's economic opportunities special objective to target HIV positive individuals and children affected by AIDS. Activities will focus on improving access to micro-enterprise lending programs, introducing affordable technologies (such as drip irrigation systems and drought-tolerant edible cash crops) to increase food production and generate income in AIDS-affected households and communities and linking AIDS-affected entrepreneurs with market opportunities. In the June 2000 design document, USAID/Zimbabwe's support for economic opportunities was focused exclusively on employment generation for youth affected by AIDS. Experience over the past two years has indicated the need to expand this target group to include HIV affected households and infected adults.

USAID's support for these activities are expected to result in increased incomes and improved food security among HIV-infected individuals and families caring for children affected by AIDS.

E. Comprehensive Medical Care (Primary stakeholders/partners: NAC, MOH, CDC, Deliver)

Almost four thousand Zimbabweans are dying each week because of AIDS. Without life-prolonging highly active antiretroviral therapy, the majority of HIV positive persons will develop AIDS and die. Given the heavy burden of the disease in Zimbabwe, current and sometimes inappropriate use of antiretroviral therapy in Zimbabwe, and USAID's continued commitment to international efforts to reduce HIV/AIDS mortality through expanded access to social support and medical care, including antiretroviral therapy for HIV positive persons, USAID/Zimbabwe has made a strategic decision to explore its role in the clinical treatment of HIV positive persons. In 2002, USAID/Zimbabwe funded an initial assessment on issues and opportunities for initiation and expansion of highly active antiretroviral therapy in Zimbabwe, either singularly or in support of other nascent programs. The primary strategies suggested by this assessment address both logistic and clinical services:

- Develop and implement an effective logistics management system for all HIV/AIDS related products, including a manual to track product use
- Develop clear protocols for patient selection and screening, ARV prescribing, monitoring and management, adherence support, and management of side effects, and treatment failure.
- Initially introduce antiretroviral therapy into sites with key HIV care services. (relevant sites were highlighted in the assessment, including certain mission hospitals)

- Establish a standard set of basic site requirements to ensure their full readiness
- Engage the private sector, including private practitioners and corporation medical staff in national plans and ongoing activities
- Build on existing PMTCT programs

With additional funding, the mission will further explore the feasibility of supporting models of comprehensive medical care and social support programs that might include antiretroviral therapy and adherence support, treatment of and prophylaxis against opportunistic infections, palliative care, including home-based care, and supportive programs for affected families, including OVC. Within the next six months, the mission will fund a broad, comprehensive assessment addressing ethical, sustainability and programmatic feasibility issues. This assessment will help to detail the requirements for a successful program in Zimbabwe and shed light on the models which are most likely to work in the future. Discussions of the results of this assessment with the Office of HIV/AIDS in USAID/Washington and local partners will ensure that there is full consensus on the way forward (including ethical programmatic implications), that parameters for future program interventions are set (including USAID's relationship with the CDC, GOZ and other partners) and that full complementarity with other local initiatives involving highly active antiretroviral treatment, including research protocols, is achieved.

USAID/Zimbabwe is particularly interested in linking medical treatment (including antiretroviral therapy) and social support interventions with its support for PMTCT. HIV positive pregnant women participating in PMTCT programs and their HIV positive family members may be promising candidates for care and support programs that include antiretroviral therapy. Extending the lives of HIV positive parents is a promising intervention to delay the creation of OVC. Active case finding for tuberculosis among HIV positive persons is also believed to be a promising approach to tuberculosis control in high prevalence settings.[20] These possibilities will be explored in the assessment. USAID intends to leverage resources from the private sector e.g. Coca Cola company to increase the number of people on ARV treatment. For example, USAID partners are supporting the Coca Cola Company with community mobilization, workplace education programs and voluntary counseling and testing for employees and their families in preparation for the ARV program which will be launched in August/September 2003. In addition, USAID will leverage the $2.2 million approved by the Global Fund for ARV to scale up programs based on site assessment tool developed by USAID.

If the mission does not receive the additional funding required to explore a disease treatment program that includes antiretroviral therapy, it will rely on the assessment to direct program efforts in ways that strengthen existing programs and policies and enhance capacity, including logistics systems and VCT, for existing and future comprehensive treatment efforts.

Including antiretroviral therapy and prevention and treatment of opportunistic infections in care and support activities for HIV positive adults and children is expected to result in:

- Reduced inpatient hospitalizations and costs
- Reduced morbidity and mortality for HIV positive persons
- Reduced stigma with availability of treatment

[20] Chaisson, R. "Beyond DOTS-Approaches to TB Control in Areas Where HIV Prevalence is High." Presentation at CROI, Feb. 2003

- Increased participation in VCT and PMTCT
- Improved care and support for vulnerable children (fewer orphans) through increased longevity of HIV infected parents.

V. Vulnerability to Conflict

In January 2003 USAID/Zimbabwe hosted a contingency planning retreat to develop scenarios of how the current situation may evolve over the next twelve to sixteen months. Representatives of key international NGOs, United Nations agencies, other implementing partners and USAID staff (from Zimbabwe, Washington, and the regional office in Kenya) participated in the exercise. Three possible scenarios for Zimbabwe were developed and used as the basis for planning a humanitarian response strategy. The three scenarios were:

- **Decline:** A continuation of the status quo of steady, gradual deterioration of principal humanitarian, economic and political indicators and increasing dependence of large segments of the population on external assistance to survive.
- **Collapse:** An acceleration of the current trend of deterioration resulting in near total dependence on humanitarian assistance of all but the most well off.
- **Improvement:** Substantive change in the political and policy environment sufficient to enable recovery of agricultural production and economic activity.

While all participants agreed that the "improvement" scenario was unlikely, opinions were split over whether the "decline" or "collapse" scenario was more likely.

The USAID/Zimbabwe HIV/AIDS team discussed these three scenarios and the implication of each for the HIV/AIDS strategy. It was clear to all that no matter what happens politically or economically in the country, the HIV/AIDS crisis will continue. As such, a continued response to the pandemic is necessary. Over the past few years, as the situation in Zimbabwe has deteriorated, the HIV/AIDS program has gradually positioned itself to be able to operate and succeed in a crisis environment. The USAID program outlined in this strategy document is premised on the “decline,” or continuation of the status quo, scenario. Should either of the other scenarios take place, adjustments to the strategy would be required.

Improvement scenario: Should Zimbabwe’s political and policy environment improve, USAID/Zimbabwe would expect to receive additional HIV/AIDS funds and become a President’s Initiative country. Under this scenario, USAID would continue to implement, and most likely expand, the NGO and community-based programs described in this document. Increased emphasis might be placed on advocacy, as USAID may be able to capitalize on the improving situation to positively influence the direction of change. Undoubtedly new NGOs (both local and international) would begin to operate in Zimbabwe, expanding the number of potential USAID partners and hence the potential reach of the USAID program.

In addition to continuing and expanding the ongoing program, USAID would initiate an aggressive, new program of support to the GOZ, rebuilding relationships with many of the institutions that USAID has historically supported. In particular, USAID would focus on helping the GOZ to reestablish those key elements of the public sector that would enable the GOZ to mount a Government-led, coordinated national response to the HIV/AIDS pandemic. At a minimum, USAID would provide support to the National AIDS Council, help strengthen the

capacity of the Ministry of Health's National AIDS and TB Unit, help to reestablish Zimbabwe's public health delivery system and support the rebuilding of a public sector commodities logistics system. These efforts would inevitably lead to increased USAID involvement in PMTCT and the provision of comprehensive medical care.

Under the improvement scenario, it is anticipated that both multilateral and bilateral donor organizations would return to Zimbabwe and initiate new HIV/AIDS programs. Because of its continued presence in the country, USAID would expect to assume a leadership role in donor coordination.

Collapse scenario: Under the collapse scenario, USAID would continue to implement an HIV/AIDS program as long as possible, making increased use of partner community-based and faith-based organizations, as it is believed that they would be able to continue operations for the longest period of time. Under such a scenario, the emphasis would be on providing continued support to orphans and vulnerable children and continuing behavior change interventions such as behavior change communication, VCT, condoms and pre- and post-test clubs. Programs connected with the Government of Zimbabwe, such as the PMTCT and family planning community-based distributor programs, would be terminated. The continuation of IR2 (advocacy) would depend on the level of collapse. The initiation of efforts to expand medical care would be postponed.

Should the collapse scenario sink into a period of chaos in which USAID's community-based partners were no longer able to perform, USAID would be forced to abandon the strategy described in this document and develop an alternative strategy that responded to the actual level of collapse in the country.

VI. Results and Reporting

A. Magnitude and nature of expected results

USAID will work collaboratively with other USG agencies, other donor organizations, the GOZ, the NGO community and others to mitigate the impact of Zimbabwe's HIV/AIDS pandemic. The impact of this collective effort will be measured at the national level through standard indicators such as HIV seroprevalence rates and sexual risk-reduction behaviors.

B. Country reporting and performance indicators & targets

As part of its "Expanded Response to HIV/AIDS," USAID is establishing a comprehensive system to routinely monitor its HIV/AIDS program worldwide, manage its resources and periodically report on the Agency's progress toward achieving its stated results. As an intensive focus country, USAID/Zimbabwe is required to establish a program monitoring and reporting system and issue annual reports on progress at the country level.

Under these guidelines, USAID/Zimbabwe will report the following data as it becomes available:

- HIV seroprevalence levels (collected from national sentinel surveillance system and reported annually)
- Changes in sexual risk-reduction behavior (collected from national surveys every three to five years and supplemented by other, smaller population-based surveys)
- Progress on USAID-funded program implementation/coverage (based on USAID program data and reported annually)

USAID will collaborate closely with CDC, the GOZ and other donors to ensure that this monitoring and reporting system meets the reporting requirements, to the extent possible, of all participating agencies.

Progress on USAID-funded program implementation and coverage is currently being measured at the SO and IR levels using the indicators below. Additional activity level indicators have also been identified, using USAID's "Guidance on the New Monitoring and Reporting System Requirements for HIV/AIDS Programs" as a model. Annex IV contains a draft Performance Monitoring Plan for the strategic objective, including a baseline and targets for each indicator and a description of the indicator. This draft was developed in November 2002. Given that this strategy update process has resulted in some adjustments to the strategy, it will be necessary to also update the Performance Monitoring Plan before it can be finalized. This process is expected to take place later this year with assistance from either a monitoring and evaluation team of experts or an individual expert.

SO level indicators:	HIV prevalence in the 15-24 age cohort (disaggregated by gender and 15-19 and 20-24 year old) % of people living with AIDS on ARV drugs or treatment for opportunistic infections % of OVC reached with care and support
IR1 indicators:	Condom use at last risky sex Median age at first sex among men and women (disaggregated) High risk sex in the last year Young people with multiple partners in the last twelve months[21] # of people tested for HIV at New Start VCT centers # of condoms sold through social marketing
IR2 indictors:	# of HIV/AIDS policies drafted and/or adopted % of participating civil society organizations with improved Advocacy Index scores # of institutions involved in HIV/AIDS advocacy # of employers practicing HIV/AIDS "affirmative action"
IR3 indicators:	# of OVC receiving care and support Average % change in OVC support index score

[21] With this indicator, USAID/Zimbabwe has elected to monitor young people (age 15-29) rather than the sexually active population (which is USAID's standard indicator) because CDC's Young Adult Survey, which will be implemented every 3 to 4 years, covers only the 15-29 age cohort. Trends within the larger sexually active population will be monitored through the DHS every five years.

# of OVC benefiting from improved access to education
# of people receiving treatment at USAID supported sites
# of people attending post test clubs

C. Contribution to international and expanded response goals

By adopting the USAID/Washington guidelines, USAID/Zimbabwe will also contribute to the measurement of progress with respect to

- National/United Nations General Assembly Special Session on HIV/AIDS (UNGASS) targets and
- USAID Expanded Response targets

To the extent possible, USAID/Zimbabwe has adopted the UNAIDS and UNGASS standards for the Agency reporting system so that most data are compatible with all three systems. USAID will work closely with the National AIDS Control Program, other bilateral and multilateral agencies as well as civil society groups to support the expansion of services in order to make progress towards reaching the international goals.

VII. Resources

A. Funding

USAID/Zimbabwe currently receives approximately $7 million annually for HIV-related activities. Under USAID's Expanded Response, that figure could increase to as much as $15 million per year. Under either funding scenario, USAID/Zimbabwe's strategy remains much the same—scaling up to achieve greater impact. Differences are highlighted below:

<u>$7.0 million annually</u>

With $7.0 million a year for the next four years, USAID/Zimbabwe will focus on maintaining ongoing successful activities. VCT and associated post-test support services will be the cornerstone of the program, focusing on reaching those at highest risk both in urban and rural populations. Programs that support community-based distributors and advocacy and policy development will also be a focus. Increased emphasis will be placed on prevention and care services for children infected and affected by HIV/AIDS. The impact of these services will improve as lessons learned from ongoing operational research are applied in the national scale up. In addition, A new commodity logistics program will be funded. Following a situation analysis of PMTCT in Zimbabwe, USAID will complement and support other donor programs in PMTCT in areas in which USAID has a comparative advantage. USAID/Zimbabwe will also fund a feasibility study to elucidate in more detail its potential role in providing integrated prevention, care and support across the continuum of HIV/AIDS , with particular attention to the inclusion or exclusion of antiretroviral therapy in that approach.

Under this scenario, it is estimated that approximately 25% of funds will be allocated to prevention-specific activities (social marketing, behavior change communication); 20% to OVC programs, 15% to new PMTCT and ARV programs, 10% to each policy/advocacy and

commodity logistics, 10% to family planning and HIV/AIDS/FP integration, 5% to HIV/AIDS micro enterprise and the balance to operations research and program management.

$15.0 million annually

Should USAID/Zimbabwe receive a significant increase in funding, the focus will continue to be on scaling up successful interventions, to increase coverage of services in line with the USAID and UNGASS goals, albeit at a more rapid rate. The major difference will be that, with increased funding, USAID will move more aggressively into PMTCT, expand the coverage of children affected by HIV/AIDS receiving quality services, and follow the recommendations of "continuum of care" feasibility assessment as it significantly expands its portfolio of activities that provide care and support (including antiretroviral therapy) for HIV positive adults and children. It is anticipated that the PMTCT and comprehensive medical care initiatives will be linked and will be designed to reinforce and complement VCT and other behavior change and care activities.

Under this scenario, funds for social marketing and behavior change will continue to receive some 25% of the budget. Funds allocated to policy, commodity logistics, operations research and program management will remain constant, consuming a smaller percentage of the overall budget. The percent of the budget allocated to OVC and PMTCT/ARV programs will increase to 30% each. In September/October 2002, JSI/Deliver, with support from USAID, undertook a comprehensive ARV logistic assessment to gauge the capacity and readiness of existing infrastructure to manage ARV and to determine what it would take to introduce ART at national and local level. A number of sites were identified as possible initiation sites. USAID will support different service delivery models at different geographical locations across the country. Increased resources will allow USAID to scale up treatment programs to more sites that require minimum input to provide such services.

B. Staffing

USAID/Zimbabwe's HIV/AIDS office is currently staffed with four professionals and two support staff. The position of team leader is expected to be filled by a U.S. Direct Hire shortly. To implement the program set forth in this updated strategy, two additional staff members will be required. The first should be a HIV/AIDS specialist with strong program/administrative skills and experience with behavior change and HIV prevention. This person should have an international perspective on AIDS, but should also be familiar with and understand USAID/Washington. The second should be a food specialist, who will be responsible for looking at the short-term impact of food shortages on the health conditions of the general population.

