

ZIMBABWE HIV/AIDS PARTNERSHIP PROJECT & BEHAVIOUR CHANGE PROGRAMME

A Joint USAID/DFID Assessment

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ZIMBABWE HIV/AIDS PARTNERSHIP PROJECT & BEHAVIOUR CHANGE PROGRAMME

A JOINT USAID/DFID MID-TERM ASSESSMENT

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ACRONYMS

AIDS	Acquired immune deficiency syndrome
AIPPA	Access to Information and Protection of Privacy Act
ART	Antiretroviral therapy
BCC	Behavior change communication
BF	Be faithful
CBO	Community-based organization
CSW	Commercial sex worker
CSO	Civil society organization
CSP	Concurrent sexual partnerships
DDC	Delayed (Sexual) Debut Campaign
DFID	Department for International Development (UK)
DHS	Demographic and Health Survey
EU	European Union
FBO	Faith-based organization
FHI	Family Health International
FP	Family planning
FOREX	Foreign exchange
GDP	Gross domestic product
GIS	Geographic information system
GOZ	Government of Zimbabwe
HIV	Human immunodeficiency virus
IEC	Information, education, and communication
IOM	International Organization for Migration
IPC	Interpersonal communication
IQC	Indefinite Quantity Contract
IR	Intermediate Result
JSI	John Snow, Inc.
MDG	Millennium Development Goal
M&E	Monitoring and evaluation
MIS	Management information system
MOHCW	Ministry of Health and Child Welfare
MOU	Memorandum of Understanding
NGO	Nongovernmental organization
OI	Opportunistic infection
PICT	Provider-initiated counseling and testing
PLWHA	People living with HIV and AIDS

PMTCT	Prevention of mother to child transmission
POSA	Public Order Security Act
PSI/Z	Population Services International/Zimbabwe
PSP	Private Sector Partnerships
RH	Reproductive health
SDC	Stigma and Discrimination Campaign
SFH	Safe from Harm
T&C	Testing and counseling
TOT	Training of trainers
TRaC	Tracking results continuously
UNFPA	United Nations Family Planning Assistance
US	United States
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WAG	Women's Action Group
WFP	World Food Programme
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZNFPC	Zimbabwe National Family Planning Council

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EXECUTIVE SUMMARY

PURPOSE OF THE EVALUATION

The U.S. Agency for International Development (USAID)/Zimbabwe's Health Office commissioned an independent mid-term assessment of its HIV/AIDS Partnership Project (PSP Zimbabwe). The co-funded aspects of the program, PSI/Zimbabwe, were assessed jointly with DFID, which identified a consultant to join the review team. The DFID-funded PSI elements compose a core element of its Behaviour Change Programme. The goal of the assessment was to determine the strengths and weaknesses of the program to inform the future direction of services provided by the Partnership Project. USAID, DFID, and the project plan to use the assessment to evaluate progress and set the project's course through 2010.

BACKGROUND

The Zimbabwe Partnership Project is a five-year program managed under a task order mechanism from the global Private Sector Partnerships-One (PSP-One) project, which is part of the PSP-One multiple indefinite quantity contract (IQC) awarded to Abt Associates, Inc. and its partners: Population Services International (PSI), Family Health International (FHI), Banyan Global, and a host of local implementing partners. It began on October 1, 2005, and will end on September 30, 2010.

The project was designed to reduce the risk of sexual transmission of HIV by supporting and reinforcing the national response to HIV/AIDS in Zimbabwe. Its approach includes increasing public knowledge of HIV risks; promoting sound behavior; reducing stigma toward those infected; enhancing access to HIV-related products and services (including testing and counseling [T&C] and prevention of mother-to-child transmission [PMTCT]); and building the capacity of local research, policy, and service providers.

The Partnership Project has a funded ceiling of \$34,999,780 from USAID, and DFID provided separate funding of £20 million over a five-year period directly to PSI/Z to implement the Behaviour Change Programme for HIV prevention. The project has had to operate within a rapidly changing and challenging environment, characterized by a plunging economy with extraordinary hyperinflation and by social disruptions after the 2008 election that significantly hampered implementation.

In the 1980s and early 1990s, Zimbabwe had one of the best health systems in sub-Saharan Africa, but health system has been undermined by rising inflation, political instability, and a crumbling infrastructure in which even basic services such as water and electricity are no longer a given.

METHODOLOGY

Assessment activities began with a document review. Information gained from the review was used in formulating questions for informants and interpreting quantitative information. Existing data became the basis for quantitative analyses of program activities. Estimations of the program's impact and its contribution to reaching national HIV/AIDS goals were based on program statistics and current Government of Zimbabwe demographic and health data. Qualitative information was generated primarily through interviews and observation at program sites. As patterns in the quantitative data were found, they were probed or verified during interviews.

FINDINGS

- Communications efforts are reaching substantial numbers of people with prevention messages. In 2007, for example, radio and television ads reached nearly 4 million people. Interpersonal communication is reaching growing numbers of people, an increasing proportion of them female.
- The Behaviour Change Programme has made efforts to reach vulnerable, neglected, and at-risk groups in Zimbabwe. For example, it has targeted college youth with an expanded communications message mix, including messages to promote more use of condoms and fewer partners. However, additional efforts to reach adolescents and other special-needs groups are needed.

- Condom sales have been increasing despite the collapse of the formal commercial sector. More than 59 million male condoms were distributed in 2007, the equivalent of 25 condoms for every Zimbabwean male aged 15 to 49. Distribution of female condoms has increased every year, through both the project and public sector channels.
- HIV counseling and testing services have grown despite the difficult environment.
- Outreach testing now covers 40 percent more clients, and access to testing is improving.
- Provider-initiated testing is dramatically increasing the numbers of persons tested through the public health network. However, there are questions about the quality and comprehensiveness of related counseling services.
- Client-initiated counseling and testing (through outreach and static sites) is growing along with provider-initiated testing. The project contributes 46 percent of national testing totals. Voluntary counseling and testing (VCT) appears to be serving segments of the population that may not regularly access public health facilities.
- A variety of partners (hairdressers, work-sites, local NGO outreach, alcohol sellers, etc.) has extended availability and improved access.
- Product pricing controls in Zimbabwe have eliminated the normal dynamic in which socially marketed health products return significant revenues to help offset packaging, distribution, and communication costs.
- Female condom distribution has been facilitated by creative product promotion and distribution efforts, such as through hair salons, volunteer peer-educators, and commercial sex worker (CSW) groups.
- Combined funding from DFID and USAID has provided synergistic opportunities for broader programming and increased potential for impact.
- The role of the Partnership Fund envisioned in the original USAID design seems to have been unrealistic and is unsuited to current circumstances. Donors have used other mechanisms for supporting HIV/AIDS activities in Zimbabwe, and the method seems to be a costly, unsustainable format for mobilizing local initiatives through nongovernmental organizations (NGOs).
- Data collection for research and monitoring is innovatively used to inform program planning and choices. Tracking Results Continuously (TRaC) surveys represent a unique way to monitor progress while implementation is underway and to adjust efforts to affect the epidemic.
- The management information system (MIS) includes geographic information systems (GIS) to link service, communication, and product efforts with population density and other variables so as to maximize impact and manage evidence-based interventions, work planning, and decision-making.
- Research and evidence-based planning by PSI/Z and partners identifies gender inequalities and power differentials in sexual partnerships and then incorporates the information into annual programming to maximize gender-neutral impact.
- Given the unusually severe environment, very flexible and creative approaches that rapidly find innovative solutions to new impediments have been key to the program's success. PSI/Z in particular has excelled in finding functional alternatives.
- At first in the Partnership Project managerial and structural challenges slowed the pace of implementation, but these have been resolved.
- For the Behaviour Change Programme, PSI/Z has successfully increased roles for local staff, decreasing the number of expatriates from six to three and expanding activities through local partners.

CONCLUSIONS

The Zimbabwe HIV/AIDS Partnership Project and the Behaviour Change Communication Programme are making excellent progress. Achievement in most indicator areas identified in contractually agreed areas is on or ahead of schedule. It is likely that the project and the BCC program will exceed the results anticipated.

Analysis of intermediate or proxy variables for impact suggest that their work is contributing substantially to national HIV/AIDS goals and making a major difference for both priority at-risk groups and the population as a whole. The services and products the donors provide constitute a major proportion of what is available to the people of Zimbabwe. It also appears that the donors are realizing significant returns on their investment in terms of mitigating the HIV/AIDS epidemic in Zimbabwe—beyond the return that would have been possible if support had been provided separately or to a variety of organizations.

RECOMMENDATIONS

The following recommendations are based on the findings of the assessment and relate to future efforts within current funding:

- Support of client-initiated and voluntary counseling and testing services should be continued even as provider-initiated testing expands.
- Outreach services for T&C should increasingly focus on specific hard-to-reach, at-risk populations.
- Communications strategy should identify additional methods to reach socially excluded groups, such as former commercial farm workers, displaced populations, and people with disabilities.
- Since directly managed PSI/Z sites for T&C contribute 55–60 percent of monthly client volumes for T&C within the project, any phase-over or transfer of these functions to other organizations should be delayed until the end of the implementation period.
- Mass media should continue to be an active part of the BCC media mix. Even with power outages they still reach sizable numbers of people and are highly cost-efficient.
- Those program elements that directly support the delivery of services and products to clients should be given priority for funding. Implementation costs, given the constantly changing economic environment, are difficult to predict; some costs, such as product packaging, have soared.
- As donors like DFID and the EU extend support to reinforce the public and nongovernmental service-delivery system, the project should expand opportunities to share or transfer the experience it has gained in successfully delivering HIV prevention services.
- Until viable private commercial alternatives for product distribution re-emerge in Zimbabwe, the project should strengthen direct distribution mechanisms.
- A ready supply of packaged product is necessary to keep pace with demand for condom products.
- As PSI/Z implements its USAID and DFID-funded activities, it should explore strategic partnerships with women's groups, such as the Women's Action Group (WAG), the Women's Trust, the Zimbabwe Women's Resource Centre and Network, and Padare.
- PSI/Z should continue to be gender-sensitive and conduct research to identify gender issues that affect the potential for progress in such areas as concurrent relationships, cross-generational sex, and sexual debut.
- To complement what PSI/Z is already doing, DFID and USAID should facilitate linkages between PSI/Z's programs and other efforts (livelihood programs, care and support, OVC activities, youth, and reproductive health) that can complement project programs and broaden their impact.
- Although the project already disseminates its work through national working and technical groups (for condoms, commodity security, and comprehensive condom programming) and strives to disseminate innovative approaches through presentations at international conferences, it should find more ways to share with others in Zimbabwe that are active in HIV/AIDS work the knowledge gained through its successful BCCs and its T&C activities.
- For the USAID-supported Partnership Fund within the HIV/AIDS Partnership Project, current agreements should be modified to acknowledge that the partnership mechanism functions as a grants-under-contract activity for grantees delivering core project services and cannot achieve sustainability or spin-off status when funding ends.

- Project family planning (FP)/PMTCT activities should better document impact or results in achieving greater service delivery capacity or improvements in FP/PMTCT services.
- For PSI/Z's Behaviour Change Communication Programme supported by DFID, there is a need for mentoring for both local managers and lower-ranking staff to build on other capacity-building efforts.

SUGGESTIONS FOR FUTURE DIRECTIONS

Based on the information gained during the assessment and observations of HIV/AIDS efforts in Zimbabwe, the assessment team considered options that go beyond current agreements and activities. The following suggestions also take into account recent changes in the political environment:

- As the public sector becomes a more eligible recipient of assistance, provide support to revitalize HIV/AIDS services within the national health service delivery network.
- Even with more vibrant public services, continue support of private initiatives to improve the prospects for rapid and substantial results.
- Given the success and synergistic benefits of joint funding of a program, DFID and USAID should identify other opportunities to combine efforts.
- Since one of the most promising measures to combat HIV/AIDS is male circumcision, donors should move quickly to support introduction and activation of such a program in Zimbabwe.

I. INTRODUCTION

BACKGROUND: ZIMBABWE PARTNERSHIP PROJECT

The five-year Zimbabwe Partnership Project is funded by USAID/Zimbabwe through a task order mechanism under the global Private Sector Partnerships-One (PSP-One) project. PSP-One is an indefinite quantity contract (IQC) awarded to Abt Associates, Inc., and its partners: Population Services International (PSI), Family Health International (FHI), Banyan Global, and a number of local partners. The project began on October 1, 2005, and is scheduled to end on September 30, 2010. USAID/Zimbabwe also funds other groups (such as the Elizabeth Glaser Pediatric AIDS Foundation, World Education, and SCMS through the JSI/DELIVER Project) working on HIV/AIDS in Zimbabwe.

The Partnership Project was intended to help reduce the risk of sexual transmission of HIV by reinforcing the national response to HIV/AIDS in Zimbabwe through a multipronged approach that includes increasing public knowledge of HIV risks; promoting behavior change; reducing stigma; enhancing access to HIV-related products and services (including T&C and PMTCT); and building the capacity of local research, policy, and service providers to address the epidemic.