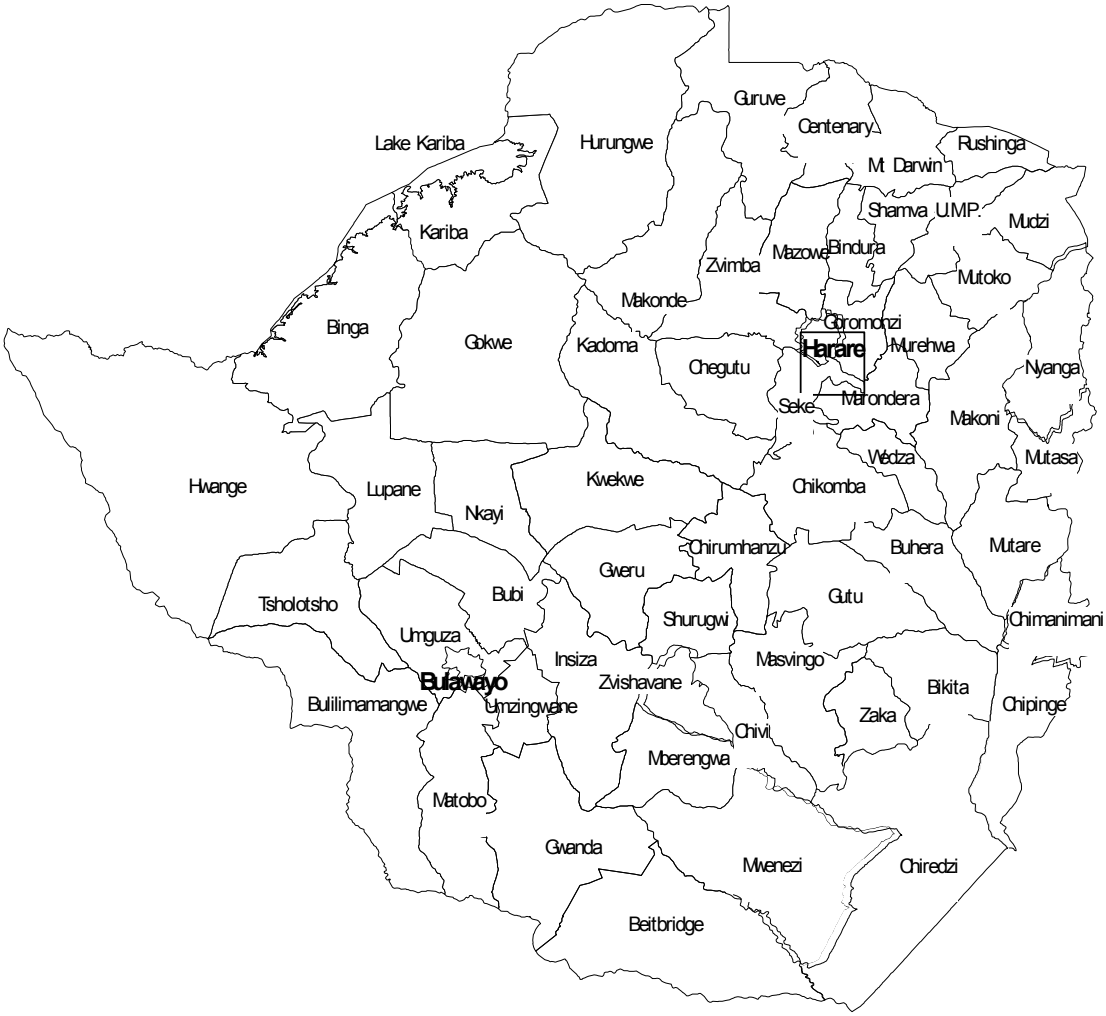
C. Procurement

For the most part, the activities outlined in this strategy are ongoing. The mission currently foresees a continuing relationship with the major implementing partners. For the most part, new procurements will be determined by funding levels, specifically those related to new initiatives in PMTCT and ARVs. It is the team's intent to make maximum use of Indefinite Quantity Contracts and Field Support.

ANNEX I

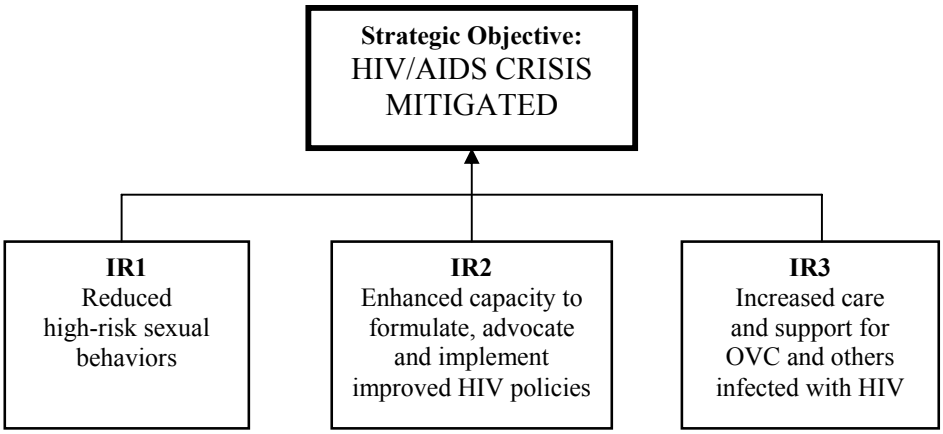
(with location of projects marked?)

MAP OF ZIMBABWE



ANNEX II

Result Framework



Supporting Activities:

- Behavior change communication
- Social Marketing
  - VCT
  - Condoms
  - Contraceptives
- Commodity logistics
- CBD
- PMTCT
- Mgmt. of STIs

Supporting Activities:

- Building advocacy capacity
- Improving information and data for advocacy and policy development

Supporting Activities:

- Support to OVC
- Pre- and post-test services
- Legal assistance
- Creation and expansion of economic opportunities
- Medical care

ANNEX III

Implementing Partners

1. **Futures Group International/ZAPA: Zimbabwe AIDS Policy and Advocacy Project**
   - Purpose: Advocate for improved HIV/AIDS policies to reduce stigma and strengthen the capacity of Civil Society.
   - Activities: Woman's empowerment, youth reproductive health,

2. **CRS/STRIVE: Catholic Relief Services/Support To Replicable, Innovative, Village/Community Level Efforts For Children Affected By HIV/AIDS in Zimbabwe**
   - Purpose: Enhance capacity at the regional and local levels in Zimbabwe to support Community responses to children affected by AIDS.
   - Activities: Education assistance (scholarships)-focus on girls, economic strengthen and safety nets of household affected by AIDS, food security, psychosocial support, life skills training.

3. **PSI/Zimbabwe: Population Services International**
   - Purpose: Behavior change resulting from increased use of quality services with proven effectiveness to prevent HIV transmission and mitigate impact at the household level.
   - Activities: Voluntary Counseling and Testing, social marketing of condoms, behavior change communication, distribution of HIV/AIDS behavior change materials at general food distribution points, HIV/AIDS prevention activities at boarder posts and STI treatments.

4. **Elizabeth Glaser Foundation:**
   - Purpose: Support a national strategy for the prevention of mother to child transmission at provincial, district and church related hospitals.
   - Activities: Prevention of mother to child transmission, training of health care workers to administer the treatment, technical assistance to the Ministry of Health and Child Welfare.

5. **JSI/Deliver/ARVS: John Snow International/Deliver/Antiretroviral Drugs**
   - Purpose: Logistics Management . Ensures a reliable and consistent supply of HIV/AIDS and related commodities.
   - Activities: Logistics Management of public sector condoms, ARV distribution, training and logistics of institutions receiving ARVs.

6. **AA: Advance Africa**
   - Purpose: Integration of Family Planning services into voluntary counseling and testing and HIV/AIDS activities.
   - Activities: Training of community based distributors to offer services in family planning, condom distribution, HIV/AIDS prevention and referring clients to VCT.

7. **IAA: International HIV/AIDS Alliance**
    - Purpose: Scale up community support for Orphans and Vulnerable Children (OVC).
    - Activities: To Be Determined following the Design Workshop July 21st-23rd 2003.

8. **DAI/LEAD: Development Alternatives, Incorporated/Linkages for the Economic Advancement of the Disadvantaged**
    - Purpose: Support to HIV/AIDS affected households to access market linkage opportunities, skills training and microfinance.
    - Activities: Market linkages of communities to commercial buyers, legal voucher services to HIV/AIDS affected and infected families and drip irrigation kits to communities and households affected by HIV/AIDS.

ANNEX IV

PARTNER FAITH-BASED ORGANIZATIONS

Faith-based Organizations providing support to OVCs through CRS sub-grants:

Faith Based Organizations	OVC Activity
Archdiocese of Bulawayo	▪ Education Assistance ▪ Food Security ▪ Psychosocial support
Bethany Project	▪ Education Assistance ▪ Food Security ▪ Psychosocial support
Chinhoyi CADEC	▪ Education Assistance ▪ Psychosocial support ▪ Food Security
Diocese of Mutare Community Care project – Gowakowa	▪ Education Assistance ▪ Economic strengthening ▪ Psychosocial support
Masiye Camp	▪ Psychosocial support
Scripture Union	▪ Psychosocial support.
Bekezela	▪ Psychosocial support ▪ Education Assistance ▪ Food Security
Uzumba Orphan Trust	▪ Psychosocial support ▪ Education Assistance ▪ Food Security

FBO's providing support for HIV/AIDS policy and advocacy through sub-grants from the Futures Group International

FAITH BASED ORGANISATIONS	HIV/AIDS POLICY & ADVOCACY ACTIVITIES
WORLD PENTECOSTAL EVANGELISM MINISTRIES (WPEM)	Mothers` fellowship workshop. The main objective was to break the silence on HIV/AIDS
WORLD PENTECOSTAL EVANGELISM MINISTRIES (WPEM)	Leadership forum for church policy development. Church's response to the infected and affected. Enable participants to take responsibility and ownership of the HIV/AIDS problem in their communities. Address issues of stigma and discrimination

KADOMA MINISTERS` FRATENAL (Methodist church in Zimbabwe)	HIV/AIDS counselling skills development for pastors and their spouses.
Seventh Day Adventist (ARDRA)	SDA Church Regional Workshop on HIV/AIDS Sensitize church leaders and reduce fear/stigma associated with AIDS Establish enabling policies which the address HIV/AIDS pandemic

Churches represented in Futures Group International workshops for church leaders in order to break the silence on the HIV/AIDS pandemic. A total of 247 church leaders participated.

1. The Salvation Army
2. Seventh Day Adventist
3. Alliance church
4. Family of God
5. Pentecostal Assemblies of Zimbabwe
6. World Pentecostal Assemblies of Zimbabwe
7. Methodist Church in Zimbabwe

Annex V

Social and Gender Analysis [22]

Although every Zimbabwean is affected by the HIV/AIDS pandemic, women and children—especially girl children—are particularly endangered by both the disease and the socio-economic upheaval that accompanies it. In Zimbabwe, HIV is transmitted primarily through heterosexual sex. However, preexisting power imbalances between men and women severely threaten women's ability to control the safety of their sexual encounters, their reproductive choices, and their children's and their own personal health.

Women are expected to be faithful to their partners and provide sex upon demand without requesting barrier methods, but socio-cultural norms allow men to continue having multiple sexual partners which places their partners at risk. As in much of sub-Saharan Africa, there is evidence that women suffer high levels of physical and sexual abuse in long-term relationships. Anecdotal evidence suggests that abuse may increase if women try to control sexual relations by asking to abstain from sex or asking to use barrier contraceptive methods.

Women are disproportionately poorer, and thus less economically empowered, than men. A better understanding of gender differences in employment opportunities and remuneration is essential so action can be taken to prevent the growing numbers of female-headed households from being locked into poverty. Because income-generating opportunities for women are so limited in Zimbabwe, girls and women often have few choices but to exchange sex for resources if they are not in a long-term relationship that provides such support. Girls are doubly disadvantaged in a search for employment because of child labor laws. Commercial sex places women and girls in positions where it is difficult for them to enforce safe sex practices.

Women are less likely than men to receive an education or achieve literacy. While 86% of Zimbabwean men are literate, only 72% of women are. Although educational enrollment rates are high in Zimbabwe, slight gender disparities in favor of boys now exist all through primary school, become more pronounced by grade 4, and increase through secondary and tertiary levels. In the early 1990s, girls' primary school dropout rates were 7% higher than boys' (UNICEF, 1999).

Girls and women are more likely to be disadvantaged by age imbalances in their relationships. More than 10 times as many girls as boys between the ages of 12 and 17 are married (UNICEF, 1999). Forced early marriages for girls may be increasing as extended family networks try to decrease the number of children for which they are responsible, or try to gain the girl's lobola (dowry). Girls in these marriages have little power, which makes it hard for them to request or enforce low-risk sexual exchanges.

Over 40% of girls begin childbearing by age 19. Many of these relationships are with older men—either because older men can pay dowry for the girl, or because these men have the resources to exchange for sexual favors, or because beliefs about the purity of younger girls from

[22] A social soundness analysis was conducted in 1993 by Zimbabwean social scientists. Geoff Foster, one of the authors, confirms that the findings are still valid and relevant. This analysis is found in the project files.

AIDS drives older men to seek younger partners. Girls are viewed as "safe" from disease, and therefore the men do not use protection.

The effects of these imbalances in age and social status on HIV/AIDS transmission can be observed in the age and gender structure of HIV infection data. Despite the fact that in Zimbabwe men transmit the virus more often than women, females aged 15 to 19 are six times as likely to be infected with HIV than males their age, and females aged 20-29 are twice as likely to be infected as males their own age.

Women shoulder almost all care giving responsibilities required by ill family and community members. The time and attention required for care giving can demolish the few avenues of economic or legal power a woman has. In an average married Zimbabwean household affected by HIV/AIDS, a woman may nurse her husband, then her youngest child(ren), and then herself until she is so ill she must transfer the responsibility to a daughter or other female relative.

Upon a husband's death his family may try to claim the home and land that a woman and her children lived in with her husband, leaving them with no resources. If the woman exchanges sex for resources, her infection puts new partners at risk, and endangering them and their families. When a woman dies, her children may be cared for by the extended family (most often grandmothers, who are themselves disproportionately poor), or they may be left to fend for themselves.

Girl children are particularly vulnerable to abuse when HIV devastates a family. People may take advantage of the inability of ill parents to protect their children. Mothers may take in boarders to create income after their husbands have died; there are reports of these men taking advantage of young girls in the household. Once both parents are dead, children may be split up and placed with relatives. The rates of child sexual abuse are increasing, according to the Musasa Project, and much of this abuse is committed against girls by extended family members. Lastly, extended family networks more often support boys' education than girls' education, which further disadvantages girls in their personal relationships and in future economic opportunities.

Gender imbalances in social, economic and legal power fuel the spread of HIV. Data from various surveys indicates that prevalence among young women is higher than among men in the same age cohort. Because of women's greater susceptibility to infection and their lesser ability to protect themselves, this ratio will probably increase.

Action to mitigate the AIDS crisis must concentrate on women and their empowerment in Zimbabwean society. Some studies suggest that girls know less than boys about HIV transmission and protection. Women need information from basic generalities to the specifics about their own susceptibility. Girls in particular need information to realize that their developing bodies are uniquely receptive to the HIV virus, that they are the group in which prevalence is growing most rapidly, and that their prospective partners do not share their level of risk.

The marketing of the female condom demonstrated women's interest and concern for self protection, the role that women's organizations can play, and the potential for media to reach women. Women worked to organize, inform themselves, and change gender differentiated social

norms for sexual behavior in certain social groups. In the absence of technologies that women can control independently of men, the transformation of social norms is a necessity. Women and girls need to organize social support for standing up against pressure to grant unprotected sexual access.

Women's groups have a critical role in the fight against HIV. Women's advocacy today in Zimbabwe emphasizes reform in inheritance and property laws. Women also urgently need legal protection against abuse, both violent and sexual. However, while women's advocacy is generating a better legal environment for women and children, gender neutral application of laws, de facto priority given to customary law, and the dominance of male culture continue to be a very challenging problem.

Male responsibility can halt the spread of AIDS. Men as well as women must equilibrate gender relations and sexual power. The public, private, and commercial sectors have remained relatively neutral on gender issues, focusing on the health and technology aspects of HIV and prevention. It is critical that they address gender because women cannot solve this problem alone. Advocacy to engage civil society, commercial interests, and men's organizations must be part of any program to mitigate the AIDS crisis.

ANNEX VI

Performance Monitoring Plan

Policy and Program Coordination Bureau
Center for Development, Information & Evaluation
Performance Measurement & Evaluation Division
Contract #: AEP-C-00-99-00034-00

Draft

PERFORMANCE MONITORING PLAN

Strategic Objective HIV/AIDS

USAID/ZIMBABWE

November 22, 2002

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TABLE OF CONTENTS

SECTION I. INTRODUCTION 70

A. BACKGROUND 70
B. GUIDING PRINCIPLES OF THE PMP 71
C. BUDGETING FOR PERFORMANCE MANAGEMENT 72

SECTION II. THE RESULTS FRAMEWORK 73

A. GRAPHICAL REPRESENTATION 73
B. LOGICAL CONSISTENCY OF THE RESULTS FRAMEWORK 75
C. CRITICAL ASSUMPTIONS 75

SECTION III. MANAGING FOR RESULTS77

A. COLLECTING PERFORMANCE DATA 77
B. CONDUCTING EVALUATIONS & SPECIAL STUDIES 79
C. REVIEWING PERFORMANCE INFORMATION 79
D. REVIEWING AND UPDATING THE PMP 80
E. REPORTING PERFORMANCE RESULTS: REPORTING PERFORMANCE RESULTS 80
ANNUAL REPORT 80
EXPANDED RESPONSE REPORT81
F. ASSESSING DATA QUALITY 82
G. PERFORMANCE MANAGEMENT TASK SCHEDULE (OVER LIFE OF STRATEGIC PLAN) 84

SECTION IV. PERFORMANCE DATA TABLES AND INDICATORS 88

C. SO HIV/AIDS PERFORMANCE DATA TABLE AND INDICATOR REFERENCE SHEETS 89
G. ACTIVITY-LEVEL INDICATORS 111
H. PLAN FOR MONITORING SO-LEVEL CONTEXT INDICATORS 111

SECTION V. NEXT STEPS 112

SECTION VI. ANNEXES 113

ANNEX I. RESULTS FRAMEWORK & INDICATOR QUALITY ASSESSMENT WORKSHEETS 114
ANNEX II. DATA QUALITY CHECKLISTS AND SAMPLE ASSESSMENTS 122
ANNEX III. ADS EXCERPTS ON ANNUAL REPORTS & PERFORMANCE MANAGEMENT 134
ANNEX IV. SCOPE OF WORK 1
ANNEX V. INDIVIDUALS / ORGANIZATIONS CONTACTED 4

List of Acronyms

ADS	Automated Directives System
ADSVV	Automated Directives System – Vetting Version August 2002
CRS	Catholic Relief Services
CSO	Civil Society Organization
CY	Calendar Year
EBRD	European Bank for Reconstruction and Development
FY	Fiscal Year
GDP	Gross Domestic Product
GOZ	Government of Zimbabwe
IBRD	International Bank for Reconstruction and Development (World Bank)
IMF	International Monetary Fund
IR	Intermediate Result
MOF	Ministry of Finance
MP	Member of Parliament
NAC	National AIDS Council
OMB	U.S. Office of Management and Budget
NGO	Non-Governmental Organization
PMP	Performance Monitoring Plan
RF	Results Framework
SP	Strategic Plan
SpO	Special Objective
SO	Strategic Objective

ADD TO/UPDATE LIST

SECTION I. INTRODUCTION

A. BACKGROUND

In April 2000, USAID/Zimbabwe HIV/AIDS Strategic Objective team submitted a new Strategic Plan (SP) for the period of FY 2000 – 2005, which was approved in _____ 2002. The plan builds upon great strides made in family planning, increased knowledge about HIV/AIDS, an increased contraceptive prevalence rate and reduced fertility rate. The strategy in HIV/AIDS seeks to stem increasing HIV prevalence rate, improve the policy environment by strengthening Zimbabwean organizations' capacity to advocate for HIV/AIDS policies and resource allocation and, address the suffering by providing care and support to a large and quickly increasing population of orphans and children made vulnerable by the impact of AIDS on families and communities.

The HIV/AIDS Crisis Mitigated Strategic Objective will be achieved by accomplishment of three intermediate results (IRs) through three corresponding Results Packages. Accomplishment of Intermediate Result 1 will lead to behavior change that will slow or reverse the increase in the HIV/AIDS prevalence rate. Accomplishment of Intermediate Result 2 will increase Zimbabweans' control over the progress of the epidemic among them and will be critical to ensuring that decreases in prevalence rates are sustained and broad-based. Accomplishment of Intermediate Result 3 will be critical to ensuring that social and economic conditions over the next two decades do not deteriorate so significantly that crises overwhelm the ability of Zimbabweans to reduce prevalence. These intermediate results are more fully explained in Section III of this document.

As Zimbabwe is an Intensive Focus Country for HIV/AIDS programs, the SO team expanded its activities to include three of USAID's priority programs from the Expanded Response to HIV/AIDS. These are a condom social marketing program, a voluntary counseling and testing program, and a program for orphans and vulnerable children. All three programs are encouraged by the Agency and are critical to success in the reaching the goal of HIV/AIDS Crisis Mitigated.

USAID guidance (ADS 200 series) requires Operating Units to develop a Performance Monitoring Plan (PMP) for each Strategic Objective (SO) within one year of strategy approval (ADSVV 203.3.3). The provisional PMP was completed in 2000. In order to comply with this guidance and to develop a PMP that is useful for monitoring and management purposes, the Mission requested assistance from IBM Business Consulting Services (IBM) through the Integrated Managing for Results (IMR) contract.

The IBM assistance was provided in Harare between November 13 and November 24, 2002. The IBM Team worked with the SO team (*HIV/AIDS Crisis Mitigated*) to: review the results framework and complete results statement review; suggest revisions to statements and document any changes made; suggest revisions to the PMP for the three Intermediate Results and document any changes made; review PMP Performance Indicators and assist in the completion of Performance Indicator Reference Sheets (PIRS); address initial data quality issues; identify, where necessary, additional performance indicators; and work with the SO Teams and Program Office to complete the PMP.

Specifically, IBM was asked to assist the SO team in preparing a Performance Monitoring Plan that is fully compliant with the (ADS 200 series) and that incorporates new monitoring and reporting system requirements for HIV/AIDS programs.

To achieve this objective, the IBM Team reviewed all relevant documents, engaged in in-depth discussions with the SO HIV/AIDS team and its implementing partners, and compiled the components of the PMP. The result of the IBM and SO team efforts is summarized in this revised and formalized PMP.

The PMP is organized as follows:

- Section I introduces the PMP and provides background information;
- Section II presents the Results Framework, logical consistency of the framework, and the critical assumptions underpinning the framework;

- Section III describes how the SO teams will manage their programs for results and covers issues such as responsibilities for various performance management tasks, including data collection, reporting, and analysis, as well as assessing data quality;
- Section IV contains the Performance Data Tables and Performance Indicator Reference Sheets for the performance indicators for each strategic objective; and
- Section V focuses on next steps and identifies outstanding issues that will be completed at a later date.

B. GUIDING PRINCIPLES OF THE PMP

The ADS defines performance management as "the systematic process of monitoring the results of activities; collecting and analyzing performance information to track progress toward planned results; using performance information to inform program decision making and resource allocation; and communicating results achieved, or not attained, to advance organizational learning and tell the Agency's story."

The Performance Monitoring Plan (PMP) is an important tool for managing and documenting portfolio performance. It enables timely and consistent collection of comparable performance data, which allows each SO Team to make informed program management decisions. The principles governing this PMP are based on the Agency's guidelines for assessing and learning (ADSVV 203.3.2):

a. Actively Plan for Performance Management: Operating Units should plan for performance management while developing Strategic Objectives and designing activities. Starting early is key because assembling the various elements of the system takes time. When trying to develop preliminary Performance Management Plans (PMP), some Operating Units may discover that the proposed Strategic Objectives or Results Frameworks need revision, which may require additional time.

b. Make Decisions on the Basis of Performance Data: Operating Units should use performance information to systematically assess progress in achieving results and to make management decisions. In terms of the supply of performance information, it is important that information be available when required for decision-making. On the demand side, decision-makers at all levels should use performance information to influence decision-making processes and encourage partners to do likewise.

c. Seek participation: Operating Units can strengthen performance management by involving customers, partners, and stakeholders in the process of performance management. Operating Units can promote participation by: (1) including customers, partners, and stakeholders when developing PMPs; (2) including partners when collecting, interpreting, and sharing performance information and experience; (3) integrating USAID performance management efforts with similar processes of partners; and (4) assisting partners in developing their own performance management and evaluation capacity.

d. Streamline the process: Operating Units should only collect and report on the information that is most directly useful for performance management. More information is not necessarily better because it markedly increases the management burden and cost to collect and analyze. Operating Units should also seek to align their performance information needs with those of their partners, thereby lessening the reporting burden for partner organizations. Examples include jointly defining a critical set of performance indicators or incorporating data collection directly into assistance and acquisition mechanisms.

e. Be transparent: Operating Units should share information widely and be candid in reporting. Transparency involves: (1) communicating any limitations in data quality so that achievements can be honestly assessed; (2) conveying clearly and accurately the problems that impede progress and steps that

are being taken to address them; and (3) avoiding the appearance of claiming jointly-achieved results as solely USAID results.

C. BUDGETING FOR PERFORMANCE MANAGEMENT

According to the ADSVV 203.3.2.2, "Operating Units should make sufficient funding and personnel resources available for performance management work. Experience has shown that 3 to 10 percent of total program resources should be allocated for this purpose, but special circumstances may make it necessary to deviate from this range.

Efforts should also be made to keep the system cost-effective. As much as possible, performance data collection should be integrated with the performance management activities of implementing partners and incorporated into their work plans with appropriate funds allocated. Integrating USAID and partner efforts reduces the burden on USAID and, more importantly, ensures that partner activities and USAID strategies are well aligned."

SECTION II. THE RESULTS FRAMEWORK

A. GRAPHICAL REPRESENTATION

The **Strategic Objective** is "*HIS/AIDS Crisis Mitigated*." This objective will be achieved through the accomplishment of three Intermediate Results, which in turn will be realized through a series of activities with implementing partners. According to the strategy, the accomplishment of Intermediate Result 1 will lead to behavior change that will slow or reverse the increase in the HIV/AIDS prevalence rate, particularly among youth. Accomplishment of Intermediate Result 2 will increase Zimbabweans' control over the progress of the epidemic among them and will be critical to ensuring that decreases in prevalence rates are sustained and broad-based. Accomplishment of Intermediate Result 3 will be critical to ensuring that …

NEEDS UPDATING – FILL IN THE DESCRIPTION OF RESULTS

In addition, at the Mission Level, a focus on the HIV/AIDS affected population has been incorporated into activities under all three strategic objectives, thereby encouraging synergy between the teams. Thus, the three objectives of the Country Strategic Plan are closely inter-linked. The Participation Strategic Objective will complement the HIV/AIDS Strategic Objective by supporting NGOs that advocate to parliament for HIV-related issues.[23] The Economic Opportunity Special Objective will provide microfinance and other business development activities to communities and children impacted by the HIV/AIDS epidemic. The microfinance team will continue to work closely with the health team to determine criteria for selecting microfinance/ micro enterprise initiatives for youth, house holds and orphans and vulnerable children affected by HIV/AIDS.

[23] For instance, the participating SO has funded a grant to the Child Protection Society for advocacy to change the policy that requires children to produce birth certificates before enrolling in school – a policy that makes it extremely difficult for many children affected by HIV/AIDS to enroll.

Strategic Objective: HIV/AIDS Crisis Mitigated

SO Indicators:

- HIV Prevalence in 15-19 Age Cohort
- % of Zimbabwe's Orphans and Vulnerable Children Reached with Care and Support

Context Indicator:

- Contraceptive Prevalence Rate
- Stigma Level in Country (TBD)

***IR 1**: Behavior Change Through Increased Use of Effective, Quality Services for HIV Prevention*

Indicators:

1) # Condoms sold through social marketing program

2) # of socially marketed hormonal contraceptives

3) Condom use at last risky sex

4) # of persons requesting HIV test and receiving result

5) Young people with multiple partners in last 12 months

IR 2: Enhanced Capacity of Institutions to Formulate and Advocate for Improved HIV Policies

Indicators:

1) # of HIV/AIDS policies drafted and/or adopted

2) % of participating civil society organizations with improved Advocacy Index scores

3) # of institutions involved in HIV/AIDS advocacy

4) # of employers practicing HIV/AIDS

IR 3: **Improved Care and Support for Orphans and Vulnerable Children**

Indicators:

1) # of orphans and vulnerable children receiving care and support

2) Average % change in orphans and vulnerable children support index score

3) # of orphans and vulnerable children benefiting from improved access to education

B. LOGICAL CONSISTENCY OF THE RESULTS FRAMEWORK

Progress at each result level will be measured using indicators that are identified in the framework. In addition, activity-level progress will be monitored by SO teams to assess whether the inputs and outputs that will drive results achievement are being achieved in an efficient and timely manner. Result-level measures, including those at the SO-level, and input/output measures will seek to capture only those results that are attributable to USAID assistance. In addition, contextual information will also be systematically collected and reviewed to monitor changes in sectors associated with USAID reform targets[24].

C. CRITICAL ASSUMPTIONS

As the political and economic environment in Zimbabwe is in a state of continuing deterioration, it is important that critical assumptions be reviewed and regularly monitored. Thus, the critical assumptions that underlie the HIV/AIDS SO overall strategy as noted in the Country Strategy Paper of 2000, were formally reviewed and revised by the SO Team in November 2002.

Strategic Objective Level

Two critical assumptions underlie the HIV/AIDS Strategic Objective of "HIV/AIDS Crisis Mitigated:"

1) The situation in the Zimbabwe remains at "breakdown" level or improves; no slide into "chaos."
2) The GOZ policy toward nongovernmental and civil society organizations remains constant; no deregistration of NGOs.
3) Number of Zimbabweans living in poverty does not surpass current level (80%).
4) Current USAID/Washington policies regarding collaboration with national (Zimbabwe) government on HIV/AIDS under certain circumstances continues to be permitted.

Intermediate Result Level

In addition, several critical assumptions for success at the level of each intermediate result were identified:

IR 1 Behavior Change through Increased Use of Effective, Quality Services for HIV Prevention

1) DFID continues to fund public sector condom procurement, and condom procurement, and condoms and contraceptives for social marketing activity.
2) STI drugs remain available in public sector
3) Continuation of current interpretation of Brooke Amendment i.e. ongoing permission to provide contraceptives

IR 2 Enhanced Capacity of Institutions to Formulate and Advocate for Improved HIV Policies

1) Parliamentary committees remain committed
2) Civil society remains vibrant and committed

[24] Context indicators are measures of results that are affected by a range of factors, of which USAID assistance is one. They are helpful in describing the "big picture" but are not intended to measure the impact of USAID-assisted results.

IR 3 Improved Care and Support for Orphans and Vulnerable Children

1) GOZ shows continued commitment to resource allocation (e.g., tax levy; National Aids Council)
2) Continued existence of NGOs with capacity for the absorption of assistance
3) Child Welfare Forums are functional

SECTION III. MANAGING FOR RESULTS

USAID staff and partners have specific roles and responsibilities in the overall performance monitoring system. The following table outlines these responsibilities for each of the major steps in the monitoring process, which are further discussed in detail in this section:

MAJOR STEPS	RESPONSIBILITY
Collecting performance data	USAID partners; SO HIV/AIDS Team
Conducting evaluations and special studies	SO HIV/AIDS Team, USAID Partners & Program Office
Reviewing performance information	SO HIV/AIDS Team & Program Office & Mission Mgmt.
Reporting performance results *(Annual Report process)*	SO HIV/AIDS Team & Program Office
Assessing data quality	USAID partners; SO HIV/AIDS Team
Reviewing and updating the PMP	SO Team, Program Office & Mission Mgmt.

A. COLLECTING PERFORMANCE DATA

Levels of Performance Data

Performance data is measured at three levels:

- ***Results-level*** indicators refer to indicators of program results that can be reasonably attributable to USAID efforts and for which USAID is willing to be held accountable. Attribution exists when the causal linkages between USAID activities and measured results are clear and significant. These indicators directly correspond to the IRs and SOs laid out in the Results Framework and also serve as the basis for performance reporting to USAID/Washington.

- ***Activity-level*** indicators refer to indicators that provide useful data for ongoing, continuous management of activities by the SO Team. These indicators generally provide more operational data than results-oriented data. Activity-level data can therefore be used to assess partner performance and address operational issues. These indicators are primarily drawn from the agreements and work plans agreed upon by USAID and its activity partners. Activity-level indicators will be tracked and maintained at the activity level and will therefore not be included in this PMP.

- ***Context*** indicators are measures that provide a broader perspective on the context within which USAID assistance is being provided. Sometimes they are indicators of development results that are influenced by multiple factors, such as donor assistance, government action, or climatic conditions, and therefore cannot be directly attributed to USAID assistance. Context indicators could also be measures of assumptions that underpin USAID's development strategy in a given country. In general, context indicators are macro-statistics that provide valuable information on the environment in which USAID operates.

Collectively, these indicators represent the performance data needed for both reporting and management purposes.

B. CONDUCTING EVALUATIONS & SPECIAL STUDIES

Regular, scheduled performance monitoring requires a level of simplicity and practicality in data collection efforts, which makes it difficult to assess more complex issues of management concern. Furthermore, performance indicators are only able to "indicate" progress and cannot be used to determine "why" a certain result occurs. Evaluations and special studies are ways in which the SO teams can complement its routine performance monitoring efforts with more rigorous, in-depth analysis on topics of special interest. See the Performance Management Task Schedule in Section III.G for a list of potential future evaluations and special studies.

C. REVIEWING PERFORMANCE INFORMATION

To help make effective management decisions, the SO teams will internally review and analyze performance data during the course of the fiscal year. Depending on the results of these reviews, the SO teams may need to adjust their programming and activities.

Each SO team reviews program performance at least annually, through formal portfolio reviews. The project activity reviews serve as periodic operational reviews, while the annual portfolio review focuses on strategic issues in the process of preparing the Annual Report. Both are primarily focused on reporting.

The ADS 200 guidance requires each SO team to conduct an annual Portfolio Review. The Portfolio Review is defined in ADSVV 203.3.7 as: "a periodic review of all aspects of an Operating Unit or Strategic Objective (SO) Team's programs, often held in preparation for submission of the Annual Report. It is a systematic analysis of the progress of an SO, led by the Operating Unit, to examine strategic and operational issues and to determine whether USAID supported activities are leading to the results outlined in the approved Results Framework. The Portfolio Review should bring together various expertise and points of view to determine whether the program is "on track" or if new actions are needed to improve the chances of achieving results." The Mission and SO teams should examine the following items as part of their Area Review process *(from ADSVV 203.3.7.1)*: IS THIS WHAT YOU CALL YOUR AREA REVIEW OR SOMETHING DIFFERENT??