The project has a funding ceiling of \$34,999,780 from USAID, and DFID provided separate funding of £20 million over five years directly to PSI /Zimbabwe, a Partnership Project subcontractor, to implement the Behaviour Change Programme. Both donors agree on many of the same progress indicators and program targets.

The context for the project has been extremely difficult. In the 1980s and early 1990s, Zimbabwe had one of the best health systems in sub-Saharan Africa, but it has deteriorated in recent years as inflation shot up, governance became unstable, and the social infrastructure crumbled. Basic services like water and electricity are no longer a given. Well-trained Zimbabwean public health workers have left the country for better job opportunities elsewhere. The effect on Zimbabwe's health indicators has been profound. For example, the 2006 Demographic and Health Survey revealed declines in nutritional status of children, number of births attended by a health professional, and availability of essential drugs. It is within this context that the Partnership Project has been striving to achieve its objectives.

A results framework (see Appendix A, Scope of Work) sets objectives for three project components, communications, product delivery, and services. The project was charged to use a broad range of guiding principles to achieve the desired results, such as effective and innovative management and technical approaches; continued learning and ability to adapt as a result of experience; maximum use of local organizations; involvement of skilled Zimbabweans; integration of gender equity concerns; flexibility in responding to changes in the environment; and leveraging of other HIV resources.

OBJECTIVES OF THE ASSESSMENT

The goal of this mid-term evaluation is to identify strengths and weaknesses to inform the future direction of services provided by the Partnership Project (see Appendix A: Scope of Work). USAID/Zimbabwe asked the evaluation team to assess emerging impact, review the continuing relevance of project objectives, and if necessary suggest amendments to the program. It will be used by USAID, DFID, and the project to determine the course of the project through 2010 in terms of

- Whether or not the project is on target to achieve its goals as stated in the contract
- Strengths and weaknesses within the project portfolio
- Areas and activities that warrant continued investment, and untried initiatives and approaches that would likely improve access to and use and quality of HIV/AIDS products and services
- Recommendations for mitigating weaknesses
- Recommendations for improving administration, coordination, and implementation of the project.

EVALUATION METHODOLOGY

General Approach

Assessment activities began with a review of documents related to the program. The information gained was then used to help formulate questions for informants and guide interpretation of quantitative data. Existing data provided the basis for quantitative analyses of program activities. Estimations of program impact and contribution to national HIV/AIDS goals were based on program statistics and Government of Zimbabwe (GOZ) demographic and health data. Meanwhile, qualitative information was generated primarily through interviews and observation at implementation sites and other facilities. As patterns in the quantitative data were found, they were probed or verified during interviews with knowledgeable informants.

To help ensure that comparable types of information were collected from a variety of sources, the team drafted a standard question guide for use with informants and a site-visit observation protocol (see Appendix F). These information-gathering aids reflected the major questions posed by the evaluation scope of work.

The team based its recommendations on its observations of the current status of reproductive health services and needs in Zimbabwe and the experience of the program to date. The team's concern was to make recommendations that could be achievable within three to five years and that recognized national HIV/AIDS mitigation goals, donor priorities for the health sector, and recent trends in private initiatives for health activities in Zimbabwe.

Major Information Sources

The team gathered information and data from a variety of sources. Team members sometimes divided tasks to cover more sources within the time available but conducted many interviews together to diversify and enrich the questioning. Some information sources were revisited to gain additional data.

Documents: A variety of documents were available on the status of HIV/AIDS in Zimbabwe, conduct of the HIV/AIDS Partnership Project to date, and related topics (see Appendix I). Annual or other regular reports from the project recorded progress over time. Other materials provided recent information on HIV prevalence trends, HIV/AIDS T&C services, social marketing of health commodities, and communication strategies that seek behavior change.

Data: The numerous data sets available to the team included data from the project's management information system (MIS) and recent Zimbabwe household surveys. National demographic and health surveys as well as the project's TRaC (Tracking Results Continuously) surveys provided the main quantitative definitions of proportionality of use and source of services accessed by the general population. The project's MIS database was mined for progress indicators and quantitative expressions of specific initiatives.

Interviews: In-depth interviews with stakeholders and partners were a major source of information for the assessment. Among those interviewed (see Appendix B) were staff of the Partnership Project (including representatives of Abt Associates, Inc., PSI/Z, FHI, Banyan Global, and others within the consortium); USAID (particularly the Partnership Project management unit); DFID staff; project in-country partners; the Ministry of Health; local implementing partners; service providers; and beneficiaries or clients.

Site Visits: The assessment team conducted site visits (see Appendix G) to locations where the Partnership Project and the Behaviour Change Communication Programme implement such activities as volunteer counseling and testing (VCT), provider-initiated counseling and testing (PICT), behavior change communication (BCC), and social marketing. Sites in urban, peri-urban and "growth point" settings, were chosen in consultation with USAID/Zimbabwe, DFID, the Partnership Project, and the Behaviour Change Communication Programme.

Limitations of the Assessment

- For a variety of reasons it was not possible to assemble the full number of team members envisioned in the scope of work. Given the breadth of evaluation topics, there were limits to the depth of inquiry two persons could complete in the time available.

- Given the size and complexity of the Partnership Project, the brevity of the data-collection period constrained geographic coverage and depth of information-gathering. There was not enough time to include a larger sample of project sites, beneficiaries, and other stakeholders.
- The GOZ ban on NGO work in communities, although lifted during the assessment, affected access to some groups, and travel to some locations was risky.
- Focus group discussions with beneficiaries were limited not only by time and space considerations, but also by concerns about how police or local political functionaries would respond to such gatherings, which had been banned earlier.

2. SETTING

It is important to understand the unique environment in which the project operates because it represents some of the impediments to achieving progress. Much of what is described has contributed to a massive brain drain of personnel in the public, private, and development sectors as people leave for less difficult living conditions. The loss of talented Zimbabweans has greatly affected the effectiveness of all sectors of the economy, without sparing the health sector.

OPERATING ENVIRONMENT

Socioeconomic Context

Zimbabwe's economy is declining for the ninth consecutive year. Real gross domestic product (GDP) has contracted by more than 30 percent since 1999 compared to 1998, and GDP per capita has contracted by 35 percent. The country has huge fiscal deficits, paralyzing public debt, and very little industry left; the economic decline has hit all sectors of the economy, notably agriculture, mining, tourism, transport, finance, manufacturing, and construction. Private businesses have significantly scaled down operations or closed completely. More than 80 percent of Zimbabweans are unemployed. Inflation, the highest in the world, at mid-2008 was officially at more than 11 million percent. Eroded purchasing power has increased the number of poor households. Because Zimbabwe is now considered a high-risk investment option, foreign direct investment and donor funding are extremely low. The ever-worsening economy has not only increased poverty and food insecurity but also reduced the supply of social services. It is estimated that one-third of the population has fled to South Africa and other neighboring countries and another third is dependent on remittances. More than 80 percent of the population, including nurses, teachers, and the police, is now below the Millennium Development Goal (MDG) extreme poverty floor of \$1 a day.

Political Environment

Most rural areas are not easily accessible to NGOs, which has made it difficult to implement programs that could be construed to have a political connection. The results of the 29 March 2008 harmonized elections and the June 2008 presidential runoff lack international credibility and have been widely condemned. Politically motivated violence has rocked rural areas and high-density areas in cities.

Food Security

Until 1998, Zimbabwean agriculture consisted of large white-owned commercial farms producing mostly cash crops, such as tobacco, on about 25 percent of the available land and traditional small communal farms which mainly grew cereals. The supply and marketing infrastructure developed for the commercial farms ensured that the communal sector was better supported than would otherwise have been the case. Zimbabwe was known as the bread basket of Southern Africa.

The government's expropriation of commercial farms has proved chaotic, and the infrastructure has collapsed. While evictions were targeted at white farmers, many black farm workers lost their livelihood, and the country lost major export revenue from commercial agricultural products. This situation has been exacerbated by drought and floods. It is projected that in 2008/09 the cereal harvest will be 40 percent lower than in 2007, and will meet less than half of Zimbabwe's own requirements. Although food is arriving from Malawi and Zambia, Zimbabwe lacks the foreign exchange it needs to feed its people. The Food and Agriculture Organization and the World Food Programme predict that by the peak of the hunger season in March 2009, 40 percent of the population, 5.1 million people, will need help.

Human Rights Democracy and Good Governance

The rule of law is at an unacceptably low level, and repressive legislation that is selectively applied further restricts democratic space. The introduction of the NGO bill, which Parliament passed but the President did not assent to, was widely seen as a way of controlling civil society organizations (CSO). To make matters worse, an estimated

700,000 Zimbabweans were left homeless in 2005 after their informal urban habitats were demolished in operation *murambatsvina* (Operation Restore Order). Although the government claimed the intent was to restore law and order, it is widely considered to have been a political move against potential strikers and opposition supporters. Promises of re-housing have not been fulfilled. Violence linked to the 2008 elections resulted in further displacements.

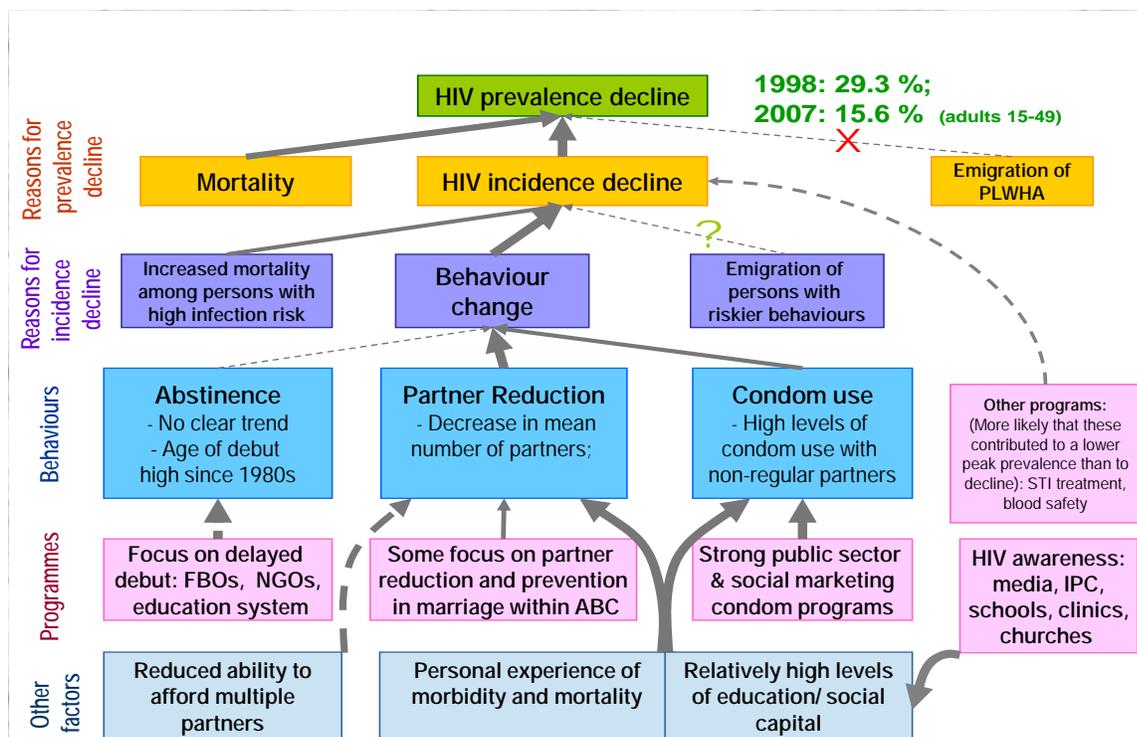
Information and Media

Zimbabwe Broadcasting Holdings—comprising the four radio stations and one television station in Zimbabwe—is state-owned. Fortunately, PSI/Z still has access to radio and TV. The privately owned newspapers are expensive weeklies (*The Independent*, *The Standard*, and *The Financial Gazette*). No foreign journalists are accredited. New media technologies like blogging and text messaging are publishing trustworthy stories for local and global audiences, but they are threatened by the new Interception of Communications Act which enables the authorities, with a warrant, to eavesdrop on electronic and telephone communication.

HIV AND AIDS: SITUATION AND RESPONSE

The first reported case of AIDS in Zimbabwe occurred in 1985. By the end of the 1980s, about 10 percent of the adult population was thought to be infected with HIV, mainly through heterosexual contact. This number shot up to peak at 29 percent between 1995 and 1997 and then fell over the next 10 years to 15.6 percent (Ministry of Health and Child Welfare (MOHCW) National Estimates, 2005). Today an estimated 1,610,000 Zimbabweans are living with HIV and AIDS, of which 115,000 are under 15 (MOHCW, 2005). Of those known to be infected, 55 percent are women. Young women (15–29 years) are the most vulnerable to infection. Among Zimbabweans 15–24, it is estimated that three times as many women as men have HIV (ZNASP, 2006-2010). Although Zimbabwe is the first Southern African country to record a significant drop in HIV and AIDS among adults 15–49, the rate is still unaccepted (Figure 1).