- Progress towards the achievement of SOs during the past year, and expectations regarding future progress
- Evidence that activities are adequately supporting the relevant Intermediate Result(s) and ultimately contributing to the achievement of the SO
- Adequacy of inputs for producing planned outputs
- Adequacy of the performance indicators selected in the PMP
- Status and timeliness of input mobilization (such as receipt of new funding, procurement processes, agreement negotiations, and staff deployments)
- Status of critical assumptions (i.e., whether they continue to hold) and causal relationships defined in the Results Framework, along with the related implications for performance
- Status of related partner efforts that contribute to the achievement of IRs and SOs
- Status of the Operating Unit's management agreement and the need for any changes to the approved Strategic Plan

- Pipeline levels and future resource requirements
- SO Team effectiveness and adequacy of staffing
- Vulnerability issues and related corrective efforts

Note: The Performance Management Task Schedule in Section III G includes the reporting schedule for performance information.

D. REVIEWING AND UPDATING THE PMP

The PMP serves as a "living" document that the SO teams will use to guide their performance management efforts. One of the key principles of the PMP is that it will be a useful tool for management and organizational learning; the PMP is *not* merely a mechanism to fulfill USAID/Washington reporting requirements. As such, it will be updated as necessary to reflect changes in SO strategy and/or activities.

PMP implementation is therefore not a one-time occurrence, but rather an ongoing process of review, revision, and re-implementation. The PMP will be reviewed and revised at least annually (during the Annual Portfolio Review) and as necessary. The Mission's Program Office, in coordination with each SO team, will coordinate this process. When reviewing the PMP, the SO teams will consider the following issues:

- Are the performance indicators working as intended?
- Are the performance indicators providing the information needed?
- How can the PMP be improved?

If the SO teams make major changes to the PMP regarding indicators or data sources, then the rationale for adjustments will be documented. If more minor PMP elements, such as indicator definition or responsible individual, change, the PMP will be updated to reflect these changes, but the rationale does not need to be documented.

E. REPORTING PERFORMANCE RESULTS: REPORTING PERFORMANCE RESULTS

Annual Report

USAID uses performance information not only to assess Operating Unit progress but also as the basis of its resource request for subsequent years and to share knowledge and enhance learning throughout the organization. Like other Operating Units, USAID/Zimbabwe submits an Annual Report on its performance against expected results, including both its successes and areas identified for improvement.

Each year, the Annual Report is prepared in accordance with the specific guidance for that year issued by the Agency. More information guidance on the Annual Report process is contained in guidance received from USAID/Washington. The PMP is a key document in preparing the Annual Report since it contains information on all SO and IR performance indicators, including indicator and data quality assessments, responsibilities for data collection and analysis, and the management utility of each indicator. Agency guidance requires that all indicators sent to Washington -- for performance reporting to Congress -- to adhere to indicator and data quality standards. These standards are described in ADS 203 (ADSVV203.3.4.2). Procedures for conducting indicator and data quality assessments have been established and are contained in Annex I, Annex II and Section III.F of this PMP.

In its FY 2003 Annual Report, USAID/Zimbabwe will report on the following indicators:

RESULTS LEVEL	PLANNED FY 2003 ANNUAL REPORT PERFORMANCE INDICATORS
Selected Indicators for Assessing Progress Towards the SO*	
IR 1 - #1	*Number of Condoms Sold Through Condom Social Marketing Program*
IR 1 - #4	*Number of Persons Requesting Test and Receiving Result ("Persons Seen at VCT")*
IR 2 - #1	*Number of HIV/AIDS Policies Drafted and/or Approved*
IR 3 - #1	*Number of Orphans and Vulnerable Children Receiving Care and Support*
Indicators for Optional Indicator Table	
IR 3 - #3	*Number of Orphans and Vulnerable Children Benefiting From Improved Access to Education*

*For FY 2002, the SO Team will complete its self-assessment tool for the Annual Report based on IR1- #1, IR1- #4, and IR1- #2 (*Number of Socially Marketed Hormonal Contraceptives Sold*). Two of the selected FY 2003 indicators (IR2 - #1 and IR3 - #1) measure progress on new activities and thus, cannot be used in FY 2002.

Expanded Response Report

Zimbabwe is an Intensive Focus Country mission which has established three USAID priority Expanded Response Programs:

1) Condom Social Marketing Program
2) Orphans and Vulnerable Children Program
3) VCT Program

As part of the Annual Report, USAID/Zimbabwe's SO 3 will report specifically on its HIV/AIDS Expanded Response Program. The Agency "Guidance on the New Monitoring & Reporting System Requirements for HIV/AIDS Programs" from October 30, 2002, includes standard indicators for Missions to report on in 2003. The USAID/Zimbabwe HIV/AIDS Team has included six of the recommended indicators in its Performance Monitoring Plan. These selected indicators are standard indicators for both USAID and UNAIDS. To assist the Agency in completing its "Annual Report on USAID's HIV/AIDS Program for Congress," USAID/Zimbabwe will collect data and report on the following indicators:

MAY BE UPDATED WITH FEEDBACK FROM DC

RESULTS LEVEL	PLANNED FY 2003 EXPANDED RESPONSE TO HIV/AIDS INDICATORS
Expanded Response to HIV/AIDS Indicators (Selected Performance Measures)	
HIV Seroprevalence Levels Indicators	
SO HIV/AIDS -1	*HIV Seroprevalence Level of 15 –24 Year Olds (Disaggregated by 15-19 and 20-24)*
Changes in Sexual Risk Reduction Indicators	
IR 1 -3	*Condom Use at Last Risky Sex (15-49 years old)*
IR 1 -6	*Median Age at First Sex Among Young Men and Women*
Progress in Implementing Three USAID Program Areas and Population Program Indicators	
IR 1 -1	*Number of Condoms Sold Through Social Marketing Program*
IR 3 -1	*Number of Orphans and Vulnerable Children Receiving Care & Support*
IR 1 -4	*Number of Clients Seen (Requesting HIV Test and Receiving Result) at VCT Centers*

LOOK AT FREQUENCY OF THIS DATA. MAY ALSO NEED TWO ADDITIONAL (DEPENDS ON DC)

F. ASSESSING DATA QUALITY

Internal USAID standards for data quality have become increasingly rigorous, primarily due to growing scrutiny of USAID resource use and performance results by external reviewers – namely, Congress, OMB, and the public. Poor-quality data poses a two-fold problem: (1) it prevents accurate decision-making by management; and (2) it skews information used for reporting purposes. In order to measure and attribute results accurately – for both reporting and management needs – the SO teams will ensure that data meets certain criteria, as outlined in ADS 203 guidance (ADSVV 203.3.5.1):

- **Validity.** Data should clearly and adequately represent the intended result. While proxy data may be used, the Operating Unit must consider how well the data measure the intended result. Another key issue is whether data reflect a bias such as interviewer bias, unrepresentative sampling, or transcription bias.

- **Integrity.** Data that are collected, analyzed, and reported should have established mechanisms in place to reduce the possibility that they are intentionally manipulated for political or personal reasons. Data integrity is at greatest risk of being compromised during collection and analysis.

- **Precision.** Data should be sufficiently precise to present a fair picture of performance and enable management decision-making at the appropriate levels. One key issue is whether data is at an appropriate level of detail to inform related management decisions. A second key issue is what margin of error (the amount of variation normally expected from a given data collection process) is acceptable given the management decisions likely to be affected. In all cases, the margin of error should be less than the intended change; if the margin of error is 10 percent and the data show a change of 5 percent, the Operating Unit will have difficulty determining whether the change was due to the USAID activity or due to variation in the data collection process. Operating Units should be aware that improving the precision of data usually increases the cost of collection and analysis.

- **Reliability.** Data should reflect stable and consistent data collection processes and analysis methods from over time. The key issue is whether analysts and managers would come to the

same conclusions if the data collection and analysis process were repeated. Operating Units should be confident that progress toward performance targets reflects real changes rather than variations in data collection methods. When data collection and analysis methods change, the PMP should be updated.

- **Timeliness.** Data should be timely enough to inform management decision-making at the appropriate levels. One key issue is whether the data is available frequently enough to inform the appropriate level of management decisions. A second key issue is whether data is current enough when it is available.

The minimum ADS requirement is that all Annual Report indicators must meet the Agency's standards for data quality. For these indicators, data quality will be assessed initially when indicators are being established and baseline data are collected, and re-assessed at least every three years. (ADSVV 203.3.5.2). Good practice recommends that this be undertaken for *all* indicators so that the SO Team's confidence in the data increases. The IBM team worked with the SO team and partners to review data quality assessment procedures.

NEED TO WORK ON PLAN FOR ESTABLISHING DOCUMENTED QUALITY ASSESSMENT ON ALL REPORTED INDICATORS – ESPECIALLY NEW ONES

Data Quality Assessment Procedures: As much as possible, SO teams will integrate data quality assessment into ongoing activities (e.g., combine a random check of partner data during a regularly scheduled site visit). This minimizes the costs associated with data quality assessment. When conducting data quality assessments, SO team members will use data quality assessment tools (contained in Annex II of this PMP) as a guide. Findings should be written up in a short memo and filed in the team's performance management files. If the SO teams determine that any data limitations exist for performance indicators (either during initial or periodic assessments), they will address these limitations to the greatest extent possible. The SO teams will document any actions taken to address data quality problems in the appropriate Performance Indicator Reference Sheet(s). If data limitations prove too intractable and damaging to data quality, the SO teams will seek out alternative data sources, or possibly even develop alternative indicators.

During June and November, 2002, the IBM team facilitated discussions with the SO team to assess results frameworks and performance indicators using the worksheets contained in Annex I of this PMP. SO teams should maintain completed copies of the relevant indicator quality assessment worksheets in their team files. The SO team, in coordination with the PROGRAM Office, will implement data quality assessment procedures, including the planned incorporation of data quality items into field visits/reports.

The Program Office will coordinate the entire performance monitoring and data quality assessment process. It will work with the SO teams to schedule initial data quality assessments, particularly for new activities, once partners are identified and activities commence. As part of their technical and cost proposals, potential partners should be asked to submit their approaches to maintaining data quality. This will also include proposed budgets for key performance management components, such as baseline surveys, performance measurement, and ongoing monitoring and evaluation responsibilities.

G. PERFORMANCE MANAGEMENT TASK SCHEDULE (Over Life of Strategic Plan)

Use this worksheet to plan all of the SO team's monitoring and reporting activities over the life of the strategic plan. Modify the table to include additional indicators and years as needed.

KEY TO SYMBOLS: **"☑" = regularly scheduled task**
"V" = task schedule varies by activity

INSERT FY 2006 QUARTER ONE COLUMN

PERFORMANCE MANAGEMENT TASKS	Varies	FY 2003				FY 2004				FY 2005				NOTES
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
COLLECT PERFORMANCE DATA: RESULTS-LEVEL INDICATORS														
SO HIV/AIDS Crisis Mitigated														
SO - # 1: % HIV/AIDS prevalence among 15-19 year olds														CDC YAS done every three years. Next is ? 20005.
SO - # 2: % of Zimbabwe's orphans and vulnerable children receiving care and support						☑				☑				Collect information annually. Calculate based on IR Indicator.
Context Indicator 1: Contraceptive Prevalence Rate										☑				This data is collected every five years through DHS. Next results will come in ? ____,2005
Context Indicator 2: Stigma indicator - TBD														To be developed in May 2003
IR Indicators														
IR 1 Behavior Change Through Increased Use of Effective, Quality Services for HIV Prevention														
IR 1 - # 1.Number of condoms sold through Condom Social Marketing Program		☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	Monthly data collection by partner (PSI).
IR 1 - # 2. Number of socially marketed		☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	Monthly data collection

PERFORMANCE MANAGEMENT TASKS	Varies	FY 2003				FY 2004				FY 2005				NOTES
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
hormonal contraceptives sold OR CYP??														by partner.
IR 1 # 3. Condom use at last risky sex														Data will be gathered every other year in??? by ????
IR 1 - # 4. Number of persons requesting HIV test and receiving result		☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	Data collected by partner.
IR 1 - # 5. Young people with multiple partners in the past 12 months						☑								To be done every other year. Add check to Q1 2006
IR 1 # 6. Median age at first sex						☑								To be done every other year (ADD FY 2006 (Q1) checked box
IR 2. Enhanced Capacity of Institutions to Formulate and Advocate for Improved HIV Policies														
IR 2 - # 1. Number of HIV policies drafted and/or approved						☑				☑				This will be calculated annually by partner. ADD FY 2006 Q1 box
IR 2 - # 2. Percentage of participating CSOs with improved Advocacy Index scores		☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	
IR 2 - # 3. Number of institutions involved in HIV/AIDS advocacy		☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	
IR 2 - # 4. Number of employers practicing HIV/AIDS 'Affirmative Action'		☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	
IR 3. Improved Care and Support for Orphans and Vulnerable Children														
IR 3 - # 1. Number of orphans and vulnerable children receiving care and support		☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	Annually
IR 3 - # 2. Average percentage change in Orphans and Vulnerable Support Index.					☑				☑				☑	This will calculated annually.
IR 3 - # 3. Number of orphans and vulnerable children benefiting from improved access to education					☑									Initial numbers will be reported in qtr 4 year 2 of the project and thereafter every qtr

PERFORMANCE MANAGEMENT TASKS	Varies	FY 2003				FY 2004				FY 2005				NOTES
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
COLLECT PERFORMANCE DATA: ACTIVITY-LEVEL & CONTEXT INDICATORS														
Gather activity data/partner progress reports		☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	Activity level information collected monthly
CONDUCT EVALUATIONS & SPECIAL STUDIES														
Evaluations:														
1. PSI evaluation						☑								To be done in Nov. 2003
2. Evaluation of IR 3				☑										Evaluation to be done in May 2003
3. CRS/STRIVE Mid-Term Assessment Review				☑					☑					To be done in May 2003.
Special Studies:														
1. Study on IR 1 (VCT project)	ongoing	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	The study will be done throughout the project period. Three or 5 year study with result available in ??
2. AIDS Impact Model Study			☑											AIM study to be done in Jan 2003
3. Operations Research for CRS Strive Program	Already in progress	☑	☑	☑	☑	☑	☑	☑						Done between Jan 2002 to May 2004
4. Demographic Health Survey	Throughout 2004									☑				DHS to be completed end 2004.
5. Young Adults survey										☑				To be done in November, 2004. By whom
6. Antenatal Survey					☑				☑				☑	This will be an annual CDC survey
REVIEW PERFORMANCE INFORMATION														
Review of Partnership Information	Also ongoing	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	This will be a quarterly activity.
Area Review at Mission What a/b Porflio Reviews?		☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	November, February, May, August
REPORT PERFORMANCE RESULTS														

PERFORMANCE MANAGEMENT TASKS	Varies	FY 2003				FY 2004				FY 2005				NOTES
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Annual Reports			☑				☑				☑			Due to Agency January 6, 2003
HIV/AID Expanded Response report														Part of Annual Report submitted same time
Congressional Reporting – Check with DC on other require														
ASSESS DATA QUALITY														
Needs serious planning for each indicator we report on	V													Some assessment is done through weekly meetings with partners
REVIEW & UPDATE PMP														
Review and Update as and when required			☑				☑				☑			A strategy review expected in Jan 2003. Team will monitor on ongoing basis and review formally (internally) on an annual basis during the Annual Portfolio Review.

VERIFY INFO/ADD DETAILED INFO/NOTES – THIS DOCUMENT WILL BE YOUR REMINDER FOR PLANNING

SECTION IV. PERFORMANCE DATA TABLES AND INDICATORS

The following section contains Performance Data Tables for SO HIV/AIDS and detailed Performance Indicator Reference Sheets for each indicator. If current results-level indicators are refined and/or additional indicators developed, the SO team will create new indicator sheets based on this template and update the Performance Data Table. Each reference sheet is fully consistent with the guidance (mandatory and suggested) contained in ADS 200 series and provides information on:

- Indicator definition, unit of measurement, and any data disaggregation requirements;
- USAID data acquisition method, data sources, timeline for data acquisition, and USAID staff responsible for data acquisition;
- Plans for data analysis, review, and reporting;
- Any data quality issues, including any actions taken or planned to address data limitations; and
- Notes on baselines, targets, and data calculation methods.

This section contains information on ***SO level, IR level and context-level*** indicators. ***Context-level*** are generally macro-statistics that provide valuable information on the environment in which USAID operates but cannot be directly attributed to USAID because they are influenced by multiple factors of which USAID is only one.

Note on Baselines and Targets

Several indicators included in this section do not yet have baselines or targets, mainly because two of the three intermediate results under the SO HIV/AIDS have only recently contracted with new implementing partners. Deadlines for setting targets and designation of responsibilities are summarized in the "Next Steps" chart on page ?? Similarly several baseline figures are missing from the indicator reference sheets. Baseline data for these indicators will need to be collected once data is available. The SO HIV/AIDS team will continue to work very closely with their implementing partners by including them in discussions related to the gathering of baseline data and the setting of targets for performance indicators.

C. SO HIV/AIDS PERFORMANCE DATA TABLE AND INDICATOR REFERENCE SHEETS

Performance Indicators for Strategic Objective: HIV/AIDS Crisis Mitigated

SO HIV/AIDS Crisis Mitigated
Indicator 1: Percent (%) of HIV/AIDS Prevalence Among 15-19 Year Olds*
Indicator 2: Percent (%) of Zimbabwe's Orphans and Vulnerable Children Receiving Care and Support

Context Indicator 1: Contraceptive Prevalence Rate**
Context Indicator 2: Indicator on Reduction of Stigma Towards People with HIV/AIDS***

IR 1 Behavior Change through Increased Use of Effective, Quality Services for HIV Prevention
Indicator 1: Number of Condoms Sold through Condom Social Marketing Program
Indicator 2: Number of Socially Marketed Hormonal Contraceptives by Type of Contraceptive
Indicator 3: Condom Use at Last Risky Sex (15-24 year olds)
Indicator 4: Number of Persons Requesting HIV Test and Receiving Result****
Indicator 5: Young People with Multiple Partners in last 12 Months (15-24)
Indicator 6: Median Age at First Sex

IR 2 Enhanced Capacity of Institutions to Formulate and Advocate for Improved HIV Policies
Indicator 1: Number of HIV/AIDS Policies Drafted and/or Approved
Indicator 2: Percent (%) of Participating CSOs with Improved Advocacy Index Scores
Indicator 3: Number of Institutions Involved in HIV/AIDS Advocacy
Indicator 4: Percent (%) of Employers Practicing HIV/AIDS "Affirmative Action"

IR 3 Improved Care and Support for Vulnerable Children
Indicator 1: Number of Orphans and Vulnerable Children Receiving Care and Support
Indicator 2: Average % Change in Vulnerable Children Support Index
Indicator 3: Number of Vulnerable Children Benefiting form Improved Access to Education

*** While data will be collected on the broader age cohort of 15-24, experience indicates that impact is greatest at the 15-19 year age range and USAID/Zimbabwe programs focus messages on this age group. Thus, success will be best measured within this age cohort.**

**** This indicator was moved from the level of IR 1 to a SO Context indicator because the USAID family planning program was phased out in 2000 and therefore the indicator is no longer directly linked /attributable to USAID input. However, it is still considered a critical measure of the environment that will have significant impact on the mitigation of the AIDS crisis as contraceptive use effects everything from MTCT to the ability to care for HIV/AIDS infected family members.**

***** Indicator to be developed _____ . Activities under all three IRs include efforts to reduce stigma as stigma reduction is critical to the mitigation of the crisis. However, as stigma is an issue affected to a large degree by influence outside of USAID's control, this will be a** context level **indicator.**

****** The SO team will use this indicator as the figure for "Number of Clients Seen at VCT Centers" for the Expanded Response Report. For IR monitoring purposes, it was felt that clients "requesting HIV test and receiving the result" is a more meaningful measure of impact than "seen at centers."**

Performance Data Table: SO HIV/AIDS

RESULT	PERFORMANCE INDICATOR			BASELINE DATA		FISCAL YEAR									
				(FY)		2003		2004		2005		2006		2007	
Results Statement	**Indicator**	**Unit of Measure**	**Disaggregation**	**Baseline Year**	**Baseline Value**	**Target 2003**	**Actual 2003**	**Target 2004**	**Actual 2004**	**Target 2005**	**Actual 2005**	**Target 2006**	**Actual 2006**	**Target 2007**	**Actual 2007**
Strategic Objective: HIV/AIDS Crisis Mitigated															
SO HIV/AIDS	1. % of HIV/AIDS prevalence among 15-19 year olds	Percentage	1. 2.												
SO HIV/AIDS	2. % of Zimbabwe's orphans and vulnerable children receiving care and support	Percentage	1. 2.												
Intermediate Result 1: Behavior Change Through Increased Use of Effective, Quality Services for HIV Prevention															
IR 1	1. Number of condoms sold through condom social marketing program	Simple Number	1. 2.	2002	20 million	18 million		18.6 million		19.4 million sold Cumulative: 75 million sold (Life of IR)					
IR 1	2. Number of socially marketed hormonal contraceptives	Simple Number	1. Type of contraceptive	2002	118,000	85,000		90,000		107,000 Cumulative: 400 000 Hormonal CYP (Life of IR)					

RESULT	PERFORMANCE INDICATOR			BASELINE DATA		FISCAL YEAR									
				(FY)		2003		2004		2005		2006		2007	
Results Statement	**Indicator**	**Unit of Measure**	**Disaggregation**	**Baseline Year**	**Baseline Value**	**Target 2003**	**Actual 2003**	**Target 2004**	**Actual 2004**	**Target 2005**	**Actual 2005**	**Target 2006**	**Actual 2006**	**Target 2007**	**Actual 2007**
IR 1	3. Condom use at last risky sex (15-24 years old)	Percent	1. Gender 2. Age	08/01	52.5% -65.3% of males -30% of females					52.5% -56% of males -49% of females					
IR 1	4. Number of clients requesting HIV test and receiving result	Simple Number	1. Gender 2. Age 3.Prevalence	2002	58,000 -19.2% HIV+ -49% females -51% males -10% 15-19yrs and 33% 20-24 yrs	52,000		67,5,500		72,500 cumulative: 250,000 people counseled and tested (Life of IR)					
IR 1	5. Young people with multiple partners in last 12 months (15-24)	Percent	1.Gender 2.Age	08/01	48% total -52% of males -43% of females					38% overall -41% of males -33% of females					
IR 1	6. Median age at first sex	Simple number – age in years	1.Gender	08/01	18.5 years -18 years for females and 19 years for males					19.5 years -20 years for males -19 years for females					

RESULT	PERFORMANCE INDICATOR			BASELINE DATA		FISCAL YEAR									
				(FY)		2003		2004		2005		2006		2007	
Results Statement	**Indicator**	**Unit of Measure**	**Disaggregation**	**Baseline Year**	**Baseline Value**	**Target 2003**	**Actual 2003**	**Target 2004**	**Actual 2004**	**Target 2005**	**Actual 2005**	**Target 2006**	**Actual 2006**	**Target 2007**	**Actual 2007**
Intermediate Result 2: Enhanced Capacity of Institutions to Formulate and Advocate for Improved HIV Policies															
IR 2	1. Number of HIV/AIDS policies drafted and/or approved	Simple number	1.Themes 2.Sector 3.Gender	2003	5	5		5		5					
IR 2	2. Percentage of participating CSOs with improved Advocacy Index scores	Percent %	None	2003 or Year that CSO receives grant		80%		80%		85%					
IR 2	3. Number of institutions involved in HIV/AIDS advocacy	Simple number - each separate institution = one unit	1.Gender 2. Region 3.Theme 4. Sector	2003	0?	30		60		65					
IR 2	4. Number of employers adopting HIV/AIDS "affirmative action"	Percent	1.Gender 2.Region 3.Theme 4.Sector	2000?	0?	25%		50%		65%					
Intermediate Result 3: Improved Care and Support For Vulnerable Children															
IR 3	1. Number of orphans and vulnerable children receiving care and support	Simple number	1.Gender 2. Age	2002	64,000	109,000		250,000		500,000		750,000		895,000	

RESULT	PERFORMANCE INDICATOR			BASELINE DATA		FISCAL YEAR									
				(FY)		2003		2004		2005		2006		2007	
Results Statement	**Indicator**	**Unit of Measure**	**Disaggregation**	**Baseline Year**	**Baseline Value**	**Target 2003**	**Actual 2003**	**Target 2004**	**Actual 2004**	**Target 2005**	**Actual 2005**	**Target 2006**	**Actual 2006**	**Target 2007**	**Actual 2007**
IR 3	2. Average % change in vulnerable children support index score	Percentage	1. Gender 2. Age	2002	35%	15%		40%		90%		1 15%		140%	
IR 3	3. Number of Orphans and vulnerable children benefiting from improved access to education	Simple number	1. Gender 2. Education Level	2002	4500	35000		85000		170000		340000		680000	
Context Indicators:															
SO	1.Contraceptive prevalence rate														
SO	2. Stigma Indicator	TBD	TBD												

INSERT SO AND CONTEXT INDICATOR SHEETS

Performance Indicator Reference Sheet
Strategic Objective: HIV/AIDS Crisis Mitigated **Intermediate Result 1:** Behavior Change Through Increased Use of Effective, Quality Services for HIV Prevention **Indicator # 1:** Number of Condoms Sold Through Condom Social Marketing Program
DESCRIPTION
Precise Definition(s): Condoms sold to trade outlets through condom social marketing program **Unit of Measure:** Simple Number **Disaggregated by:** **Justification/Management Utility:** Condoms sold are a good proxy for condoms used.
PLAN FOR DATA ACQUISITION BY USAID
Data Collection Method: Sales data - MIS **Method of Acquisition by USAID:** Quarterly reports submitted by PSI/ZIM **Data Source(s): PSI/Z** **Frequency/Timing of Data Acquisition:** Reports due to USAID from PSI on ?? **Estimated Cost of Data Acquisition:** **Responsible Individual(s) at USAID:** Patrick Osewe, IR1 Manager
DATA QUALITY ISSUES
Date of Initial Data Quality Assessment: Missing section **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:** **Date of Future Data Quality Assessments:** **Procedures for Future Data Quality Assessments:**
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data Analysis: Missing section **Presentation of Data:** **Review of Data:** **Reporting of Data:**
OTHER NOTES
Notes on Baselines/Targets: 75 Million Protector plus male condoms sold by 2005 **Location of Data Storage:** **Other Notes:**
THIS SHEET LAST UPDATED ON: 11/19/02

Performance Indicator Reference Sheet
Strategic Objective: HIV/AIDS Crisis Mitigated **Intermediate Result 1:** Behavior Change Through Increased Use of Effective, Quality Services for HIV Prevention **Indicator # 2:** Number of Socially Marketed Hormonal Contraceptives Sold OR CYP??
DESCRIPTION
Precise Definition(s): Couple years of protection (how is it calculated) sold through USAID supported social marketing program by type of contraceptives **Unit of Measure:** Simple number **Disaggregated by:** Contraceptive type **Justification/Management Utility:** Fill in rational/reason for using this indicator. Why is it useful in tracking IR 1
PLAN FOR DATA ACQUISITION BY USAID
Data Collection Method: Sales Data (Management Information System) **Method of Acquisition by USAID:** Quarterly report submitted by PSI/Zimbabwe **Data Source(s):** PSI/Z **Frequency/Timing of Data Acquisition:** Every Quarter due to USAID on ?? **Estimated Cost of Data Acquisition:** Within contract award **Responsible Individual(s) at USAID:** Patrick Osewe, IR 1 Manager
DATA QUALITY ISSUES
Date of Initial Data Quality Assessment: Whole section missing **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations: NONE** **Date of Future Data Quality Assessments:** **Procedures for Future Data Quality Assessments:**
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data Analysis: Section missing **Presentation of Data:** **Review of Data:** **Reporting of Data:**
OTHER NOTES
Notes on Baselines/Targets**: 400 000 Hormonal CYPs delivered through the social marketing program by 2005** Location of Data Storage: Other Notes:
THIS SHEET LAST UPDATED ON: 11/19/02

Performance Indicator Reference Sheet
Strategic Objective: HIV/AIDS Crisis Mitigated **Intermediate Result 1:** Behavior Change Through Increased Use of Effective, Quality Services for HIV Prevention **Indicator # 3**: Condom Use at Last Risky Sex (15-24 yrs)
DESCRIPTION
Precise Definition(s): Percent of respondents who report using a condom the last time they had sex with a non-marital and non-cohabitating partner of those who report having sex with such a partner in the last 12 months **Unit of Measure:** Percentage % **Disaggregated by:** Gender, age **Justification/Management Utility:** Fill in rational/reason for using this indicator. Why is it useful in tracking IR 1
PLAN FOR DATA ACQUISITION BY USAID
Data Collection Method: Population based surveys **Method of Acquisition by USAID:** KAP Survey Report **Data Source(s):** PSI/Z and Advance Africa **Frequency/Timing of Data Acquisition:** Every other year: 2003, 2005 **Estimated Cost of Data Acquisition:** US$50 000.00 Is this an addition cost to USAID or is it "Included in partner award" **Responsible Individual(s) at USAID:** Patrick Osewe, IR1 Manager
DATA QUALITY ISSUES
Date of Initial Data Quality Assessment: Missing whole section **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:** **Date of Future Data Quality Assessments:** **Procedures for Future Data Quality Assessments:**
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data Analysis: Univariate and Bivariate analysis **Presentation of Data:** Tables and graphs **Review of Data:** **Reporting of Data:** Quarterly reports **(USAID Reporting to DC?)**
OTHER NOTES
Notes on Baselines/Targets: PSI/Z KAP survey of 1997, 1999; Advance Africa KAP of 2001 End of SO target (2005): 56% among male youths (15-24); 49% among female youths (15-24) Location of Data Storage: **PSI/Z** Other Notes:
THIS SHEET LAST UPDATED ON: 11 /19 /02

Performance Indicator Reference Sheet
Strategic Objective: HIV/AIDS Crisis Mitigated **Intermediate Result 1:** Behavior Change Through Increased Use of Effective, Quality Services for HIV Prevention **Indicator #4:** Number of Clients Requesting HIV Test and Receiving Result
DESCRIPTION
Precise Definition(s): Number of people who have been counseled, tested and received their results at USAID supported VCT sites **Unit of Measure:** Simple Number **Disaggregated by:** Age; Gender **Justification/Management Utility:** Fill in rational/reason for using this indicator. Why is it useful in tracking IR 1
PLAN FOR DATA ACQUISITION BY USAID
Data Collection Method: Contractor review of New Start Centers' service records **Method of Acquisition by USAID:** Progress reports submitted by contractor **Data Source(s):** PSI/ZIM **Frequency/Timing of Data Acquisition:** Monthly Quarterly when **Estimated Cost of Data Acquisition:** **Responsible Individual(s) at USAID:** Patrick Osewe, IR3.1 Manager
DATA QUALITY ISSUES
Date of Initial Data Quality Assessment: **Known Data Limitations and Significance (if any):** None **Actions Taken or Planned to Address Data Limitations:** **Date of Future Data Quality Assessments:** **Procedures for Future Data Quality Assessments:**
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data Analysis: **Presentation of Data:** **Review of Data:** **Reporting of Data:**
OTHER NOTES
Notes on Baselines/Targets: 250,000 clients counseled and then received results at New Start Centers by 2005 **Location of Data Storage:** **Other Notes:**
THIS SHEET LAST UPDATED ON: 11/19/02

Performance Indicator Reference Sheet
Strategic Objective 3: HIV/AIDS Crisis Mitigated **Intermediate Result 3.1:** Behavior Change Through Increased Use of Effective, Quality Services for HIV Prevention **Indicator #5:** Young People with Multiple Partners in the Last 12 Months (15-24 years old)
DESCRIPTION
Precise Definition(s): Proportion of respondents who have had sex with more than one non-marital and non-cohabitating partners in the last 12 months **Unit of Measure:** Percent % **Disaggregated by:** Gender; age **Justification/Management Utility:**
PLAN FOR DATA ACQUISITION BY USAID
Data Collection Method: KAP SURVEY **Method of Acquisition by USAID:** PSI/ZIM Final Survey **Data Source(s): PSI/Z** **Frequency/Timing of Data Acquisition:** Every other year when? **Estimated Cost of Data Acquisition:** **Responsible Individual(s) at USAID:** Patrick Osewe, IR1 Manager
DATA QUALITY ISSUES
Date of Initial Data Quality Assessment: Fill in section **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:** **Date of Future Data Quality Assessments:** **Procedures for Future Data Quality Assessments:**
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data Analysis: Fill in section **Presentation of Data:** **Review of Data:** **Reporting of Data:**
OTHER NOTES
Notes on Baselines/Targets: **BASELINE KAP SURVEY CONDUCTED 2001** Location of Data Storage: **PSI/Z** Other Notes:
THIS SHEET LAST UPDATED ON: 11/19/02

Performance Indicator Reference Sheet
Strategic Objective: HIV/AIDS Crisis Mitigated **Intermediate Result 1:** Behavior Change Through Increased Use of Effective, Quality Services for HIV Prevention **Indicator # 6:** Median age at first sex
DESCRIPTION
Precise Definition(s): The age by which half of men and women aged 15-24 have penetrative sex Is this standard definition (UN USAID)? **Unit of Measure:** Simple Number (age in years) **Disaggregated by:** Gender **Justification/Management Utility:** Fill in rational/reason for using this indicator. Why is it useful in tracking IR 1
PLAN FOR DATA ACQUISITION BY USAID
Data Collection Method: Young Adult Survey **Method of Acquisition by USAID:** CDC Report **Data Source(s):** CDC **Frequency/Timing of Data Acquisition:** Every other year in ??? Next one in ??? **Estimated Cost of Data Acquisition:** US$400 000.00 Cost to you – USAID for acquiring report? **Responsible Individual(s) at USAID:** Patrick Osewe, IR1 Manager
DATA QUALITY ISSUES
Date of Initial Data Quality Assessment: fill in section **Known Data Limitations and Significance (if any):** **Actions Taken or Planned to Address Data Limitations:** **Date of Future Data Quality Assessments:** **Procedures for Future Data Quality Assessments:**
PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING
Data Analysis: fill in section **Presentation of Data:** **Review of Data:** **Reporting of Data:**
OTHER NOTES
Notes on Baselines/Targets: **Baseline 2001 Data Collection by CDC, dissemination of results, November, 2002** **By end of SO (2005), target to increase Median Age at first sex to 19 years for females and 20 years for males** Location of Data Storage**: CDC** Other Notes:
THIS SHEET LAST UPDATED ON: 11/19/02