Figure 1: HIV Incidence/Prevalence in Zimbabwe



Source: Daniel Halperin, Backson Muchini, Exnavia Gomo, Reko Mate, Tapuwa Magure, Owen Mugurungi, Bruce Campbell, and Clemens Benedict, International AIDS Conference Mexico City, August 4, 2008.

The national response to HIV and AIDS covers strategic planning and coordination, prevention of new infections, treatment, care, and support. This report focuses on prevention efforts. The Zimbabwe National HIV and AIDS Strategic Plan (2006–2010) states that prevention of new infections is the cornerstone of the national HIV and AIDS response. HIV awareness is high and behavior has begun to change: Both men and women have fewer sexual partners, and condom use with occasional partners has risen.

Per capita condom distribution, marketing, and consumption, which have steadily expanded since the 1990s, are the highest in Southern Africa. Major radio and TV programs have also addressed HIV prevention. Billboards, posters, and brochures are used for reminders. VCT sites, both mobile for hard-to-reach populations and integrated into health institutions, have been established throughout the country.

While national efforts to prevent new HIV infections have significantly expanded over the past few years, many infections actually occur among married adults—a group that BCC strategies do not sufficiently address. Nor has there been enough focus on the most at-risk groups: young people who are already sexually active, sex workers, and mobile populations. Furthermore, prevention service coverage and uptake, such as counseling and testing and PMTCT, are not yet adequate, especially in rural areas.

3. EVALUATION FINDINGS

PROGRESS TOWARD PLANNED RESULTS

A broad-based approach to HIV prevention is clearly warranted. The interventions chosen by PSI/Z and the other organizations within the Partnership Project are sound. The wide reach of services offered through PSI/Z and the numbers of individuals it is reaching are evidence that the interventions chosen are appropriate. Private sector-based activities add to the options available through the public sector.

Communications

The Partnership Project's communication activities have focused on behavior change, marketing, and service communications. The project worked closely with major stakeholders in Zimbabwe, such as the National AIDS Council (NAC), MOHCW, United Nations Population Fund (UNFPA) and the Zimbabwe National Family Planning Council (ZNFPC) in drafting the National Behaviour Change Strategy (2006–2010).

Behavior Change Communication (BCC)

The BCC strategy was based on a balanced portfolio with abstinence and being faithful as major themes. So far the BCC component has made significant progress in increasing adoption of safer sexual behaviors through communications tailored to specific groups. The evidence-based BCC component was informed by a quantitative study¹ in the fourth quarter of the first year that was used to guide national mass media and interpersonal communications campaigns. BCC consists of three complementary campaigns: Delayed Debut, Be Faithful, and Stigma and Discrimination. PSI also implements BCC through interpersonal communication (IPC) activities promoting condom efficacy and self-efficacy to negotiate condom use and use condoms correctly. This activity is implemented in areas that have high population density, high HIV prevalence, and less media reach.

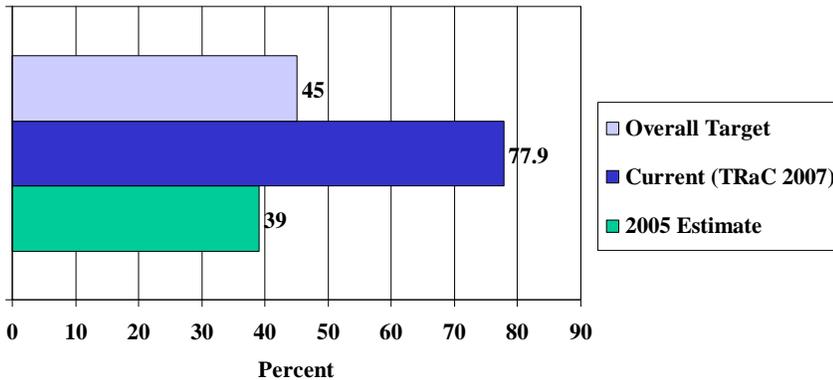
Delayed Debut Campaign

Through mass media the DDC reached 415,000 young boys and girls in year 1 (2005/2006) with messages about delaying their sexual debut. The mass media effort was supported by information, education, and communication (IEC) materials in the form of brochures, posters, and stickers distributed at popular meeting places for youth, such as movie houses, churches, schools, and public libraries. Safe from Harm (SFH), an IPC program that promotes parent-child communication to help address factors leading to early sexual activity among youths 13–19 was also part of the DDC. SFH activities were conducted through faith-based organizations (FBOs) whose pastors were given training. With their new skills, pastors were expected to communicate with young people and others in their congregations. The SFH program operated in Harare, Matebeleland, Manicaland, Bulawayo, Bindura, and Marondera. All methods used in the campaign stressed creating positive role models for young men and women; broadening the view of youth about manhood and womanhood; and other issues that could motivate individuals to delay their first sexual activity.

The DDC contributes to safer sexual behavior by helping youth to identify and deal with pressures to engage in early sex. These and other efforts seem to be working. Recent information shows there has been an increase in the percentage of never-married young people 15–24 who have never had sex from 39 percent in 2005 to 77.9 percent in 2008 (May 2007–April 2008; TRaC data). The end-of-project target for this statistic was 45 percent (see Figure 2).

¹ Zimbabwe (2006): HIV Prevention TRaC Study among General Population (15–49 years); Second Round

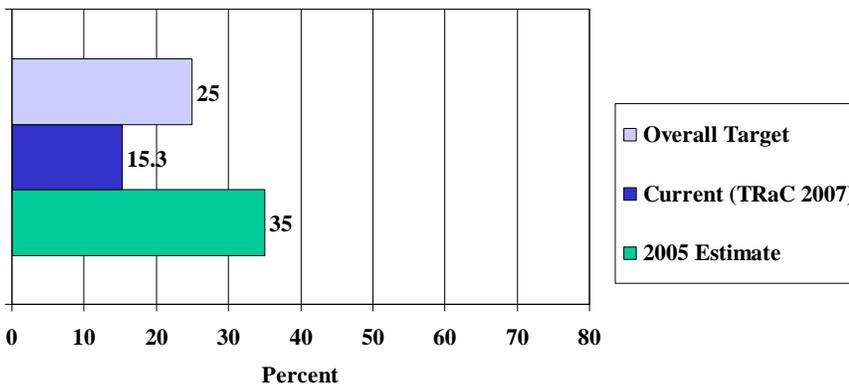
Figure 2: Portion (%) of Never Married Young People (aged 15-24 yrs.) Who Have Never Had Sex (Abstinence)



Source: PSI/Zimbabwe Data

The project has also helped reduce the proportion of never-married young people (15–24) who had sex in the previous 12 months (secondary abstinence) from 35 percent in 2005 to 15.3 percent in 2008 (May 2007–April 2008; TRaC Data)—which means it has already surpassed the 25 percent end-of-project target (see Figure 3). However, the program has found it difficult to motivate parents and adolescents to participate in campaigning sessions due to economic problems and numerous unplanned power outages.

Figure 3: Portion of Never Married Young People (ages 15-24 yrs.) Who Had Sex in the Previous 12 Months (Secondary Abstinence)



Source: PSI/Zimbabwe Data

For college youth the project has expanded the message mix to promote condom use and fewer partners, to better use limited resources and have more impact on the epidemic. At tertiary institutions the project’s current IPC activities consist of road shows to promote desirable behaviors. Its new IPC program raises awareness of the risks of concurrent sexual partnerships (CSPs). DDC efforts at colleges, however, were limited. The team also found no evidence that it is being directed to former commercial farm workers and displaced populations.

Be Faithful Campaign

The Be Faithful (BF) campaign was preceded by a national quantitative survey in the last quarter of 2006 that sought to understand the demographic characteristics of CSPs. Concurrency is a primary driver of the epidemic. A qualitative study was conducted in July 2008 to provide descriptive data on potential determinants of CSPs. These studies will make possible a deeper understanding of the context of heterosexual partnerships in Zimbabwe and interventions to address concurrency.

The team noted that the first two and one-half years were spent gathering evidence to identify determinants of multiple partner behaviors before the BF campaign was begun. Using evidence from the two phased studies, PSI/Z has now created an IPC program addressing cross-generational sex and concurrency among youth in tertiary colleges and universities. Although the mass media campaigns to address CSPs had not been designed at the time of the evaluation, plans call for the launch of BF campaigns on CSPs in the last quarter of 2008.

In formulating CSP messages the project is using an innovative approach that builds on determinants of CSPs identified through the surveys and also on the qualitative input from the target audience to help define the

archetype and give potential audiences the opportunity to process messages. The intent is to make the messages more effective.

Stigma and Discrimination Campaign

The project’s SDC activities contribute to ongoing work to reduce HIV and AIDS-related stigma and discrimination by working with people living with HIV and AIDS (PLWHA). The SDC is being conducted through mass media (television, radio, and print) in phases. Phase 1, in the first year of the project, reached 2,400,000 people 15 and older. Supportive IEC materials in the form of posters and calendars were distributed in workplaces, churches, retail outlets, bars, hospitals, and clinics nationwide.

Phase 2 was based on TRaC data collected in the first year. The second phase focused on highlighting stigma and discrimination within the community and the family and promoted knowledge, acceptance, and disclosure of HIV status. Prominent personalities in the community (pastor, lecturer, teacher, and nurse) were portrayed as productive members of the community even though they were HIV positive. In this the mass media campaigns reached 2,570,000 people 15 and older.

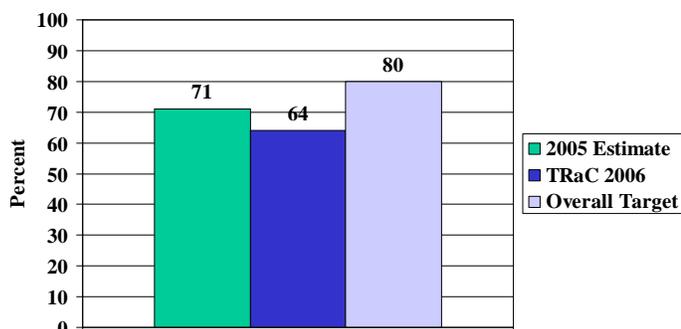
In the third quarter of the third year, the use of mass media expanded from short commercials to include television talk shows that discuss complex health issues, such as stigma and discrimination. The shows are hosted by Mai Chisamba, a leading Zimbabwe talk show host, and strive to help people at all levels understand HIV-related stigma and discrimination. Examples on television and radio of PLWHA have generated much public discussion of issues like testing and disclosure.

Also in the third quarter of the third year, IPCs were added to support mass media anti-stigma messages. IPC activities focused on increasing understanding of the different forms stigma can take and dispelling myths related to fear of casual transmission. IPC activities also were conducted with the audience after the Mai Chisamba TV show was recorded live.

Although there has been considerable progress, there is still room to craft more messages based on real-life testimonials to evoke empathy for those living positively and to normalize knowledge of status in the general population. There is also a need to increase recognition of the different forms stigma can take and its effects on PLWHA.

All in all, the project’s BCC activities are increasing the accuracy and prevalence of knowledge of HIV and AIDS issues among the general population. Targeted messages address known barriers to adoption of safer sexual behavior and are designed to dispel misconceptions that foster stigma and discrimination. However, so far the project may still fail to meet the intended target of increasing the proportion of the general population with accepting attitudes toward PLWHA to 80 percent by 2011. At the time of the proposal (2005) it was estimated that the proportion was then 71 percent, but the 2006 TRaC survey puts it at 64 percent (see Figure 4). This may be a more accurate baseline value; depending on the findings of subsequent TRaC surveys, the target for this result area may need to be revised.

Figure 4: Percent of General Population with Accepting Attitudes Towards PLWHAs



Source: PSI/Zimbabwe Data

The BCC approach adopted by PSI/Z is consistent with the national goal of reducing the number of new infections through objective 1.3 of the National Plan outcome area 1 (*Reduced stigma and discrimination as well as increased number of PLWHA openly discussing their status and involved in programs including prevention initiatives*) and outcome area 2 (*Increased adoption of safer sexual behavior and reduction in risk behavior*).

The Partnership Project’s approach to BCC has done a good job of using mass media and IPCs. The main constraints faced are continuing unexpected power

cuts and the high cost of reaching people using IPCs, which is \$794 per 1,000 people compared to \$5.65 per 1,000 in electronic mass media.

The project does reach sex workers through IPC activities promoting the female condom. In this program, sex worker leaders (Queens) are trained to promote messages on correct condom use to their peers in areas of high risk activity mapped through GIS, such as border towns, squatter camps for displaced populations, and rural growth points. However, additional avenues of outreach to socially excluded groups (such as sex workers, former commercial farm workers, and displaced populations) could be explored.

Service Communication

The objective of the project's service communications is to increase knowledge and uptake of public sector programs, such as PMTCT, T&C, and antiretroviral therapy (ART) and to better integrate FP into HIV and AIDS services. PSI/Z worked closely with the MOHCW and a task force of representatives from different HIV and AIDS programs within the MOHCW to draft the national communications plan for HIV and AIDS programs.

Using resources provided by DFID and USAID, the project has drafted communication plans for three national HIV and AIDS programs: ART, PMTCT, and T&C. Before the drafting, there was a situational analysis of all three areas to ensure that each plan would be evidence-based.