Performance Indicator Reference Sheet
Strategic Objective: HIV/AIDS Crisis Mitigated
Intermediate Result 2: Enhanced Capacity of Institutions to Formulate and Advocate for Improved HIV/AIDS Policies
Indicator # 1: Number of HIV/AIDS policies drafted and/or approved
DESCRIPTION
Precise Definition: HIV/AIDS policies can include: 1. National policies such as the Zimbabwe National HIV/AIDS policy; 2. Bills, laws and acts such as the National Aids Act; 3. Operational policies such as guidelines for VCT and use of ARVs; 4. Institutional policies or guidelines that affect the way HIV/AIDS is addressed. Examples might be policies or guidelines developed by Anglican bishops for Anglican churches in the country, r policies or guidelines developed by labour unions or employers to guide policies towards workers or policies or guidelines developed by CSO's to guide policies towards their contintuents. Drafted policies are those that have been fully prepared but are still in the review and approval stage while approved policies are those which have been passed by appropriate Zimbabwean authority.(s) **Unit of Measure:** Simple number. Each draft or approved policy is a unit of measure. **Disaggregated by:** Themes (women's empowerment, youth, stigma & discrimination, orphans and vulnerable children, reproductive health); gender; sector (public, commercial, faith-based, NGO etc.) **Justification/Management Utility:** The number of drafted and or approved policies allows ZAPA to monitor and measure the impact of engaging various institutional officials/leaders in HIV/AIDS meetings and/or policy review and development initiatives. This measure will help project management to target project resources by sector
PLAN FOR DATA ACQUISITION BY USAID
Data Collection Method: ZAPA team will collect from appropriate Zimbabwean institution. **Method of Acquisition by USAID**: Contractor quarterly reports. **Data Source(s):** The draft or approved documents obtained from appropriate Zimbabwean institution. **Timing/Frequency of Data Acquisition:** The project will collect and report quarterly to USAID. **Estimated Cost of Data Acquisition:** Included within award. **Responsible Individual(s) at USAID:** Mercia Davids, IR2 Manager
PLAN FOR DATA ANALYSIS, REVIEW, and REPORTING
Data Analysis: Quarterly review of contractor analysis by Mercia Davids **Presentation of Data:** Chart and narrative. **Review of Data:** SO team will review data through SO team meetings and internal mission reviews on a quarterly basis. **Reporting of Data:** Will be included as indicator in annual report, ambassadorial reports, and area reviews.
DATA QUALITY ISSUES
Date of Initial Data Quality Assessment: November, 2002 **Known Data Limitations and Significance (if any):** None **Actions Taken or Planned to Address Data Limitations:** N/A **Date of Future Data Quality Assessments:** TBD **Procedures for Future Data Quality Assessments:** TBD
OTHER NOTES

Notes on Baselines/Targets: **Baselines/targets based on ZAPA Project situational analysis.** Data Storage: **USAID/Zimbabwe office, with reference to results datafiles at ZAPA Project Office.** Other Notes:
THIS SHEET LAST UPDATED ON 11/19/02

This one needs some more clarity – the indicator is a percentage but the scoring is numerical so it has to be crystal clear what you USAID are looking to measure and report

Performance Indicator Reference Sheet
Strategic Objective: HIV/AIDS Crisis Mitigated
Intermediate Result 2: Enhanced Capacity of Institutions to Formulate and Advocate for Improved HIV/AIDS Policies
Indicator #2: Percent of Participating CSOs with Improved Advocacy Index Scores
DESCRIPTION
Precise Definition: The Advocacy Index is a composite scoring instrument that measures the ability of CSOs to undertake advocacy along 11 separate but interrelated dimensions: from issues identification and research; through outreach, public education and networking; to effecting policy change, serving as a watch dog and institutionalizing advocacy within organizations. The language used to define each dimension has been refined over time to eliminate ambiguity and the risk of having a broad range of interpretations by participating CSOs. The instrument and process are "issue neutral," and are applicable to a wide range of advocacy issues, including HIV/AIDS. The instrument may be applied both as a self-assessment tool and as an external assessment tool. In the former case, the Index creates CSO ownership of and competence in the process of defining advocacy capacity needs, in tracking capacity enhancement, and in managing advocacy performance. Combination of the self-assessment and external assessment approaches results in a more objective rating system. [Note: Under the ZADF program in Zimbabwe, **for example**, USAID/Zimbabwe CA Pact uses a series of assessments by CSOs, by ZADF staff, by USAID D&G team, and finally by a panel of 6 Zimbabwean civil society leaders; the results of the last assessment in the series provide the official scores used for data analysis and performance evaluation, included for Annual Report purposes.] **Unit of Measure:** The unit of measure is the number of CSO's showing significant progress on the advocacy index score compared with the total number of participating CSO's. The advocacy index employees a rating scale for each dimension of advocacy. The values are well defined, and range from 0 for no capacity to 5 for strong capacity with little room for improvement. Respondents also provide additional comments for each dimension to better identify and articulate problems or unanticipated events affecting progress. In addition, the external Advocacy Panel provides narrative comment to accompany numerical scoring, as a guide to the CSOs, **the CA**, and USAID, for future action. **Disaggregated by:** The Advocacy Index generates a total of 12 scores, one for each dimension of advocacy, as well as a composite score covering the entire inter-related process. Comparison and analysis of scores across time or across CSOs may be made by specific Advocacy Index dimension and/or the composite result. For PMP reporting the aggregate score will be obtained for each CSO at baseline and again at 12 month intervals. **Justification/Management Utility**: The findings and process of the Advocacy Index allow CSOs (1) to chart and manage their course and capacity for advocacy; and (2) to identify areas of weakness where external financial or technical support would be useful. Through repeated applications, with suitable intervals between each application, the Advocacy Index allows CSOs to monitor and measure progress in capacity and performance. The Advocacy Index process is a strong internal monitoring and reporting mechanism and, at the same time, an effective mechanism for USAID evaluation of progress in CSO capacity for advocacy.
PLAN FOR DATA ACQUISITION BY USAID
Data Collection Method: . The Index requires completion of a standardized form or score card by a team of at least 3-4 staff members from each participating CSO; each team must be composed of a solid mix of technical and management personnel. ZAPA project will arrange for application of Advocacy Index for all participating CSOs. **Method of Acquisition by USAID**: Quarterly reports from ZAPA project. Arrangements will be made by the contractor at the outset of each CSO grant for establishment of Advocacy Index baseline scores, annual progress assessments by the CSOs and the Advocacy Panel, and transmittal of the Index findings (by the CSOs and the Panel) by delivery, fax, or e-mail to the Project Office. The findings and indicator scores will be delivered to USAID in the form of quarterly reports. **Data Source(s):** ZAPA project to USAID. The data sources are the CSOs or supporting efforts in advocacy within the participating CSOs and the members of the Advocacy Panel.

Timing/Frequency of Data Acquisition: Quarterly reports from ZAPA project. Baseline Index scores are established by the CSOs and the Advocacy Panel within the first three months of commencement of each CSO grant and are then reviewed annually. To reduce costs for operation of the Panel, the Panel is convened (for baseline and/or progress assessment) when there are 5–10 CSOs to be reviewed.

Estimated Cost of Data Acquisition: Costs for data acquisition are covered within the award.

Responsible Individual(s) at USAID: Mercia Davids, IR2 Manager

PLAN FOR DATA ANALYSIS, REVIEW, and REPORTING

Data Analysis: As stated earlier, a variety of valid comparisons may be made within sectors, across sectors, across CSOs tackling the same issues, and/or across CSOs addressing different issues and different thematic areas.

Presentation of Data: The results of applying the Index may be presented in a variety of formats: tables, charts and graphs, accompanied as needed by narrative pieces discussing constraints on or potential for advocacy. Some suggested presentations include "snap-shots" in time displaying differences in aggregate/composite scores and disaggregated scores by CSO and across CSOs; longitudinal presentations showing changes in aggregate/composite scores and disaggregated scores by CSO and across CSOs.

Review of Data: Reviews of data by participating CSOs and project staff occurs annually.

Reporting of Data: Data will be collected at 12 month intervals for each CSO and reported via quarterly and annual reports to USAID.

DATA QUALITY ISSUES

Date of Initial Data Quality Assessment: Within three months of date of induction of new CSOs as grantees, to establish Advocacy Index baseline information against which future progress is to be compared. Also need to plan for quality assessment.

Known Data Limitations and Significance (if any): The Index has a strong and growing reputation among CSOs in Zimbabwe as a tool that enhances the quality and focus of advocacy. Its principal limitation as an evaluation tool is that the Advocacy Index process does not provide for precise attribution to the Futures Group team of the Project's contribution (for example, through technical assistance) to the CSO progress results that may be established by application of the Index.

Actions Taken or Planned to Address Data Limitations: The indicated limitation of the Index may be overcome (a) by findings of the independent Advocacy Panel concerning linkage of CSO performance to Futures Group Project performance, and (b) USAID evaluation (e.g., with reference to the Project's Workplan) of the causative relationship between Project outputs and CSO performance.

Date of Future Data Quality Assessments: Within one year of induction of CSO grantees into program, to measure progress against the baseline.

Procedures for Future Data Quality Assessments: CSO self-assessments and Advocacy Panel external assessments.

OTHER NOTES

Note on Baselines/Targets: **The Project will target that 85% of the CSOs covered by the Advocacy Index process will show significant progress for advocacy capacity. "Significant progress" will be defined as an Advocacy Panel determination (a) showing a minimum of a 20% increase in composite Index scoring for each CSO, and (b) at least a 1 point improvement in at least 5 of the 11 dimensions of the Index. Does not match with data table targets earlier in report**

Data Storage: **USAID will maintain contractor Quarterly reports with reference to NGO database at contractor Project Office.**

THIS SHEET LAST UPDATED ON 11/19/02

Performance Indicator Reference Sheet
Strategic Objective: HIV/AIDS Crisis Mitigated
Intermediate Result 2: Enhanced Capacity of Institutions to Formulate and Advocate for Improved HIV/AIDS Policies.
Indicator #3: Number of Institutions Involved in HIV/AIDS Advocacy
DESCRIPTION
Precise Definition: This indicator counts the number of institutions involved in advocacy and reflecting ZAPA project interventions. Institutions are considered to be involved if they can demonstrate adequate, articulated plans to advocate for HIV/AIDS issues relevant or beneficial to their constituencies and/or if they are engaged in substantive advocacy activities.. **Unit of Measure:** Each separate institution engaged in advocacy will be considered a unit of measure. **Disaggregated by:** The indicator will be disaggregated by gender, geographic region, theme, and sector. **Justification/Management Utility:** This indicator is a useful way to determine whether USAID interventions are enhancing the capacity to formulate/advocate for improved HIV/AIDS policies. The epidemic touches every corner of Zimbabwe; it affects virtually all aspects of Zimbabwean society; and it is raging in a volatile political and economic environment. It is therefore important to have a wide range of institutions engaged in HIV/AIDS advocacy. The indicator also has considerable management utility, particularly in helping USAID evaluate and structure its assistance to civil society.
PLAN FOR DATA ACQUISITION BY USAID
Data Collection Method: ZAPA will track the number of its partners engaged in HIV/AIDS advocacy as a key component of its monitoring system **Method of Acquisition by USAID**: Quarterly reports from ZAPA project. **Data Source(s):** ZAPA project to USAID. ZAPA, in turn, will depend on progress reports from its advocacy partners **Timing/Frequency of Data Acquisition**: Quarterly reports from ZAPA project. **Estimated Cost of Data Acquisition:** Included within award. **Responsible Individual(s) at USAID:** Mercia Davids, IR2 Manager
PLAN FOR DATA ANALYSIS, REVIEW, and REPORTING
Data Analysis: Quarterly review of contractor analysis by Mercia Davids. **Presentation of Data:** Chart and narrative. **Review of Data:** SO team will review data through SO team meetings and internal mission reviews on a quarterly basis. **Reporting of Data:** Will be included as an indicator in Annual Report?, area reviews, ambassadorial reports.
DATA QUALITY ISSUES
Date of Initial Data Quality Assessment: November 2002. **Known Data Limitations and Significance (if any):** None. **Actions Taken or Planned to Address Data Limitations:** NR **Date of Future Data Quality Assessments**: Annually **Procedures for Future Data Quality Assessments:**
OTHER NOTES
Note on Baselines/Targets: **Targets have been established based on a situational analysis, the initial set of small grant applications, and the availability of funds for small grants.** Data Storage: **USAID Zimbabwe office, with reference to results data files at ZAPA Project Office.**
THIS SHEET LAST UPDATED ON 11/19/02

Performance Indicator Reference Sheet
Strategic Objective: HIV/AIDS Crisis Mitigated
Intermediate Result 2: Enhanced Capacity of Institutions to Formulate and Advocate for Improved HIV/AIDS Policies.
Indicator# 4: Percent of Employers Adopting HIV/AIDS "Affirmative Action"
DESCRIPTION
Precise Definition: "Affirmative action" means that through an adopted personnel policy, or staff notice, or other mode the employer ensures that HIV-infected employees will not be discriminated against nor suffer an economic or employment penalty because of their status. It can also mean that employers provide positive support and care for those employees (and their families) who are HIV-infected or otherwise affected by the epidemic. **Unit of Measure:** Each separate employer who adopts "affirmative action" policies will be considered a unit of measure **Disaggregated by**: The reporting on this measure will be disaggregated by geographical region. **Justification/Management Utility**: This indicator is a valid measure to see whether the workplace environment is improving for the HIV-infected. Workplace interventions are particularly key in Zimbabwe and elsewhere because one of the key factors underlying the cultural "silence" on the epidemic is a tremendous fear of losing employment in bad economic times. The indicator has considerable management utility in guiding USAID assistance for workplace interventions.
PLAN FOR DATA ACQUISITION BY USAID
Data Collection Method: ZAPA will track the number of its private sector partners institutions engaged in HIV/AIDS advocacy as a key component of its monitoring system **Method of Acquisition by USAID:** Quarterly reports from ZAPA project. **Data Source(s):** ZAPA project to USAID. In turn, ZAPA will assemble data based on progress reports from its partners. **Timing/Frequency of Data Acquisition:** Quarterly reports from ZAPA project. **Estimated Cost of Data Acquisition:** Negligible. Responsible Individual(s) at USAID: Mercia Davids
PLAN FOR DATA ANALYSIS, REVIEW, and REPORTING
Data Analysis: Quarterly review of contractor analysis by Mercia Davids. **Presentation of Data:** Chart and narrative. **Review of Data:** SO team will review data through SO team meetings and internal mission reviews on a quarterly basis. **Reporting of Data:** Will be included as an indicator in annual report, area reviews, ambassadorial reports.
DATA QUALITY ISSUES
Date of Initial Data Quality Assessment: November 2002. **Known Data Limitations and Significance (if any):** None. **Actions Taken or Planned to Address Data Limitations:** NR **Date of Future Data Quality Assessments:** Annually **Procedures for Future Data Quality Assessments:**
OTHER NOTES
Note on Baselines/Targets: **Targets will be expressed as a percentage of those employers with which ZAPA Project works that adopt "affirmative action" and are expressed as a cumulative percentage over the life of the project. The actual number of employers with which ZAPA will be working is not targeted. The actual number of employers with which ZAPA will be working is not targeted but will be reported.** Data Storage: **USAID Zimbabwe office, with reference to results data files at ZAPA Project Office.**
THIS SHEET LAST UPDATED ON 11/19/02

Performance Indicator Reference Sheet
Strategic Objective: HIV Crisis Mitigated **Intermediate Result 3:** Improved Care and Support for Vulnerable Children **Indicator # 1**: Number of Orphans and Vulnerable Children Reached (Receiving Care and Support)
DESCRIPTION
Precise Definition(s): Children who: are orphans (single or double); have a chronically ill parent; have a parent caring for PLWA; are living in households, which have absorbed additional children. "Reached" implies that care and support is offered directly and indirectly through activities relating to food security; educational assistance; psychosocial support; primary health care. **Unit of measure:** Simple Number **Disaggregated by:** Gender **Justification/Management utility:** Indicator is simple, clear and immediately understood. Directly measures impact relating to IR 3.3. Useful in decisions regarding resource allocation.
PLAN FOR DATA ACQUISITION BY USAID
Data Collection Method: Care and support form in implementing partner's sub grantee quarterly reports; baseline report and census forms from implementing partner. **Method of Acquisition by USAID:** Implementing partner's quarterly reports to USAID **Data source(s):** Implementing partner—Catholic Relief Services (CRS) **Frequency/Timing of Data Acquisition:** Quarterly on FY schedule **Estimated Cost of Data Acquisition:** Included in partner award **Responsible individual(s) at USAID:** Victoria James
DATA QUALITY ISSUES
Date of Initial Data Quality Assessment: 2002 **Known Data Limitations and Significance (if any):** Limited records and documentation by sub-grantees, poorly written and analyzed baseline information **Actions Taken or Planned to Address Data Limitations**: Training, rewriting and analyzing baseline information **Date of Future Data Quality Assessments**: 2004 **Procedures for Future Data Quality Assessments: spot checks**
PLAN FOR DATA ANALYSIS, REVIEW & REPORTING
Data Analysis: **Presentation of Data:** Simple tables showing numbers of children disaggregated by gender **Review of Data:** Field visits and assessments **Reporting of Data:** Annual report data table and activity manager's report
OTHER NOTES
Notes on Baselines/Targets: **Baseline - 64000 Y2003- 109000 Y2004 – 250000 Y 2005 – 500000 Y2006 – 750000 Y2007 - 895000** **Location of Data Storage**: USAID files **Other Notes:** n/a
THIS SHEET LAST UPDATED ON: 11/19/02

Performance Indicator Reference Sheet
Strategic Objective: HIV Crisis Mitigated **Intermediate Result 3:** Improve Care and Support for Vulnerable Children **Indicator 2**: Average % Change in Vulnerable Children Support Index
DESCRIPTION
Precise Definition(s): Index includes the following elements: nutrition; psychosocial issues (i.e. emotional and social stability relating to feelings of hopelessness, anxiety, depression and of connectedness with the larger community); access to schooling; social support network (i.e. care from neighbors, caregivers, volunteers, community groups, extended family). Each sub-grantee will reflect a % change for their project area, contractor will then compile these and submit the average %. **Unit of measure:** Percentage (%) **Disaggregated by:** Individual partner reported % change for their geographic areas of operation **Justification/Management utility:** Measures impact rather than inputs only. A way to ensure that vulnerable children are actually better off because of care and support offered through initiatives. Useful in resource allocation decisions.
PLAN FOR DATA ACQUISITION BY USAID
Data Collection Method: Care and support form in implementing partner's sub-grantee quarterly reports; Baseline report and census forms from implementing partner. **Method of Acquisition by USAID:** Implementing partner's quarterly reports to USAID **Data source(s):** Implementing partner—CRS **Frequency/Timing of Data Acquisition:** Quarterly on FY schedule **Estimated Cost of Data Acquisition:** Included in partner award **Responsible individual(s) at USAID:** Victoria James
DATA QUALITY ISSUES
Date of Initial Data Quality Assessment: Year 2002 **Known Data Limitations and Significance (if any):** Limited records and documentation by sub-grantees, poorly written and analyzed baseline information **Actions Taken or Planned to Address Data Limitations**: Training, rewriting and analyzing baseline information **Date of Future Data Quality Assessments**: 2004 **Procedures for Future Data Quality Assessments:** spot checks
PLAN FOR DATA ANALYSIS, REVIEW & REPORTING
Data Analysis: Review CRS/STRIVE database **Presentation of Data:** Simple tables showing % change in Support Index (disaggregated by gender) **Review of Data:** Field visits and assessments – Field visits, spot checks, **Reporting of Data:** Annual report
OTHER NOTES
Notes on Baselines/Targets: **Baseline – 35% Y2003- 15% Y2004 – 40% Y 2005 – 90% Y2006 –115% Y2007 – 140%** **Location of Data Storage**: USAID files with reference to CRS Strive Project files **Other Notes:** n/a
THIS SHEET LAST UPDATED ON: 11/19/02

Performance Indicator Reference Sheet

Strategic Objective: HIV/AIDS Crisis Mitigated

Intermediate Result: Improved care and support for vulnerable children

Indicator: # of orphans and vulnerable children benefiting from improved access to education

DESCRIPTION

Precise Definition(s): Vulnerable children are orphans (single or double); have a chronically ill parent; have a parent caring for PLWA; are living in households which have absorbed additional children. Access to improved education will include block grants to schools, direct payments of school fees, supplementary feeding, vocational training and early childhood education and care.

Unit of Measure: simple #

Disaggregated by:- gender, primary and secondary school, sub grantee

Justification/Management Utility: It gives an indication of number of vulnerable children accessing education from the STRIVE intervention

PLAN FOR DATA ACQUISITION BY USAID

Data Collection Method: Care and support form in implementing partner's sub grantee quarterly reports; baseline report and census forms from implementing partner

Method of Acquisition by USAID: Implementing partner quarterly reports to USAID

Data Source(s): Implementing partner **-** CRS

Frequency/Timing of Data Acquisition: quarterly

Estimated Cost of Data Acquisition: Included in partner award

Responsible Individual(s) at USAID: Victoria James

DATA QUALITY ISSUES

Date of Initial Data Quality Assessment: Year 2002

Known Data Limitations and Significance (if any): Unavailability of records of children accessing education assistance during baseline exercise, poor baseline findings.

Actions Taken or Planned to Address Data Limitations: Training on documentation, baseline report revisited

Date of Future Data Quality Assessments: 2004

Procedures for Future Data Quality Assessments: surveys, assessments

PLAN FOR DATA ANALYSIS, REVIEW, & REPORTING

Data Analysis: Review database of CRS/ STRIVE and verify with data at implementing partner level

Presentation of Data: Simple tables showing #s of children disaggregated by gender

Review of Data: Field visits, spot checks and assessments

Reporting of Data: Annual report data table, activity manager report

OTHER NOTES

Notes on Baselines/Targets: Baseline - 4500 Y2003- 35000 Y2004 – 85000 Y 2005 – 170000 Y2006 – 340000 Y2007 - 680000

Location of Data Storage: USAID files

Other Notes:

THIS SHEET LAST UPDATED ON: 22 /11 /2002

G. ACTIVITY-LEVEL INDICATORS

Activity level indicators are contained in the agreements and/or work plans agreed between the SO teams and each of its partners. The purpose of these indicators is mainly to monitor operational progress on a relatively frequent basis. The work plans/agreements for each activity will be consulted for more detail on the specific indicators for each activity.

H. PLAN FOR MONITORING SO-LEVEL CONTEXT INDICATORS

In addition to results-level measures, one context indicator was identified in the PMP development process. The SO-level context indicators track the higher level results (above USAID's manageable interest) that the SO team hopes its activities will contribute to. As noted previously, these measures cannot and should not be directly attributed to USAID since they are influenced by multiple factors.

SECTION V. NEXT STEPS

NEXT STEPS	RESPONSIBILITY	COMPLETE BY:
Baselines and Targets SO 3		
❖ Collect or update baseline data and set targets for all SO-level indicators.	Peter Halpert	Summer 2003
❖ Collect baseline data and set targets for SO3 IR 3.1, all indicators	Patrick Osewe	January 2003
❖ Collect baseline data and set targets for SO3 IR 3.2, four indicators	Mercia Davids	December 2002
❖ Collect baseline data and set targets for SO3 IR 3.3, two indicator	Victoria James	December 2002
❖ After baseline data and preliminary targets are set, finalize performance targets *in consultation* with partners and update Performance Data Table.	?	
Data Quality Assessments		
❖ Complete Data Quality Assessment for Indicators		
❖ Complete Initial Data Quality Assessments for: CCC, ISC, and CEC	???	December 2002
❖ Complete Initial Data Quality Assessment for IR 3.2 indicator	SO 3 Team	January 2003
❖ Complete Initial Data Quality Assessments for IR 3.3 indicator	SO 3 Team	Summer 2003
	All SO Team Leaders	Summer 2003
Complete Key PMP Tables and Performance Indicator Reference Sheets		
❖ Complete Performance Management Task Schedule and calendar	SO 3 Team	ASAP
❖ Complete Performance Data Tables once baselines and targets are identified/updated	SO 3 Team	ASAP
❖ Complete blank/highlighted sections of Indicator Reference Sheets	?	ASAP
❖ Review indicators selected by SO teams for FY 2003 Annual Report	?	April 2003
Other Items		
❖ Complete Indicator Reference Sheet for SO 3 Level and Context Indicators	Peter Halpert	ASAP
❖ Identify baseline figures and set targets for SO indicator	Peter Halpert	ASAP
❖ Review Advocacy Index with partners	Mercia Davis	December 2002
❖ ?	?	?

SECTION VI. ANNEXES

Annex I. Results Framework and Indicator Quality Assessment Worksheets

Annex II. Data Quality Checklists

Annex III. ADS Excerpts on Annual Reports & Performance Management

Annex IV. PMP Assistance Scope of Work

Annex V. Individuals and Organizations Contacted

ANNEX I. RESULTS FRAMEWORK & INDICATOR QUALITY ASSESSMENT WORKSHEETS

Results Framework assessment and indicator assessment worksheets are included here. SO teams will maintain worksheets completed in November 2002, and thereafter, in their team files.

A. Results Statement Assessment Worksheet

B. Results Framework Assessment Worksheet

C. Indicator Quality Assessment Worksheet

Results Statement Assessment Worksheet

Sector: _____

Strategic Objective: _____

Results Statement (Name/Number):_____

CRITERIA FOR ASSESSING THE RESULTS STATEMENT	Yes	No	Unsure	COMMENTS
Is the results statement **MEASURABLE?**	❑	❑	❑	
Is the results statement **MEANINGFUL?**	❑	❑	❑	
Is the results statement **REALISTIC?**	❑	❑	❑	
Is the results statement focused on **USAID's STRATEGIC COMMITMENTS?**	❑	❑	❑	
Is the results statement **CUSTOMER or STAKEHOLDER DRIVEN?**	❑	❑	❑	
Is the results statement within the **MANAGEABLE INTEREST** of the Operating Unit and its development partners?	❑	❑	❑	
Is the results statement focused on **RESULTS,** e.g., impact, quality, cost/efficiency, or timeliness - (focused on the RESULTS or outcomes of activities rather than a description of activities themselves)?	❑	❑	❑	
Is the statement **UNI-DIMENSIONAL** (focused on one result rather than a combination of results)?	❑	❑	❑	

OTHER COMMENTS:

RECOMMENDATION:
___ Accept results statement
___ Revise results statement and then accept
___ Reject results statement

Results Framework Assessment Worksheet

Sector: _____

Strategic Objective: _____

CRITERIA FOR ASSESSING THE RESULTS FRAMEWORK	Yes	No	Unsure	COMMENTS
CAUSAL LINKAGE: At each level of the results framework, does achievement of one result cause the achievement of the other? Is the linkage direct?	❑	❑	❑	
CONTRIBUTIONS OF USAID PARTNERS: At each level of the results framework, have activities been identified (regardless of whether they will be conducted by USAID or its partners) to cause the result at the next level? [Note: not all results from USAID partners need to be identified in the framework but there may at least be mention of them in the narrative that accompanies the framework.]	❑	❑	❑	
MANAGEABLE INTEREST (A): Is the SO level result one that the team, working with its partners, can materially affect?	❑	❑	❑	
MANAGEABLE INTEREST (B): Is the team willing to be held accountable for all results within the results framework, including the SO level result?	❑	❑	❑	
CRITICAL ASSUMPTIONS: Have all the critical assumptions been identified at each level of the results framework?	❑	❑	❑	

OTHER COMMENTS:

RECOMMENDATION:

___ Accept results framework
___ Revise results framework and then accept
___ Reject results framework

*NOTE: Refer to **TIPS 13: Building a Results Framework** for additional information and examples of quality results frameworks.*

Performance Indicator Quality Assessment Worksheet

Indicator: _____

Relevant Result: _____

CRITERIA	COMMENTS
Is the indicator DIRECT? ▪ Does it closely measure the result it is intended to measure? ▪ Is it grounded in theory and practice? ▪ Does it represent an acceptable measure to both proponents and skeptics? ▪ If it is a proxy, is it as directly related to the relevant result as possible?	
Is the indicator OBJECTIVE? ▪ Is it unambiguous about what is being measured? ▪ Is there general agreement over the interpretation of the results? ▪ Is it unidimensional (i.e., does it measure only one phenomenon at a time)? ▪ Is it operationally precise (i.e., is there no ambiguity over what kind of data should be collected)?	

Is the indicator PRACTICAL? ▪ Are timely data available (i.e., is data current and available on regular basis)? ▪ Can the data be collected frequently enough to inform management decisions? ▪ Are data valid and reliable? ▪ Are the costs of data collection reasonable?	
CRITERIA	**COMMENTS**
Is the indicator ADEQUATE? ▪ Does it merely indicate progress rather than attempt to fully describe everything an activity accomplishes? ▪ Taken as a group, are the indicator and its companion indicators the minimum necessary to ensure that progress toward the given result is sufficiently captured?	
Is the indicator DISAGGREGATED, if appropriate?	
Is the indicator a RESULTS measure? ▪ Does it reflect an outcome of the program, not completion of an activity or process? Outcomes can include: - Impact of services - Quality of services - Customer satisfaction	

- Timeliness - Costs/Efficiency	
Is the indicator within USAID's MANAGEABLE INTEREST? ▪ Can changes in the value of the indicator be reasonably attributed to the efforts of USAID and its partners?	
Is the indicator USEFUL for management?	
Is the indicator EASY to understand, communicate, and use?	
Is the indicator CREDIBLE?	

OTHER COMMENTS:

RECOMMENDATION:

ANNEX II. DATA QUALITY CHECKLISTS AND SAMPLE ASSESSMENTS

Tools for assessing data quality include the comprehensive Data Quality Checklist contained in this annex. Also included is the Data Quality form used by the IBM Team when working with SO teams and implementing partners in November 2002.

When the SO HIV/AIDS Team begins the process of formally assessing data quality, it can use the following USAID and U.S. Government resources for additional help:

- ADS 203, "Assessing and Learning";
- TIPS No. 12, "Guidelines for Indicator and Data Quality";
- GAO, "Performance Plans: Selected Approaches for Verification and Validation of Agency Performance Information"; and
- GAO, "The Results Act: An Evaluator's Guide to Assessing Agency Annual Performance Plans".

Where possible and appropriate, the SO Team should use the following checklist to assess the quality of performance data, specifically in terms of validity, reliability, timeliness, precision, and integrity:

Data Quality Assessment Checklist

Refer to this checklist when the SO team conducts both initial and periodic data quality assessments. The full list does not have to be completed—the SO team may wish to identify the most critical data quality issues for formal or informal assessment.

Strategic Objective:
_____

Intermediate Result (if applicable):
_____

Performance indicator:
_____

Data source(s):
_____

Partner or contractor who provided the data (if applicable):
_____

Year or period for which the data are being reported:
_____

Is this indicator reported in the R4 Report? *(circle one)* YES NO

Date(s) of assessment:
_____

Location(s) of assessment:
_____

Assessment team members:
_____

For Office Use Only

SO team leader approval:
X_____Date_____

Mission director or delegate approval:
X_____Date_____

Copies to:
_____

Comments:
_____

_____

_____

1. VALIDITY—Do the data adequately represent performance?

Face Validity	Yes	No	Comments
➢ Is there a solid, logical relation between the activity or program and what is being measured, or are there significant uncontrollable factors?	❑	❑	
Measurement Error			
Sampling Error (only applies when the data source is a survey)			
➢ Were samples representative?	❑	❑	
➢ Were the questions in the survey/questionnaire clear, direct, easy to understand?	❑	❑	
➢ If the instrument was self-reporting were adequate instructions provided?	❑	❑	
➢ Were response rates sufficiently large?	❑	❑	
➢ Has non-response rate been followed up?	❑	❑	
Non Sampling Error			
➢ Is the data collection instrument well designed?	❑	❑	
➢ Were there incentives for respondents to give incomplete or untruthful information?	❑	❑	
➢ Are definitions for data to be collected operationally precise?	❑	❑	
➢ Are enumerators well trained? How were they trained? Were they insiders or outsiders? Was there any quality control in the selection process?	❑	❑	
➢ Were there efforts to reduce the potential for personal bias by enumerators?	❑	❑	
Transcription Error			
➢ What is the data transcription process? Is there potential for error?	❑	❑	
➢ Are steps being taken to limit transcription error? (e.g., double keying of data for large surveys, electronic edit checking program to clean data, random checks of partner data entered by supervisors)	❑	❑	
➢ Have data errors been tracked to their original source and mistakes corrected?	❑	❑	
➢ If raw data need to be manipulated to produce the data required for the indicator:	❑	❑	
➢ Are the correct formulae being applied?	❑	❑	
➢ Are the same formulae applied consistently from year to year, site to	❑	❑	

1. VALIDITY—Do the data adequately represent performance?

	Yes	No	Comments
site, data source to data source (if data from multiple sources need to be aggregated)?			
➢ Have procedures for dealing with missing data been correctly applied?	❑	❑	
➢ Are final numbers reported accurate? (E.g., does a number reported as a "total" actually add up?)	❑	❑	
Representativeness of Data			
➢ Is the sample from which the data are drawn representative of the population served by the activity?	❑	❑	
➢ Did all units of the population have an equal chance of being selected for the sample?	❑	❑	
➢ Is the sampling frame (i.e., the list of units in the target population) up to date? Comprehensive? Mutually exclusive (for geographic frames)	❑	❑	
➢ Is the sample of adequate size?	❑	❑	
➢ Are the data complete? (i.e., have all data points been recorded?)	❑	❑	