The project also drafted brochures on PMTCT to increase knowledge and awareness of FP choices available for HIV-positive women and couples. These were distributed through New Start centers, the New Life Post-Test support network, and other PLWHA support groups. Mass media campaigns are underway to increase awareness of PMTCT and generate informed demand for PMTCT services.

The project also is implementing an integrated community outreach program to support the mass media and IEC initiatives. PSI/Z worked closely with FHI to ensure that PMTCT communications reflect the importance of FP. Twenty thousand posters were printed in English, Shona, and Ndebele and distributed throughout the country by the MOHCW workplace program, New Start, New Life, and other organizations. However, billboards have not yet been placed in areas not well covered by mass media, though their layout is complete.

Service communication activities have done very well in campaigning for PMTCT services using mass media and IEC material, although there is no IPC on PMTCT, but there is a gap in the promotional communications for ART and T&C services, both client- and provider-initiated. The team also found few examples of service communications designed to reach socially excluded groups. People living with disabilities are also not targeted by the service communication campaign.

Although the Partnership Project has no marketing activities to promote ART and PICT, significant progress has been made toward development of mass media and IPC campaigns for these areas using funds from Global Fund Round 5. The campaigns are scheduled for launch early in 2009.

Marketing Communications

The objective of the project's marketing communications is to promote behavior change and adoption of safer sexual practices through sustained use of HIV and AIDS-related products and services. Marketing communication plans were created for the project-supported brands New Start, New Life, Protector Plus, and Care.

New Start Client-Initiated Testing and Counseling Services

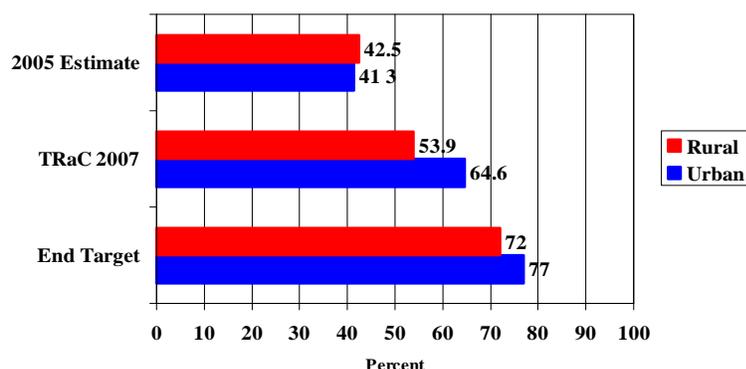
New Start communication activities focus on promoting knowledge of status to increase uptake by specific groups, such as HIV-positive individuals, pregnant women, and couples (including discordant couples). For example, the Get Real Early campaign in support of New Start positions VCT as the gateway to care, treatment, and support services. It promotes knowledge of status as the first step toward care, support, and treatment and especially targets clients testing positive. Messages also encourage partners to access VCT together. The campaign also provides information on prevention of HIV transmission and reinfection as tangible benefits for HIV-positive and discordant couples.

Posters were created to support the mass media campaign and distributed through FBOs, municipal clinics, and other stakeholders. Coupons for free tests (obviating the need to pay the nominal testing fee) were distributed to

potential users of New Start services. The project also organized activities to mark World AIDS Day. Valentine’s Day and Mother’s Day were heavily supported by television, print, and radio, and a free promotional New Start wrist band was distributed to encourage uptake of T&C.

New Start marketing has significantly addressed deep barriers to HIV testing, and the project managed to increase the proportion of couples to total clients for New Start T&C services from 11.2 percent in 2006 to 12.3 percent to date; the 2011 target is 20 percent. There has also been an increase in those 16 and older who report that their peers approve of them accessing T&C services (see Figure 5). However, more work needs to be done in rural areas to bring rates of change there up to those in urban settings.

Figure 5: Portion of Target Population (≥ 16 Years Old) Who Report Their Peers Approve of Them Accessing T&C Services



Source: PSI/Zimbabwe

In New Start communications, there has not been the same mix of mass media and IPCs seen in other communication initiatives. There may be opportunities to link promotion of New Start or T&C services with other project communication efforts and for targeting socially excluded groups.

New Life

New Life published materials to increase knowledge about referrals for care, treatment, and support services. Initially, the project updated the referral directory and nutritional

brochures, which were distributed to support groups, clinics, FBOs, and others dealing with PLWHA. Posters and brochures also were distributed to increase the uptake of post-test services.

To complement the brochures and other IEC materials, the project developed a specialized package for PLWHAs that was distributed to members of the New Life network and other support groups. The package includes information designed to increase awareness of FP and PMTCT, safer sexual practices, disclosure, and discordance. However, it does not provide information on ART adherence and opportunistic infections. No mass media campaigns were conducted for New Life; nor was there an IPC component. It is also not clear how New Life targeted or benefited socially excluded groups.

Protector Plus Condoms

Marketing activities for Protector Plus strive to improve brand appeal and increase consistent use by couples. Messages focused on improving brand efficacy and self-efficacy (condom negotiation skills among the sexually active, especially women). The project developed a new mass media² campaign on condom efficacy to address misconceptions related to condom use and promote condom effectiveness. The campaign also sought to improve risk perception and couple communication about safer sex. Calendars and posters highlighting three “life saver” facts (addressing myths and misconceptions) were distributed to retail outlets countrywide, and wall paintings promoting condom efficacy were produced to increase brand visibility in rural areas.

Another communications campaign is aligned with the national behavior change initiative, which identifies low and inconsistent condom use in regular relationships as a major driver of the epidemic. This effort used Mr. Smart³ to promote consistent use of condoms through mass media and IPCs.

² The condom campaign slogan is “For the love of your Life.”

³ Mr. Smart is an IPC initiative conducted through road shows designed to promote correct and consistent condom use by high-risk groups.

Mr. Smart activities were conducted in high-risk areas: growth points, border regions, mining areas, and resettlement farms in Manicaland, Masvingo, Midlands, Matebeleland, Mashonaland West, and Mashonaland East provinces. In the third year the theme was changed from Mr. Smart to “Love of your Life” to reinforce other mass media messages and to appeal to both sexes rather than being gender-specific. The campaign was supported by packaging, point-of-sale posters, shelf stickers, and calendars

Overall, marketing for Protector Plus has been effective. Increased brand appeal is evidenced by the sale to date of 134,926,650 (54%) condoms against a target of 250,000,000, so the end-of-project target is within reach. Due to lack of data, the team could not quantify changes in consistent condom use among regular couples.

“Love of your Life” IPC road shows promoting condom use are conducted in rural growth points, mining towns, resettlement areas, border towns, and other areas where HIV is prevalent. These areas are home to vulnerable groups like CSWs and their clients, but market penetration among displaced populations or other disadvantaged groups has not been documented.

Care Female Condoms

Marketing communications for the Care female condom were designed to increase sustained use by high-risk target groups (including married women, HIV-positive women, women in discordant relationships, and CSWs). This targeting is consistent with the findings of an assessment by NAC and UNFPA on female condom programming in Zimbabwe. Project representatives also participated in the process of defining a national strategy for female condoms and worked closely with UNFPA, NAC, ZNFPC, and the MOHCW to draft a related public sector training manual. Because Care promotional activities include elements that reflect how the option to use female condoms helps to address gender imbalances and unequal power relations within a relationship, Care promotional work is another example of a successful gender-sensitive initiative.

Marketing efforts used assessment results and other information to draft materials for new alternate channels (hair salons, CSW networks, and support groups for PLWHAs) to create informed demand for and supply of female condoms. Women living with HIV and AIDS were trained to conduct IPC sessions on positive prevention and to sell Care to support groups and other PLWHAs. They also mentor hairdressers and salon owners to conduct IPC activities with their clients.

The project has published a Care flip chart to standardize IPC messages and guide IPC agents to provide structured sessions. This approach, complemented by mass media campaigns, has increased the number of both men and women reached in high-risk areas. The campaigns position Care as the brand that gives a woman the confidence to enjoy a loving and fulfilling relationship with her partner.

The more rapid growth in total sales for female condoms (see below) attests to the effectiveness of Care marketing. The campaigns even managed to generate positive brand perceptions among men, although to a lesser extent than among women. However, the extent to which Care communications are reaching disadvantaged populations like former commercial farm workers is not clear.

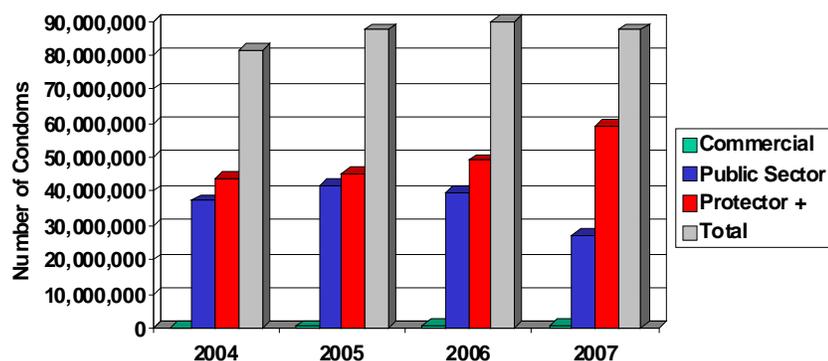
Product Delivery

Protector Plus - Male Condoms

Access to and consistent use of condoms is a critical part of the Zimbabwe’s national prevention strategy. Donor support to PSI/Z has fueled activities to make the Protector Plus male condom widely available. USAID donates the condoms and DFID helps address other costs.

Distribution of Protector Plus has increased steadily each year (see Figure 6) to more than 59 million in 2007. That is about 25 condoms for every man in Zimbabwe aged 15 to 49, or, from a different perspective, a year’s supply of condoms for about a third of all males 15 to 34.

Figure 6: Annual Distribution of Male Condoms by Type, 2004-2007



Source: MOHCW and PSI/Zimbabwe statistics

In several types of retail outlets the team found the condoms consistently present. Often, this was one of the few brands still available at stores otherwise typified by empty shelves. To achieve this feat, PSI/Z has increasingly had to do its own direct distribution. Earlier in the project, PSI/Z built relationships with Unilever and Coca Cola to carry Protector Plus within the distribution channels the firms operated. These alliances resulted in significant distribution gains (Unilever distributed about a million condoms a

month) without incurring direct costs.

However, when both firms closed down their normal operations, these partnerships ceased to be a viable option for PSI/Z, but it responded creatively and flexibly by moving to direct distribution to get the Protector Plus product out to the maximum number of potential consumers. These efforts have paid off.

One reason Protector Plus distribution has enjoyed consistent increases is the effort by PSI/Z to optimize the range of outlets carrying its condoms and reaching higher-risk populations. For example, because alcohol use is associated with higher-risk sexual encounters, many alcohol vendors now stock Protector Plus condoms as a result of PSI/Z's efforts. Another laudable aspect is the project's practice of targeting retail outlets located where population is dense.

The price control policies of the central government have undermined the ability of the project to flexibly price products in tune with normal market dynamics. The current approved price for a three-pack of Protector Plus is Z\$0.50. With hyperinflation, this means the product is virtually free to the consumer, so price is certainly not a barrier to use. But the low price also means that the normal returns from retail prices are not available to offset distribution, packaging, or advertising costs. With only a limited number of products available, many shopkeepers set their own price for Protector Plus in order to generate enough revenue to stay open. The team found retail prices ranging from Z\$0.50 to Z\$10.00 during site visits, but this unofficial pricing practice has not yet negatively impacted sales.

Public sector distribution of male condoms, however, has been declining since 2005. This may be due in part to decreased access to health facilities and fewer transportation options. It is also possible that some of the increased sales of Protector Plus may be because some users can no longer get the public brand. If so, Protector Plus sales are filling a serious gap in access to male condoms.

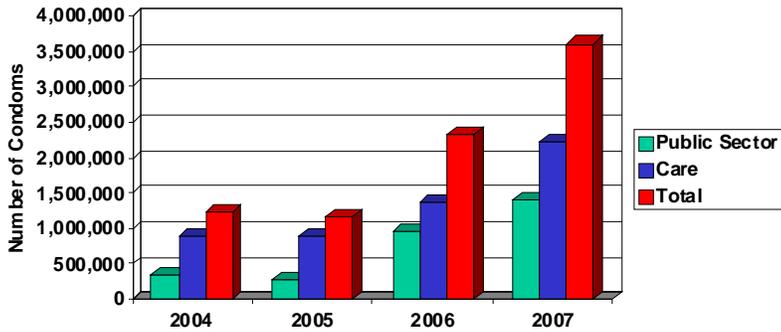
One concern is that total male condom distribution in Zimbabwe declined slightly from 2006 to 2007. If this pattern continues, additional efforts, particularly in the public sector, will be needed. Distribution of commercial brands is currently so negligible as to be useless for preventing HIV.

Recent independent research indicates that male condom awareness among both males and females is increasing. These data also show that 70 to 80 percent more males now report using a condom during casual sexual encounters.

Care Female Condoms

The distribution figures for female condoms in Zimbabwe far exceed what most other countries have realized. Distribution totals of public sector and socially marketed female condoms (Care) have increased each year (see Figure 7). Public sector distribution tripled between 2004 and 2007 while use of the socially marketed Care increased 150 percent. As a result, total distribution of female condoms in Zimbabwe has nearly doubled.

Figure 7: Annual Distribution of Female Condoms by Type, 2004-2007



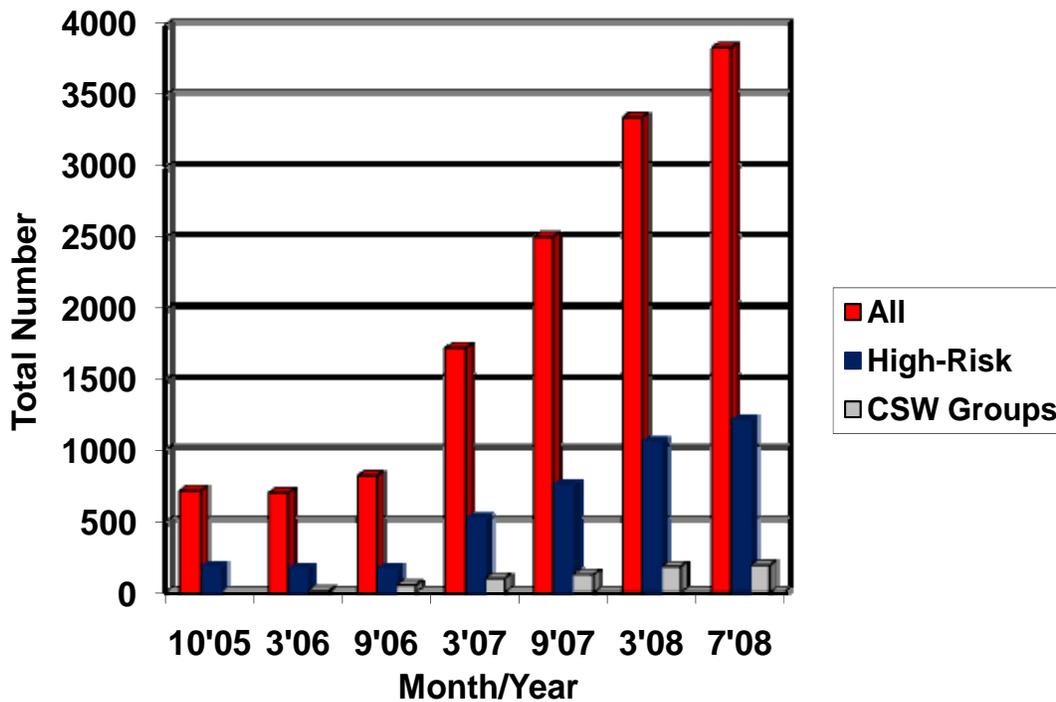
Source: MOHCW and PSI/Zimbabwe statistics

Nevertheless, the numbers distributed still represent only a relative minor proportion of the total potential market. For example, distribution of Care female condoms in 2007 is equivalent to about one for each female Zimbabwean between the ages of 15 and 29. The female condom is unfamiliar to many potential users, but the fact that sales are increasing is promising.

One reason for PSI/Z's distribution figures for female condoms is its diverse and innovative marketing strategy. For example, PSI/Z has made an active effort to make

them available not only through hair salons (catering primarily to female clients) but also barbers (for male clients). Increasing numbers of outlets also cater specifically to at-risk consumers; for instance, the number of CSW groups that sell female condoms has risen each year (see Figure 8).

Figure 8: Outlets (total, high-risk and CSW Groups) Selling Female Condoms (Care)



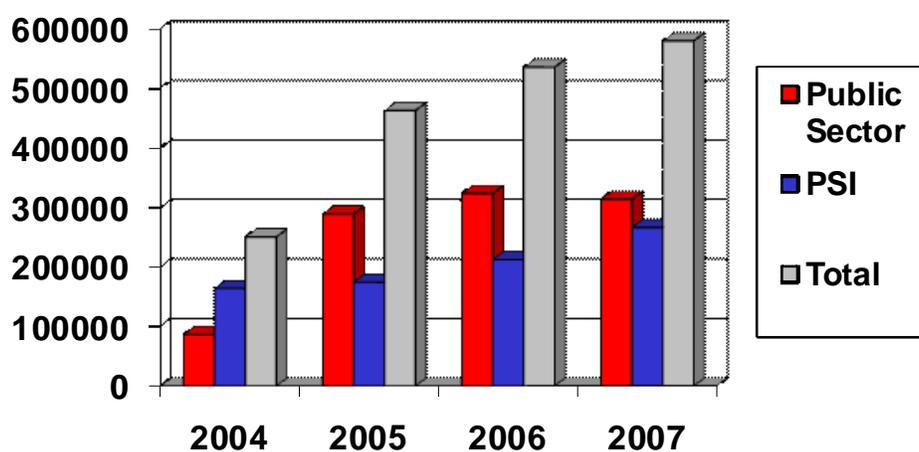
Services

Provider-Initiated Counseling and Testing

Provider-initiated counseling and testing (PICT) is widely viewed in the international arsenal of HIV/AIDS intervention options as an attractive alternative to voluntary or client-initiated testing. The belief was that such a platform for testing was more sustainable as an integrated health care service rather than a vertical effort focused on motivating clients to come for T&C at designated locations. For some, PICT was envisioned as ultimately replacing VCT.

Introduced in Zimbabwe by the MOCHW in 2005, PICT became standard in health care facilities for any client presenting for any reason. Clients are counseled and routinely offered HIV testing. The acceptance rate among clients at health facilities as reported to the evaluation team is quite high (85–90%). With PICT in place, the total numbers of persons tested through the public sector have risen substantially (see Figure 9).

Figure 9: Annual HIV Testing/Counseling by Year



PICT is now active in more than 700 facilities in Zimbabwe. Between 2004 and 2005 the number of persons reached through the public sector increased by a remarkable 334 percent, and in 2006, the percentage tested rose by another 12 percent. However, the numbers reached for T&C appear to have leveled off in 2007. The plateau in the public sector may be related to the declining economic situation, which has made it harder for some people to access services.

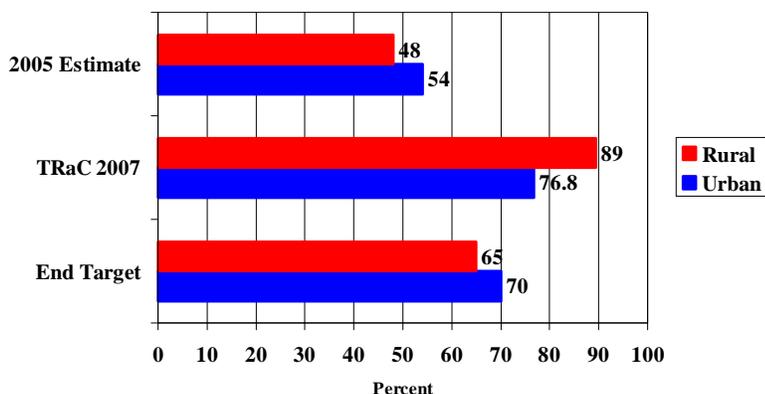
During site visits the team was able to see that the PICT process has been well integrated into both patient check-in and client-provider interaction without adversely affecting patient flow and waiting times. Given the high acceptance rates, pretest counseling seems to be functioning adequately. However, some informants have raised questions about the quality and comprehensiveness of counseling, particularly for those testing positive, in PICT facilities. Most public facilities have staff vacancies and high attrition rates. Post-test counseling at some locations is recognized as inadequate, and providers often refer patients to VCT centers for “full-service” counseling.

Client-Initiated Counseling and Testing/New Start

VCT, with its client-initiated format, has been a major area of effort for both the HIV/AIDS Partnership Project and the Behaviour Change Programme. PSI/Z has supported VCT both by financing the efforts of local organizations and by directly managing sites. So far PSI/Z activities have yielded consistent increases in the number of persons reached with T&C (see Figure 5). Between 2005 and 2007, that number had grown by over 20 percent a year. Tracked indicators for T&C include an outcome measure defined as “target population, 16 years and above, who report that they are capable of accessing T&C services.” From the evidence gathered by the project, the end-of-project (2011) targets of 70 percent for urban populations and 65 percent for rural have already been surpassed (see Figure 10).

Figure 10: Portion of Target Population (≥ 16 Years Old) Reporting They Are Able to Access T&C Services

Interestingly, the numbers of individuals accessing VCT services have grown consistently even with the introduction of PICT into several hundred public facilities. PSI/Z has used a series of innovative outreach



activities to provide a wider range of opportunities for people to access such services, among them outreach in communities and workplaces and services for mobile and vulnerable populations. In 2008, for example, outreach was active in 252 workplaces that comprised 52 different types of employer or work settings. Outreach efforts accounted for more than 40 percent of the PSI/Z’s T&C numbers in 2007.

Source: PSI/Zimbabwe

At static T&C facilities and some community outreach sites, women are more likely to receive services,

but in the workplace men are twice as likely as women to access T&C. Such diverse outreach mechanisms help to achieve greater gender-specific access.

The T&C service sites and outreach managed or operated directly by PSI/Z produce more than half of all T&C visits. Local partnering organizations offer increased geographic coverage and often provide access specific subsets of the population. However, since the bulk of the client load achieved by donor support is because of the direct efforts of PSI/Z, schedules for the phase-over of operations should be re-examined.

If PICT services successfully cater to the full range of a population, the numbers coming for T&C through VCT facilities should have declined. This did not happen. Even after PICT was introduced, the numbers of persons accessing VCT have been growing annually. Thus it appears that client-initiated services like VCT must serve a different segment of the population than those people who typically access public facilities for health care. Together, PICT and VCT services clearly have increased the total numbers of persons in Zimbabwe who have been tested and know their HIV status. If either medium was removed, Zimbabwe would not be making as much progress toward its goal of 80 percent of its people knowing their HIV status.

Post-Test Services/New Life

Post-test services include a variety of supports: psychosocial, nutritional, ART-adherence, and post-test support services to pregnant HIV-positive women and mothers (as well as their families enrolled in the national PMTCT program). In the first year, 13,941 new clients received post-test services. This remarkable achievement can be attributed to tight referral systems between New Start and New Life; increased mobilization efforts by New Life staff; wider coverage in outreach programs for post-test support services; and increased demand for such services as increased numbers of people are tested.

The project managed to expand the post-test center network from two to twelve New Life centers using a franchising approach. The project supported the transition from its direct implementation of New Life sites to indirect support with an increased capacity building role. The New Life centers in Harare and Bulawayo were established as centers of excellence to train counselors and other post-test services staff from new partners. Training guidelines and materials for counselors and site managers as well as peer counselors were published and have been used to train 81 individuals, including peer counselors, from the entire New Life network.

The New Life outreach program included assistance to PLWHA and workplace support groups. Psychosocial support is being offered at all New Life sites, and 13 ART/OI (opportunistic infection) clinics visited regularly by New Life and peer counselors.⁴

As part of its localization and enhancing sustainability interventions, the project conducted several in-house financial capacity-building workshops and trainings for all New Life franchise partners, which also benefited from individual financial management support visits from the project. Local organizations were identified to conduct capacity building and train local partner organizations; this further ensured that partners would be strategically positioned and the interventions sustainable.

Family Planning in PMTCT (FP/PMTCT)

Within the Zimbabwe HIV/AIDS Partnership Project, FP is linked to efforts of the MOHCW, the Elizabeth Glaser Pediatric AIDS Foundation (Glaser), and local NGOs in support of the national PMTCT program. Family Health International (FHI), as an implementing partner in the project, provides technical assistance on integrating FP within PMTCT.

The Partnership Project works at the policy level to integrate FP and PMTCT more closely. For example, there have been technical inputs for modifying the national PMTCT training curriculum; reviewing PMTCT strategies, policies, and guidelines; and providing up-to-date FP/HIV information. Specific policy activities included ensuring that FP is reflected in the 2006–2010 PMTCT & Paediatric HIV Care, Treatment, and Support Strategic Plan; revising the national PMTCT training manual to enhanced its FP content, which was adapted from FHI's training module *Contraception for Women and Couples with HIV*; updating national FP guidelines with information on contraceptive options for HIV-positive women; and participating in the standardization of registers and tools for HIV-positive infants and ensuring the addition of FP-related indicators for the mother.

FHI and project staff also contributed content for PMTCT mass media campaigns. In doing so, the FP/PMTCT advisor provided technical assistance to PSI/Z as communication campaign materials were drafted to ensure that the content reflected the importance of FP for PMTCT, thereby complementing the provider-focused trainings that the Partnership Project supports.

However, the main emphasis of the project's efforts for FP/PMTCT is on training to build the capacity of PMTCT providers to deliver integrated FP services. This has required intensive coordination with the training plans of the MOHCW and Glaser; delays in executing the training plans have often made it harder for the project to achieve training targets or meet its implementation schedule.

From project start through September 2008, the project was part of 13 training workshops and trained 346 persons in FP/PMTCT; 78 percent of whom were trained in the second project year. Secondary FP/PMTCT training (training by those whose skills were enhanced by the primary training) has reached another 533 people.