Recommendations for improvement:

2. RELIABILITY—Are data collection processes stable and consistent over time?

	Yes	No	Comments
Consistency			
➢ Is a consistent data collection process used from year to year, location to location, data source to data source (if data come from different sources)?	❑	❑	
➢ Is the same instrument used to collect data from year to year, location to location? If data come from different sources are the instruments similar enough that the reliability of the data are not compromised?	❑	❑	
➢ Is the same sampling method used from year to year, location to location, data source to data source?	❑	❑	
Internal quality control			
➢ Are there procedures to ensure that data are free of significant error and that bias is not introduced?	❑	❑	
➢ Are there procedures in place for periodic review of data collection, maintenance, and processing?	❑	❑	
➢ Do these procedures provide for periodic sampling and quality assessment of data?	❑	❑	
Transparency			
➢ Are data collection, cleaning, analysis, reporting, and quality assessment procedures documented in writing?	❑	❑	
➢ Are data problems at each level reported to the next level?	❑	❑	
➢ Are data quality problems clearly described in final reports?	❑	❑	

Recommendations for improvement:

3. TIMELINESS—Are data collected frequently and are they current?

	Yes	No	Comments
Frequency			
➢ Are data available on a frequent enough basis to inform program management decisions?	❑	❑	
➢ Is a regularized schedule of data collection in place to meet program management needs?	❑	❑	
Currency			
➢ Are the data reported in a given timeframe the most current practically available?	❑	❑	
➢ Are data from within the policy period of interest? (i.e., are data from a point in time after intervention has begun?)	❑	❑	
➢ Are the data reported as soon as possible after collection?	❑	❑	
➢ Is the date of collection clearly identified in the report?	❑	❑	

Recommendations for improvement:

4. PRECISION—Do the data have an acceptable margin of error?

	Yes	No	Comments
➢ Is the margin of error less than the expected change being measured?	❑	❑	
➢ Is the margin of error is acceptable given the likely management decisions to be affected? (consider the consequences of the program or policy decisions based on the data)	❑	❑	
➢ Have targets been set for the acceptable margin of error?	❑	❑	
➢ Has the margin of error been reported along with the data?	❑	❑	
➢ Would an increase in the degree of accuracy be more costly than the increased value of the information?	❑	❑	

Recommendations for improvement:

5. INTEGRITY—Are data are free of manipulation?

	Yes	No	Comments
➢ Are mechanisms in place to reduce the possibility that data are manipulated for political or personal reasons?	❑	❑	
➢ Is there objectivity and independence in key data collection, management, and assessment procedures?	❑	❑	
➢ Has there been independent review?	❑	❑	
➢ If data is from a secondary source, is USAID management confident in the credibility of the data?	❑	❑	

Recommendations for improvement:

For indicators for which no recent relevant data are available

If no recent relevant data are available for this indicator, why not?

What concrete actions are now being undertaken to collect and report this data as soon as possible?

On what date will data be reported?

DATA QUALITY SELF-ASSESSMENT

Partner: _____ Date: _____

Strategic Objective No: _____ Intermediate Result: _____

USAID is seeking the views of Partners on the quality of the data they are collecting on their respective performance indicators. Additionally, USAID is attempting to assess the burden (in time and financial costs) of data collection on organizations. We appreciate your response to these questions.

MANAGEMENT:

Does your organization systematically monitor progress toward results? _____
If yes, describe the data collected by level (i.e. household, individual, etc.), method (i.e., survey, Government report), and type (i.e. nutrition, opinion, etc.).

Do you have baseline data? _____
If so, how was the data collected, and what is the baseline figure for your USAID-funded activity?

Do you have targets for USAID-funded activities? _____
If so, how were the targets set, and what are they?

VALIDITY:

Do your IR indicators adequately measure what your program is doing?

Do you consider these indicators a direct or proxy measure of performance?

RELIABILITY:

Do you expect to be able to collect data on your indicator(s) in a consistent manner over the life of your program? Please discuss.

What procedures or mechanisms are in place to assure data consistency?

TIMELINESS:

How frequently do you plan to collect indicator data on your program? How frequently will you be reporting data findings to USAID?

Aside from meeting USAID reporting requirements, will this frequency be sufficient to serve your management needs (i.e., making informed decisions)?

PRECISION:

How well do the data on your performance indicator(s) capture your program's performance?

Please estimate the "margin of error" in your data collection procedures?

INTEGRITY:

Is there a staff member responsible for data collection and monitoring? _____

Are there controls on access to database systems? _____

Do you have procedures to ensure the quality of financial information? _____
If yes, please describe.

Based on your program management experience, what extraneous factors play a role in the quality of the indicator data you are collecting?

BURDEN:

Please estimate the level of effort involved in collecting data on your respective IR indicator(s)

Percent of total program labor/FTEs (%)_____

Percent of total program budget (%) _____

Based on the amount of resources (time and/or money) used to report on your IR Indicator, please rate the burden this has placed on your organization. Please circle the value that best reflects your assessment of this burden.

1	2	3	4	5
Low Burden		**Moderate Burden**		**High Burden**

Do these reporting requirements complement your overall project management activities?

Additional Comments:

ANNEX III. ADS EXCERPTS ON ANNUAL REPORTS & PERFORMANCE MANAGEMENT

Announcing Vetting Draft of ADS Chapters 200-203
August 2002

The final vetting draft of proposed revisions to the ADS 200 Series was released for review and comment on August 2. This draft reflects input received on an earlier vetting draft circulated March 4. Notably, this latest draft:

- Includes a revised version of Chapter 203;
- Streamlines the organization of ADS 201 to include only one set of recommended steps for activity planning, and clearly identifies which of these steps are applicable to Scenario A (obligation at the Strategic Objective level) and Scenario B (obligation at the activity level);
- Introduces the concept of a Program Support Objective; i.e., an Objective composed only of activities (e.g., training) intended to be at the service of other Objectives;
- Stresses that while use of Strategic Objective teams is strongly recommended, in some cases operating units may choose to manage SOs through some other approach;
- States explicitly that data quality standards apply only to performance data formally reported to Washington in the Annual Report.

The August 2 draft also retains the most important changes proposed in the March 4 draft. This draft:

- Re-introduces the word "project" as a standard USAID term. A "project" is defined as one type of "activity";
- Provides a simple outline for an "Activity Approval Document";
- Moves the model texts for bilateral agreements into ADS 200 and out of ADS 300 (Acquisition and Assistance);
- Turns many "musts" into "shoulds", thereby expanding flexibility;
- Clarifies that AAs have authority to waive mandatory requirements as necessary;
- Makes clear that new Strategic Objectives may begin during the life of an already-approved Strategic Plan, and/or extend beyond the expected end date of that Plan.

In sum, we've tried hard to make the ADS 200 Series even more responsive to the needs of our operating units and partners; i.e., the ones who are actually working to achieve development results on the ground.

Comments and suggestions on this draft are due to Roberta Cavitt and Parrie Henderson-O'Keefe of PPC/SPP by Tuesday, September 3. You may also post your comments in the Town Hall section of this website under the subject line "ADS 200 Series".

New USAID Annual Report Requirements[25]

Format

- The Annual Report (AR) must be submitted electronically in a new database format.
- The AR is not one fluid document. Sections will be extracted for different purposes and some information will be posted to the Agency's external website, so repetition of content should be expected.
- Do not include any graphics, tables, text-boxes, bullets or photographs in the narrative.
- The new font is Arial 10.

Content

- There are six mandatory elements: (1) Cover Memo, (2) Country Overview, (3) Program Data Sheets, (4) Performance and Budget Narratives, (5) Performance Data Tables and Results Frameworks, and (6) Resource Request Tables.
- One Program Data Sheet is required for each SO. The functional areas of assistance may follow the IRs, but should not use IR names. These Sheets constitute Congressional Notification of USAID's intent to obligate funds.
- The Resource Request Narrative should detail how program-funded staff is aligned with OE-funded staff for overall program management. There are also new budget tables showing workforce attribution to SOs, and Program Personnel/Support Expenses.
- The Agency is moving towards a strategic budgeting model to make program and budget decisions and assess performance and budget integration.
- Success stories are encouraged, but optional.
- Operating Units must report on plans to promote public-private alliances.
- Operating Units should report progress against FY 03-04 Presidential Initiatives as appropriate (e.g., Global Climate Change, Global Fund for AIDS, Trade Capacity, etc).
- E&E Operating Units should include a budget that shows funds at the SO and activity level and identifies the contractor/grantee. E&E Operating Units should not fill out the alternate FY 2004 and FY 2005 budget tables included with the application.

For specific instructions on completing the application, as well as frequently asked questions and a description of improvements made to the application this year, visit http://cdie.usaid.gov/ar.

Performance Monitoring

- The AR is not intended to supply technical offices with indicator data at the activity level. That will be done at least once every three years during mandatory triennial program reviews (ADS VV 203.3.10).
- Operating Units should include two kinds of data in the Annual Report: (1) a well-documented self-assessment of each SO ("exceeded, met, did not meet") and (2) data for Agency indicators.
- For each SO and SpO, the Operating Unit must designate a few (3-5) performance indicators from the PMP that will be used in the Annual Report to report on the performance of the program for each year. These indicators and targets must not be changed for that year.
- There is an SO Indicators Table that Operating Units may use to report up to three performance indicators for each SO, but *only* if the indicator has had a data quality assessment within the past three years.
- PPC "strongly recommends" a new indicator table linking budgeting to performance.
- Microenterprise results should be reported separately and sent to the Microenterprise Results Reporting system, *not* with the Annual Report.

[25] Prepared by IBM Team for USAID/Ukraine program office during October 2002 TDY.

- There is a mandatory table on "Selected Performance Measures." Each Operating Unit must report whether or not it has achieved a "significant result" (recognizable difference).
- If the Operating Unit addresses an Agency Objective and can/does use one of the indicators in the list of Selected Performance Measures to measure performance against the SO, then it *must* report data for that indicator, but *only* if the indicator is not new this year and has had a data quality assessment within the past three years.

Task Schedule

July 15, 2002	Set written targets for all indicators that will be used to determine whether the SO exceeded, met or did not meet its targets (ADS VV 203.3.8.2.b)
October 15, 2002	Email sent from IRM to all operating units with instructions for installing the Annual Report application
November 15, 2002	Data on all FY 02 and prior year data due in AID/W. There are 8 basic data tables required for program, operating, and workforce expenses, plus one workforce sub-table and a table for GCC countries.
December 31, 2002	Operating Unit selects 3-5 performance indicators and performance targets per SO for use in the Annual Report
January 6, 2003	Entire Annual Report due in Washington (submitted electronically via database application)
March 1, 2003	Office of Security will send a cable to request USAID security funding requirements.
Fall 2003	FY 2004 country and program levels negotiated with OMB and State. This will establish the basis for the FY 05 budget and program.

ANNEX IV. SCOPE OF WORK

USAID IMR Program

Assignment Plan for Performance Monitoring Plan Assistance to USAID/Zimbabwe

Assignment Title: USAID/Zimbabwe – Performance Management Plans

Internal Client at USAID: USAID/Zimbabwe

Assignment Overview: In June 2002, USAID/Zimbabwe invited the Integrated Managing for Results team to deliver a one-week workshop on performance management at USAID. In the afternoon technical assistance sessions of that workshop, each SO Team was able to make progress in various parts of their performance management plans, such as reviewing and revising results frameworks, brainstorming some new indicators, defining current performance indicators, and discussing data collection and data quality issues for several performance indicators. USAID/Zimbabwe has invited the Integrated Managing for Results team to provide direct technical assistance to help the SO Teams complete their performance management plans (PMP). The mission has three Strategic and Special Objectives, in HIV/AIDS, microenterprise, and participation in governance. Because the governance team has made more progress in completing its PMP, assistance is requested to focus on supporting the HIV/AIDS and microenterprise teams.

In the summer of 2002, USAID/PPC also clarified the expectations of preliminary and complete performance management plans and distributed a "Vetting Draft" of a revised ADS Chapters 201 and 203. PPC is in the process of finalizing the vetting draft and clearance is expected by the end of calendar 2002. The substance of the PMP sections of ADS Chapters 201 and 202 is not expected to change from the August 2002 Vetting Draft.

Objectives: The objectives of this assignment are:

a. To help the HIV/AIDS, participation and microenterprise teams reach consensus on what to include in their complete performance management plan, in order to be useful for management and communication purposes, and in accordance with the principles and guidelines in ADS 203 for complete PMPs.

b. To assist the HIV/AIDS, participation and microenterprise teams revise elements of their PMPs, and create new elements as needed, to meet the goal of a complete PMP.

c. To identify any needed next steps for the SO teams to produce a complete PMP.

Specific Tasks: To achieve the above objectives, the team will

1. Review pertinent documents, such as the current USAID/Zimbabwe Strategic Plan, R4 reports and Annual Reports, and any documentation about current performance management efforts.

2. Present a refresher session for relevant staff on the Agency expectations of preliminary and complete PMPs, as described in the August 2002 vetting draft of ADS Chapters 201 and 203.

3. Hold work sessions with SO team members and leaders to meet objectives a, b, and c as described above.

Deliverables:

- Components of performance management plans, produced in collaboration with SO Teams for HIV/AIDS and Microenterprise.
- A trip report with any recommendations, such as any remaining next steps to complete the PMPs or to enhance performance management at the mission.

Timeline: Two weeks of assistance in Zimbabwe. Timing TBD.

Team: Two consultants from Integrated Managing for Results[26] team, Victoria Francis and Joseph Mwangi.

Approved to proceed as described: _____

CTO Date

Travel authorization granted, subject to country clearance by Mission: _____

CTO Date

[26] The Integrated Managing for Results (IMR)Team provides services on various managing for results issues, including strategic planning and performance management, to USAID bureaus and operating units in the field. Although IMR staff continue to provide services without interruption, the name of the company changed in early October from "PricewaterhouseCoopers Consulting" to "IBM Business Consulting Services."

ANNEX V. INDIVIDUALS / ORGANIZATIONS CONTACTED

USAID ZIMBABWE STAFF

Paul Weisenfeld, Director
Michael Foster, Program Officer
Marunga Manda, Program Specialist

SO 3 Team:
Peter Halpert, Team Leader
Mercia Davids, Program Specialist – Health
Patrick Osewe, HIV/AIDS Specialist
Victoria James, Project Management Specialist
Joyce Maziya, Project Management Assistant
Chipo Sisimayi, Project Management Assistant

PARTNERS

HIV/AIDS:

Jill Donahue, Regional Technical Advisor, Catholic Relief Services
Backson Muchini, Child Psychologist, STRIVE Program, Catholic Relief Services
Lovemore Tinarwo, Catholic Relief Services
Andrew Boner, Country Director, PSI
Noah Taruberekera, PSI
Kwame Asiedu, Regional Director, Advance Africa
Alex Zinanga, Futures Group
Tom Goliber, Futures Group
Barbara Rasmussen, Futures Group

ANNEX VII

Persons Consulted in Updating the Strategy

U.S. Embassy
Ambassador Joseph Sullivan

PACT (ZIMAIDS Project)
Willie Salmond, Chief-of-Party
Joy Moizikana, Epworth Coordinator
Clayton Unoga, Chitungwiza Centre Coordinator
Benadette Sdowetas, Post-test Support Services Officer

Advance Africa
Kwame Assiedu, Southeast Africa Regional Director
Agma Prims, Deputy Director
Ms. Simba, CBD Technical Advisor

John Snow, International (Deliver Project)
Marilyn Noguera, Country Team Leader

Futures Group (ZAPA Project)
Barbara Rasmussen, Chief-of-Party
Lois Lunga, Civil Society Specialist
Alex Zinanga, Senior HIV/AIDS Specialist

Catholic Relief Services (STRIVE Project)
Backson Muchini, Project Director
Jill Donahue, RTA
Katherine Pondo, Head of Program
Choice Makufa, Project Manager

Development Alternatives, Inc. (LEAD Project)
Paul Bundick, Chief-of-Party
Don Greenberg, Commercial Linkages
Lendell Foan, Business Development
Glenrose Poyah, Monitoring & Evaluation/HIV/AIDS

Population Services International (Social Marketing)
Andrew Boner, Country Director
Chuck Szymanski, Deputy Country Director
Soumitro Ghosh, Technical Advisor

Centers for Disease Control
Mike St. Louis, Director

ANNEX VIII

USAID/ZIMBABWE AND USAID/WASHINGTON HIV/AIDS TEAMS

USAID/Zimbabwe
Paul Weisenfeld, USAID Director
Peter Halpert, HIV/AIDS Team Leader
Patrick Osewe, Senior HIV/AIDS Advisor
Victoria James, Project Management Specialist
Mercia Davids, Program Specialist-Health

USAID/Washington
Roxanna Rogers, Deputy Director, HIV/AIDS
Peter McDermott, Principal Advisor on HIV/AIDS
Charlene Brown, VCT Advisor
Amanda Gibbons, MCTC Advisor
Nomi Fuchs, Family Planning, HIV Integration Advisor
Clydette Powell, Medical Officer

Consultant
Tonya Himelfarb, Technical Writer