The numbers of persons trained to date, although in line with project targets, are quite modest, and training efforts seem to have been focused on providers in only a few areas. The aim of project FP/PMTCT training has not been national coverage but enhancing trainings undertaken by local partnering organizations in a few districts where the project supports PMTCT services. Project personnel directly involved with training report that staff limitations slow the pace. Additionally, there is a question whether training alone is sufficient to realize a change in how FP/PMTCT services are offered. Other facility-level interventions, beyond the current scope of the project, may be needed to enable providers to effectively offer enhanced FP/PMTCT services and exercise new skills daily with clients.

The relative impact of these efforts on FP/PMTCT nationally seems to be limited. Better coordination of project communication activities with the training efforts could yield greater impact. If the current mode for implementing

⁴ Harare Central Hospital (with the adult and pediatric OI clinics), Parirenyatwa Hospital, Mpilo and UBH hospitals in Bulawayo, Bulawayo City health clinics, Gweru City health clinic, Mutare Provincial hospital and Mutare City clinics, Masvingo Provincial hospital, Chegutu hospital, Chinhoyi Provincial hospital, Bindura District Hospital and Chiredzi District hospital.

FP/PMTCT continues, it seems unlikely that this component of the project will make much of an impact on demand for and use of PMTCT services.

Among the FP options available to PMTCT clients, services for long-acting and permanent methods are noticeably inadequate or inaccessible throughout much of the national service delivery network. This limits the range of real contraceptive choices available, and the general loss of skilled personnel in the health care system has reduced the number of those who have the expertise to offer clinical methods. Future training efforts could help address this need for long-acting and permanent methods, both for in- and pre-service training venues. However, this will also require more attention to referral systems to ensure that PMTCT clients have access to long-acting and permanent methods.

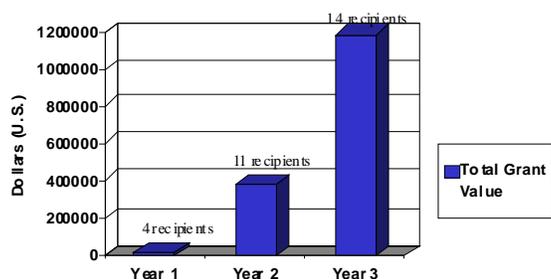
Local Partnerships

Partnership Fund

The USAID-supported partnership fund was originally designed to both finance local NGOs for HIV/AIDS work and to attract funding from enough donors to become a recurring vehicle through which international assistance fueled NGO initiatives. So far, however, there seems to be little or no donor interest in using the partnership fund to finance NGO-based HIV/AIDS activities. USAID funding through the PSP IQC task order is the only source of financing available to the partnership fund. The original program design has proved incompatible with donor financing modes.

Abt Associates manages the fund and the grant-making and administration process with USAID support through the task order. The fund is structured as a grants-under-contract mechanism. It operates with the dual objectives of building the capacity of local NGOs to provide HIV prevention and care services and also increasing the availability of services needed to address the epidemic.

Figure 11: Partnership Fund Grants by Number of Recipient Organizations (active grants) and Annual Monetary Totals of All Grants



Source: Zimbabwe HIV/AIDS Partnership Project

Although only four local NGOs received funding in the first year (see Figure 11), the pace of grant-making has picked up, and in the third year, 14 had active grants totaling almost \$1.2 million. In September 2008, three more signed grant agreements, bringing the total to 17.

The Partnership Fund has been effective in financing activities that contribute to the service and communications results of the project. Recipient organizations are being financed to provide testing and counseling or post-test support services or for communication activities related to abstinence, being faithful, and other prevention messages, including condom promotion. Grant-making thus supports increased availability of services and prevention communications.

Major complicating factors for grant-making activities have been hyperinflation and arcane banking rules. Hyperinflation makes it extremely difficult to estimate costs in local currency. Grant agreements detailing a total budget amount must be constantly revised in response to rapidly changing values and the buying power of local currency. Another issue affecting the speed at which grants can be made is the capacity of NGOs to submit adequate proposals or appropriately administer grants. The project office has hired an independent accounting firm to perform pre-award assessments to help identify whether an organization can effectively manage grants. This seems to have strengthened the grant-making process.

In the future, the fund can help local NGOs become more active and proficient in delivering HIV services. Grant-making strategies could also facilitate NGO efforts to expand HIV outreach to vulnerable, underserved, and marginalized populations in Zimbabwe.

Commercial and Private Partnerships

For the Behaviour Change Programme and the Partnership Project, PSI/Z has been working with commercial and private sector partners in certain areas. The partners perform a variety of disparate tasks in support of project goals. For example, in the communication arena, a commercial sector advertising and creative agency works directly with PSI/Z to craft and produce messages.

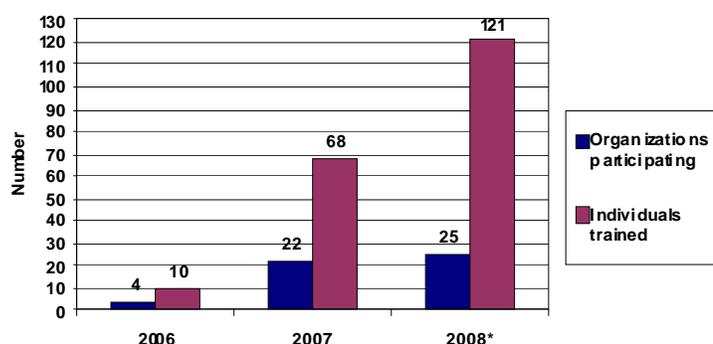
The relationships with Unilever and Coca Cola in Zimbabwe significantly expanded the distribution of condom products without any additional distribution costs to the project until the economic situation forced both companies to shut down their normal operations. The diverse retail outlets and service-delivery points represent partnerships of a different sort. Alcohol sellers and hair salons, pharmacies and CSW groups, tuck shops and grocery stores—all represent relationships in which independent operators participate in catalyzing HIV/AIDS prevention efforts. Many provide not only products but also information and advice. The workplace collaborations already discussed have been similarly successful.

PSI/Z is working with the International Organization for Migration (IOM) to offer T&C services to mobile vulnerable populations in IOM deportee centers and 10 other sites. Thus far in 2008, about 14,000 persons have been tested from this at-risk population.

Capacity-Building in Non-Government Organizations

The Partnership Project works to build the capacity of Zimbabwean NGOs that are or could be active in HIV/AIDS work by identifying their organizational development needs and then enhancing the skills or organizational practices needed to address them. Topics covered include management and administration, human resource management, activity monitoring, evidence-based decision making, and resource mobilization.

Figure 12: Capacity Building Beneficiaries in the HIV/AIDS Partnership Project by Year



Source: Zimbabwe HIV/AIDS Partnership Project

* Through August, 2008

Capacity-building began slowly and paralleled the pace of grant-making through the Partnership Fund (Figure 12), but in 2008, the number of persons from participating NGOs whose skills have been enhanced nearly doubled, and 44 percent of the organizations receiving capacity-building assistance did not have grants from the Partnership Fund.

Limited capacity does appear to constrain both the number of NGOs active in HIV/AIDS prevention and the extent of their operations. More rapid expansion of NGO-based activities may depend on a concurrent program of capacity-building, but that will be very difficult in a situation where staff attrition is common. Also, the dearth of staff and resources may slow the process. Consequently, over

the next two years of the project, a more targeted program for capacity enhancement should be formulated showing how existing resources could be most effectively applied in support of grant-making.

Evidence-Based Interventions

The project has several mechanisms for collecting information it needs to make evidence-based choices about where to operate and what to do. The extent and creativity of the information systems are among the best the team has seen in a complex multiyear undertaking. Through its data collection and analysis the project is advancing the alternatives available for using use evidence in decision-making while increasing its potential for impact. The donors are to be commended for their support for the data collection and analysis that are helping to refine activities for greater results.

Innovative Management Information System (MIS)

The MIS in place for PSI/Z-implemented activities not only tracks total progress (such as sales of a given product); it also makes it possible to differentiate between types of retail outlets or service delivery points for counseling and testing. This tracking sensitivity provides capacity to determine variations in performance by service-delivery or product-provision mechanism. With such evidence PSI/Z has been able to decide where additional efforts are likely to maximize results or which venues may need additional attention.

Particularly innovative has been the geographic information system (GIS) that allows the project to understand where service is actually delivered. This information is compared to such factors as population density patterns or locations of growth areas to place service delivery points where the most people can access them. The GIS component of the MIS is another way evidence is used to increase the impact of project activities on the general population.

Intervention Area Inquiry

Besides using the sophisticated MIS for monitoring, the project also undertakes structured inquiry to better understand specific at-risk behaviors targeted for change. For example, it recently supported analysis of factors contributing to concurrent relationships, the results of which will be used to better target communications messages designed to reduce the prevalence of multiple partner relationships. This capacity for targeted-issue analyses has enhanced the project's ability to orient its activities to overcome barriers to the desired behavior changes.

Impact and Trend Analysis (TRaC)

Perhaps the most remarkable element of evidence-based activity in the project is the annual population-based survey (TRaC) designed and conducted by PSI/Z. The relatively large sample (several thousand) and rigorous design provides insight into behavior patterns that the project is trying to influence. In essence, the regular TRaC analyses gives the project a means to estimate impact while activities are still going on rather than waiting to the end of the project. The TRaC analyses, or something like them, offer great potential for adding new dimensions in evidence-based initiatives in other public health programs.

The project also drafted research plans to improve communications and scale items that generated qualitative information to help refine scale items for use in TRaC surveys so they are more sensitive and reliable. Qualitative research was also used to improve communications through working with target audiences to understand the best archetypes to use for communications and the best opportunities for reaching target audiences and better understanding the audience's ability to process information.

PROGRAM STRUCTURE AND MANAGEMENT

Much of the program structure is a direct response to project design. In the case of the HIV/AIDS Partnership Project, the basic concept underlying the USAID-supported Partnership Fund seems ill-suited to current conditions, and the assumptions that it would mobilize significant resources seems to have been untested given its lack of relevance to present realities. Consequently, the structure and management of the project has had to adapt itself to what was realistically possible.

Challenges

At the beginning of the Partnership Project, PSI/Z, a subcontractor to Abt Associates in the PSP IQC, provided a chief of party because it was already operating in Zimbabwe. This arrangement, however, proved untenable and led to considerable managerial issues of cross-organizational cooperation. Although there are several reasons for the management difficulties encountered in the initial interface between Abt and PSI/Z, most appear related to basic differences in corporate culture and perceptions of competition for financial resources. The initial management difficulties were severe enough to affect the pace of implementation for some of the partners during the project's first year. Once Abt decided to appoint its own Chief of Party, a new set of operating relationships was defined. The new managerial format (see Appendix H) now works well; all implementing partners report productive work relationships and much improved collaboration.

Collaboration with Stakeholders

Interface with HIV/AIDS stakeholders in Zimbabwe has been effective and productive, especially with the MOHCW and the NAC, and project activities clearly complement national strategies and track annual plans. The project regularly delivers its program reporting and monitoring data to the MOHCW, where it becomes part of the national HIV/AIDS database.

Project staff consistently participate in gatherings on HIV/AIDS topics such as T&C or communications planning, which has increased information-sharing across HIV/AIDS organizations. Health sector donors contacted by the team were familiar with the project's work and general purpose.

Some of the project's innovative work, such as PSI/Z's use of evidence and inquiry to monitor the effectiveness of interventions, could inform others active in HIV/AIDS work. For example, lessons learned about communications may be useful for similar UNFPA-funded efforts. Identifying additional opportunities for experience-sharing could improve outreach.

Flexibility in a Changing Environment

The volatile and rapidly changing environment in Zimbabwe has made basic project work very difficult. Consequently, flexible and rapidly adaptive implementation modalities were required to continue to make progress. PSI/Z in particular has been extremely adept at reading changes in the environment and quickly finding alternative mechanisms when previous methods no longer worked. With much of social marketing heavily dependent on a fully functional commercial marketplace, PSI/Z was especially affected by the collapse of much of Zimbabwe's formal commercial systems. Nevertheless, it has consistently managed to identify ways to deliver progress in key areas. This feat is a testament to creativity and adaptive prowess in the face of extraordinary difficulties. It seems to have been facilitated by an organizational willingness to assume higher risk.

Other organizations within the Partnership Project have not been as quick to adjust or are more passive when problems arise. Some organizations are more risk-adverse. Such tendencies, in the special situation that Zimbabwe has become, produced fewer options and seemed to have slowed the pace of forward movement.

Financial Support to the Behaviour Change Programme

Since PSI/Z is ahead of schedule in its progress toward most major objectives, current funding from DFID should, in theory, be sufficient to allow it to achieve nearly all major targets. However, changes to respond to the volatile and unusual environment have placed unexpected demands on some specific line items. Hyperinflation and fluctuating pound-to-U.S. dollar exchange rates have also affected how much can be done within current funding. Exchange rates are extremely difficult to predict, and recent rises in the value of the dollar have meant that the DFID funding yields fewer U.S. dollars for PSI/Z.

This is the opposite of the initial period when the dollar was declining in value so that DFID BCC funding yielded more U.S. dollars than was originally anticipated. The unexpected windfall from these exchange rate gains made it possible for PSI/Z to procure additional vehicles for more direct distribution of products as the formal commercial sector collapsed, as well as to expand other outreach. That is no longer the case.

At the current project pace, which will allow several targets to be exceeded, it is likely that the Behaviour Change Programme will use up its DFID funding before the end of the support agreement, possibly by the second quarter of the 2010 operational year. Recommendations to increase activities that target underserved and vulnerable populations will place additional demands on the budget. Such undertakings for at-risk populations typically are considerably more expensive per beneficiary.

The overall "burn rate" for DFID funding is approximately where it should be, given the time elapsed in the project. There has been an increase in the resources needed for packaging products as sales have soared and packaging costs increased. Some of these additional packaging costs are being covered through line item flexibility, but there could be a need for additional support for product packaging and distribution.

DFID also may wish to consider providing more program funding for such activities as increased outreach communication and services for more vulnerable or displaced subgroups; approaches to adolescents and youth (where there is epidemiological evidence of HIV incidence peaks in 15- to 24-year-olds); HIV prevention communications that go beyond abstinence; and promotional and programmatic support for scaling up a male circumcision program.

Benefits and Disadvantages of the IQC Mechanism

USAID funding for the Partnership Project is provided through a task order under the PSP IQC mechanism. The main benefit of the IQC to USAID/Zimbabwe was the convenience it offered in getting the new endeavor up and running more quickly. Responses to the task order arrived on schedule, and an implementing group was selected quickly. Another advantage of the IQC mentioned by the project partners was the opportunity accorded to IQC participants to bid on task orders issued using the mechanism.

However, one disadvantage mentioned was that IQC mechanisms require bidding organizations to join together in an organizational mix without knowing what exactly they will be doing. This means that the combination of collaborating organizations is fixed before a specific scope of work order is released. When a task order emerges, fixed combinations of organizations may then have to propose a role for collaborating organizations even though the relative organizational strengths may not be the optimal match for the work. In such scenarios, the IQC mechanism may not offer USAID missions the optimal organizational combinations for the work requested. Another limitation is the absence or limited ability of task orders to accept or use field-support funding from USAID missions. Field support funding often offers missions the fastest way to initiate a priority effort. Although the first task order under PSP included the facility to accept field support funds, the low ceiling for such funding was quickly oversubscribed.

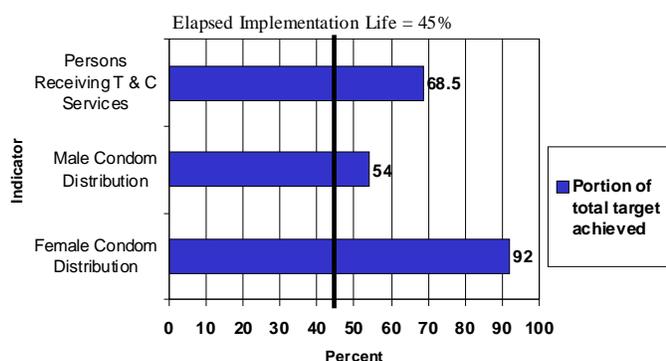
4. CONCLUSIONS

PROJECT PERFORMANCE

The Zimbabwe HIV/AIDS Partnership Project and the Behaviour Change Communication Programme display a high level of performance with excellent progress to date. The substantial progress is even more remarkable given the economic decline and political turmoil.

The rate of progress for major interventions that contribute directly to HIV/AIDS mitigation nationally is impressive (see Figure 13). At about half-way through the life of the project, achievement in most indicator and contractual agreement areas is on or ahead of schedule. The number of persons receiving T&C services has already reached nearly 70 percent of the total targeted for the end of the project, and current totals for female condom distribution have nearly attained the entire project goal.

Figure 13: Rate of Progress in Selected Key Indicators (Through July, 2008)



Source: PSI/Zimbabwe

Consequently, the project should exceed many original expectations and will return better results than donors anticipated. Given the high rates of achievement, it may be useful for donors and project staff together to revise the goals upward for high-performing interventions.

To enhance performance, PSI/Z uses a gender-sensitive approach to programming, as evidenced in the use of research (such as the TRaC Surveys) that is gender-specific, especially on concurrent relationships, cross-generational sex, and sexual debut. Implementation of the BCC component, for example, is guided by clear and data-supported gender-specific indicators. This information is then incorporated within annual programming to maximize beneficial impact without regard to gender.

However, there is little evidence on how well the project reaches such socially excluded groups as former commercial farm workers and displaced populations. People living with disabilities also are not targeted by the communication campaigns. Communication efforts for youth are more oriented on abstinence; there is limited content for youth in Be Faithful campaigns or BCC related to concurrent relationships and cross-generational sex. Marketing campaigns on condom use also need to more actively reach out to adolescents—a group particularly vulnerable to HIV infection.

IMPACT OF THE PROGRAM ON THE HIV/AIDS EPIDEMIC

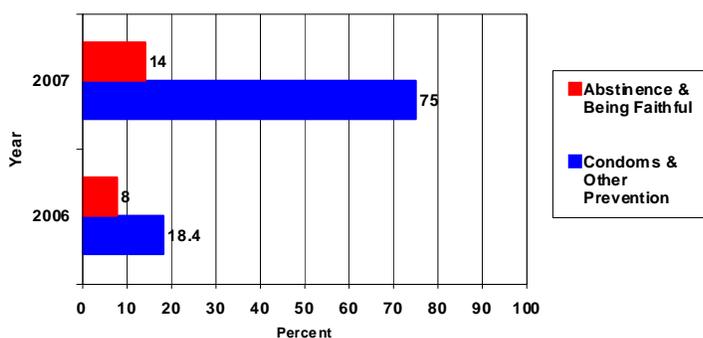
Both the availability of and access to HIV/AIDS key services have improved. Project-supported counseling and testing reach increasing numbers of people each year and in 2007 represented nearly half (46%) of all the persons tested in Zimbabwe. About 70 percent of all male condoms distributed in the country in 2007 were a result of project social marketing. Male condoms are one of the few products still regularly available in many shops.

NGOs are more active in service delivery as a result of the project, and their efforts have expanded outreach in communities. Creative approaches to finding new venues for offering products and services are increasing functional access for a wider spectrum of the population. Good examples are workplace counseling and testing, collaboration with IOM for mobile and vulnerable populations, and using hair salons and CSW groups to distribute female condoms.

Communication activities are also reaching substantial numbers of people, particularly the condom and other prevention campaigns, which have reached an estimated 75 percent of all adult Zimbabweans (see Figure 14). In

2007, project-supported communication efforts also reached nearly 20 percent of those 10 to 24 with prevention messages.

Figure 14: Portion of Total Adult Population (15-49 yrs.) in Zimbabwe Reached with Behavior Change Communication through Mass Media by Message Content, 2006-2007



(Analysis based on data from PSI/Zimbabwe, 2006 Demographic and Health Survey and current estimates of total population size)

CONTRIBUTIONS TO NATIONAL HIV/AIDS GOALS

A primary goal of the national HIV/AIDS program in Zimbabwe is to reduce the rate of new HIV infections and the impact of HIV/AIDS on Zimbabweans. The HIV prevalence rate has declined from 21.3 percent in 2005 to 15.6 percent in 2007. Similarly, HIV incidence has fallen from 2 percent in 2005 to 0.4 percent currently. An analysis of intermediate and proxy variables for impact suggest that the project has contributed to these declines. Clearly, its efforts are making a

substantial difference nationally in the availability of information, T&C services, and needed products. It is also making a difference in how such services and products are accessed within priority at-risk groups and the population at large.

The project uses annual population-based surveys to monitor change in reported behavior. This offers an evidence-based mechanism for assessing whether program efforts are influencing behavior choices. Information from independent studies by the Battelle Memorial Institute show that condom use by males in Zimbabwe during casual sexual encounters has increased.⁵ Most of the condoms used (possibly as much as 70%) would be Protector Plus products.

JOINT DONOR PROGRAMMING

Joint donor funding of PSI/Z-implemented activities has produced valuable synergies in financing and increased what could be accomplished. For example, the greater flexibility of DFID funding allowed PSI/Z to respond more quickly to rapidly changing realities while USAID financing continued to cover increasing volumes of commodities needed to support consumer responses to social marketing. The total funding available, of course, was also greater and allowed for a more expansive program.

Program performance to date demonstrates that DFID and USAID are realizing significant public health returns on their investment in mitigating the HIV/AIDS epidemic in Zimbabwe. Interestingly, the impact of the funding on positive change in the HIV/AIDS program appears to be greater because of the joint donor programming than if funding was programmed separately through different organizations. One important reason for this benefit is the complementarity of financing that has been possible within PSI/Z because of the presence of two donors.

A major factor in the success of the program so far is that the donors adopted common goals for it. Another is the use of the same indicators by both donors to monitor progress.

HIV/AIDS PARTNERSHIP PROJECT DESIGN AND STRUCTURE

Unfortunately, key elements of the design of the HIV/AIDS Partnership Project were ill-suited to the realities in Zimbabwe. Weaknesses in the basic design led to an unrealistic structure that had to awkwardly find a managerial

⁵ Danuta Kasprzyk and Daniel E. Montano, personal communication, 2008

and operational modality to allow the program to function productively. Many of the assumptions behind the Partnership Project's design had obviously not been tested before the program began. In particular, the vision of the Partnership Fund as a significant engine to drive meaningful NGO interventions over the long term was at best over-optimistic.

Although USAID's decision to use an IQC mechanism may have offered conveniences, that contracting vehicle produced an array of implementing organizations that may be more numerous and costly than was necessary to accomplish significant gains in HIV/AIDS prevention. Again, the variety of activity areas and the roles for various organizations are also related to the original project design. If USAID were to begin such an effort today, a different design and operational structure would be advisable.

As the project is currently structured, activities undertaken by PSI/Z receive the most financing and are making the most progress. In terms of mitigating the HIV/AIDS epidemic at the national level, the PSI/Z components provide the most substantial evidence that the project is making a difference. The magnitude of their results raises questions about the relative added value of some other activities called for in the original design. If funding should become constrained, USAID may need to re-examine the relative merits of the various components.

THE EXTERNAL ENVIRONMENT AND RELATIVE PROGRAM RISK

Although the environment has deteriorated dramatically during the life of the project, the alternative operational modalities discovered have mitigated many of the negatives, and the program is still making progress toward its goals. The team's assessment (see Appendix C) is that currently the program is at medium risk from the environment, but the risk is manageable level. Donor investments in the project are still realizing substantial public health returns.

With the recent power-sharing accord, the probability that the "situation-worsening" scenario described in Appendix C will occur would seem more remote. Should the power-sharing accord hold and prudent economic policies begin to emerge, the "situation-improving" scenario in Appendix C appears more likely than perpetuation of the status quo.

5. LESSONS LEARNED

Models of private sector partnering and social marketing are affected by market or general economic conditions. Hyperinflation, poor fiscal policies, and legal restrictions on commercial firms together have had a disastrous effect on commerce and the economy in Zimbabwe. As a result, the traditional strengths of the for-profit private sector have largely disappeared, as have options for partnering with an important part of the private sector and for pursuing aspects of proven social marketing models. When the number of potential private partners declines, more direct implementation by a funded intermediary organization becomes necessary. As cost-sharing partnerships become less feasible, the unit cost of directly delivered goods and services may increase. However, creative intervention approaches by a committed implementing organization and the availability of flexible funding can still achieve significant results.

Flexibility is essential when circumstances become adverse. In the face of political unrest and severe economic conditions, the project has been able to make progress by using flexible modalities and rapidly identifying operational alternatives as the situation changed. Clearly, organizations that can adapt quickly to get the work done can successfully implement programs despite adversity. A key ingredient in operational flexibility is acceptance of some organizational risk as new implementation alternatives are explored.

Provider-initiated testing and counseling does not replace client-initiated services. While PICT dramatically increases the number of persons tested for HIV each year, the experience of the project vividly shows that VCT can still serve substantial numbers of people. Even with PICT in place, client-initiated services continue to fill a need for a segment of the population that may not regularly access health facilities for other reasons.

Outreach increases the use of testing and counseling. Going beyond fixed service-delivery sites and extending T&C into a variety of locations through outreach greatly increases access. Outreach through targeted locations such as the workplace or deportee depots brings T&C to at-risk or vulnerable groups. It can also increase the numbers of at-risk individuals who know their HIV status.

Repeat exposure to communication may not make behavior change more likely. Analyses supported by the project found that exposure to communication messages increases the chance that a person will accept or go for T&C services and increases the likelihood of condom use. However, it appears that exposure to multiple communication messages, once an audience has already been reached, did not significantly increase the likelihood of behavior change. The project is using this finding to refine its communication planning.

Diversification of outlets increases product availability to at-risk populations. Placing condom products in a wide range of outlets that may be frequented by at-risk populations has increased condom availability for them. Because alcohol consumption is often accompanied by high-risk sexual encounters, the project selected alcohol vendors to carry condoms for sale. CSW groups also serve as condom sales points. Such targeting of outlets for products increases the opportunity for at-risk segments of the population to access and use condoms. However, most BCC activities do not reach many of the socially excluded and at-risk populations, such as former commercial farm workers, CSWs, and people living with disability.

PSI/Z capacity-building efforts have enhanced local human resources. DFID supports PSI/Z activities partly because of an interest in building Zimbabwean human capacity. PSI/Z as a registered Zimbabwean trust has an active local board of directors, and as its local affiliate, PSI/Z benefits from a broad range of technical and financial management services offered by PSI/Washington. These services, along with a talented Zimbabwean team, have reduced the number of full-time expatriate advisors from six to three. PSI/Z has one of the lowest expatriate-to-budget ratios in the 65 countries where PSI operates, and steps to reinforce local ownership continue. For example PSI/Z's Business Operations Director, previously an expatriate, is now a Zimbabwean. Localization of senior staff positions and giving more responsibilities to local staff is a continuing PSI/Z process that has greatly empowered and motivated local staff to take ownership of the program. Other benefits are very low staff turnover and increased motivation. However, more still needs to be done to mentor local managers so that they can mentor the people below them. There is also a need to build capacity among the lower ranks as well as managers. Junior staff tend to feel left out, and greater clarity is needed about prospects for advancement.

Effective collaboration and capacity-building at the national level contribute to sustainability.

As project activities contribute to the expansion and scaling up of HIV prevention activities in Zimbabwe, USAID and DFID support are contributing to a significant and sustainable health impact. Sustainability is being achieved through building local capacity and increasing Zimbabwean ownership of the program. To enhance sustainability, for example, PSI/Z has adopted a strategic approach informed by lessons learned from the previous program and uses evidence-based strategies to tailor activities to local needs. The guiding operational principles (collaboration and coordination; support for national HIV response; local ownership of HIV response through partnerships; and reliance on evidence-based decision making) all combine to make the program more sustainable for the long term.

The program also works with the MOHCW and the NAC to build national capacity. These efforts enhance the scale and quality of local HIV and AIDS initiatives by providing technical and communications support to public program and structures at the central and district levels. PSI/Z is transferring technical expertise, management capacity, and financial resources to build long-term national capacity to implement HIV prevention program in Zimbabwe. Local CBOs, FBOs, and other NGOs are working with PSI/Z to design and operate activities for wider coverage and sustainability. PSI/Z also supports local organizations in the design and realization of community and participatory BCC approaches.

6. PROGRAM RECOMMENDATIONS

The following recommendations based on the findings of the assessment relate to future efforts within current funding levels. They are offered with a view to maximizing total project results and increasing the potential for furthering the national HIV/AIDS program.

- Support of client-initiated and other VCT services should be continued even as provider-initiated testing expands. Client-initiated testing, particularly through outreach, currently is extending T&C alternatives to those who might not otherwise access health care services and making such services available to more at-risk segments of the population.
- Outreach for T&C efforts should increasingly be directed to hard-to-reach, at-risk, mobile, displaced, and other vulnerable populations. Better definition is needed of subsets of these target populations as a basis for planning work and monitoring progress. The research and evidence-based planning capacities within the program offer important bases for identifying the most effective ways for increasing VCT access within priority segments of the population.
- Communications strategies should identify new ways to reach socially excluded groups, such as former commercial farm workers, displaced populations, and people living with disabilities.
- Since directly managed PSI/Z sites for T&C contribute 55–60 percent of total monthly client volumes for T&C within the project, any planned phase-over or transfer of these functions to other organizations should be delayed until the project ends.
- Mass media should continue to be an active part of the BCC media mix. Even with power outages, radio and television still reach sizable numbers of people and are among the most cost-efficient ways to reach people.
- The program should scale up the current BCC campaigns on concurrent sexual practices, both within the general population and for socially excluded groups, with campaign materials addressed specifically to individual vulnerable populations.
- In communications to support HIV/AIDS services, more intensive work is needed for PMTCT among the general population and vulnerable groups. Strategic partnerships could be strengthened with others who already work with socially excluded groups.
- PSI/Z should reassess its current goals related to stigma and discrimination. The present target of 80 percent seems too ambitious; it may not be achievable by 2011. A lower target would be more realistic.
- Those program elements that directly support the delivery of services and products to clients should be given priority for funding. Costs in a constantly changing environment are difficult to predict. Without additional funding, it may become necessary to choose between program components to keep operations within budget. If so, current care and support efforts, such as those represented in the New Life centers, could be limited or transferred to organizations already active in supporting positive living with HIV.
- New Life centers need to make more deliberate efforts to respond to the needs of youth and adolescents; linkages could be enhanced between PSI/Z and local organizations and centers for young people living with AIDS.
- If the environment improves and donors like DFID and the EU extend support for the service-delivery system, both public and private, the project should expand opportunities to share or transfer its experience with HIV prevention service-delivery to local and national organizations.
- Until viable private alternatives for product distribution re-emerge in Zimbabwe, the project should continue to build up its direct distribution mechanisms, but exploration of indirect product distribution is important as a means to expand market coverage and reduce distribution costs if commercial options return to the marketplace.
- A ready supply of packaged product is necessary to keep pace with demand for condom products, both male and female. Sufficient financial resources for packaging need to be guaranteed so that product uptake will not be artificially limited.

- To further promote the female condom product, PSI/Z should explore additional strategic partnerships with women's groups such as the Women's Action Group (WAG), Women's Trust, Zimbabwe Women's Resource Centre and Network, and Padare.
- The donors should facilitate programmatic and referral linkages between PSI/Z programs and other efforts (livelihood programs, care and support, OVC activities, youth and reproductive health) that can broaden the impact of project activities.
- Although the project disseminates its work by participating in national working and technical groups (for condoms, commodity security, and comprehensive condom programming) and strives to disseminate innovative program approaches through presentations at international conferences, it should increase opportunities to share with others in Zimbabwe that are active in HIV/AIDS work the knowledge it has gained from its BCC and counseling and testing activities. With the innovative use of analyses and its MIS for evidence-based implementation, the project has documented impressive lessons about what approaches work best that could benefit similar activities in Zimbabwe.
- Given the complementary nature of donor funding for PSI/Z-implemented activities, DFID and USAID should meet at least annually to review PSI/Z progress and their support. This is especially important if PSI/Z continues to achieve its objectives ahead of schedule.
- For the partnership fund within the USAID-supported HIV/AIDS Partnership Project, existing agreements should be modified to acknowledge that the partnership fund functions as a grants-under-contract activity for grantees delivering core project services and cannot achieve sustainability or spin-off status by the end of the implementation period. Similarly, there should be no expectation that the fund will become a central channel through which donors support HIV/AIDS efforts for NGOs in Zimbabwe.
- FP/PMTCT activities in the Partnership Project should better document results in terms of greater service delivery capacity or improvements in FP/PMTCT services. Otherwise it is not clear the current interventions are making a noticeable difference.
- For PSI/Z's Behaviour Change Communication Programme supported by DFID, there is a need for a mentoring program for local staff, both managers and others, to reinforce current capacity-building efforts.

7. SUGGESTIONS FOR FUTURE DIRECTIONS

Based on the information gained during the assessment and observations on HIV/AIDS efforts generally in Zimbabwe, the assessment team considered options for the future that go beyond current agreements and implementation mechanisms. The following suggestions also take into account the recent power-sharing accord that may change the political environment. The team also attempted to anticipate various scenarios for how the economy could evolve.

- As the public sector becomes a more eligible recipient of assistance, provide support to revitalize HIV/AIDS services within the national health service-delivery network.
- Even with more vibrant public services, there will still be a role for the private sector and social marketing to speed achievement of national health goals. Continued support of private initiatives is warranted to more rapidly achieve substantive results.
- Given the success and synergistic benefits of joint funding, DFID and USAID should identify other opportunities to jointly finance the work of a single entity. Such financing approaches allow for a larger effort and greater flexibility in achieving innovation and progress.
- If the new political setting should bring additional funding for USAID, the agency could consider using IQC mechanisms like PSP and TASC 3 to rapidly mobilize greater capacity. Some IQC mechanisms that offer options for pass-through funding could be used to expand the work of organizations that are already active in country and possess capacities on the ground.
- Central projects (contracted from Washington) may also be able to accept field support funds to more quickly respond to USAID/Zimbabwe needs. However, a directly contracted bilateral mechanism might offer the mission more flexibility to obtain the institutional strengths best suited to new health sector programs.

Since one of the most promising measures to combat HIV/AIDS is male circumcision, donors should move quickly to provide additional support for the introduction of a male circumcision program in Zimbabwe. There is already considerable interest among host-country counterparts, and the MOHCW appears ready to undertake a national effort. Such a countrywide program will be a long-term intervention so that there are a sufficient number of circumcised males to substantially reduce the rate of new infections. Ultimately, the contribution of a male circumcision program could be quite dramatic. The MOHCW has expressed a preference for providing male circumcision primarily through the public sector. NGOs like PSI could have an important role in generating demand and raising awareness through the project's evidence-driven communications techniques.

In a national program for male circumcision, social marketing can help raise awareness of circumcision benefits and the acceptability of the procedure, although caution may be needed to avoid any negative impact on consistent condom use once a male is circumcised. Careful integration of communication strategies may be required to keep the messages (condom use and circumcision) complementary.

APPENDIX A. SCOPE OF WORK

MID-TERM ASSESSMENT OF THE ZIMBABWE HIV/AIDS PARTNERSHIP PROJECT (GH Tech Revised: 05-05-08)

BACKGROUND

The Zimbabwe Partnership Project is a five-year bilateral project, managed separately under a task order mechanism from the global Private Sector Partnerships-One (PSP-One) project, under the previously competed PSP-One multiple award indefinite quantity contract (IQC) mechanism to Abt Associates, Inc. and the following partners: Population Services International (PSI), Family Health International (FHI), Banyan Global, and a host of local implementing partners. It began on October 1, 2005, and will end on September 30, 2010. The Elizabeth Glazer Pediatric AIDS Foundation, World Education, and SCMS through the JSI/DELIVER Project make up the rest of USAID's prime partners in the Zimbabwe HIV/AIDS program.

The Partnership Project is designed to reduce the risk of sexual transmission of HIV by supporting and strengthening the overall national response to HIV/AIDS in Zimbabwe through a multipronged approach that includes increasing public knowledge of HIV risks, promoting sound behavior change, reducing stigma toward those infected, enhancing access to HIV-related products and services (including testing and counseling, and prevention of mother to child transmission), and building the capacity of local research, policy, and service providers to address the epidemic. The project enjoys a funded ceiling of \$34,999,780 from USAID.

A key component of the Partnership Project is support to PSI, which is joint-funded by DFID and USAID. It has been agreed to highlight PSI activities in this joint review to assess emerging impact, review the continuing relevance of objectives for the remainder of the program, and, if necessary, suggest amendments to the scope of the program.

The project's activities have been implemented within a rapidly changing and challenging environment. In the 1980s and early 1990s, Zimbabwe had one of the best health systems in Sub-Saharan Africa, with strong health indicators. However, this once robust health system has deteriorated in recent years with the rising inflation rate, political instability, and crumbling social infrastructure in which basic services such as water and electricity are no longer a given. The well-educated and trained public health workers of Zimbabwe continue to leave for better job opportunities in neighboring countries and overseas. The effect on Zimbabwe's health indicators is profound. For example, the 2006 DHS results reveal declines in nutritional status of children, in the number of births with a health professional in attendance, and in the availability of essential drugs. It is within this wider context that the project has strived to achieve its objectives.

The following results framework sets the ultimate objectives for all activities conducted by the Partnership Project:

Strategic Objective: Reduce the risk of sexual transmission of HIV by promoting behavior change through improved knowledge and increased access to HIV-related products and services.

Component 1: Communications: Development and management of a broad-based communications initiative that does the following:

1. a *Behavior Change Communications* to increase Zimbabweans' adoption of safer sexual behaviors and to reduce stigma;
1. b *Service Communications* to provide accurate information on and create informed demand for available HIV services, including provider-initiated T&C, PMTCT, and ART services; and

1. c *Marketing Communications* to increase sustained use of HIV products and services.

Component 2: Product Delivery: Implement a targeted distribution strategy to improve overall access to, and coverage of, male and female condoms; this entails coordinating with the national strategy and forming strategic partnerships to ensure cost-effective delivery. Products include:

2. a *Protector Plus male condoms*

2. b *Care female condoms*

Component 3: Services: Implement a broad-based service delivery program that will support the Ministry of Health and Child Welfare (MOHCW)'s transition to a provider-initiated testing and counseling (T&C) approach, maintain the availability of client-initiated T&C through the *New Start* network, expand the *New Life* franchised post-test service network, and complement proposed communication activities designed to increase T&C service demand under both the client- and provider-initiated approaches. The following service delivery approaches include:

3. a *Client-Initiated Testing and Counseling*

3. b *Provider-Initiated Testing and Counseling*

3. c *Post-test services*

3. d *Strengthening Integration of Family Planning within PMTCT*

Component 4: The Partnership Fund: Establish and maintain practical, cost-effective partnerships with multiple, primarily local, organizations from Zimbabwe's not-for-profit and for-profit sectors for substantial roles in the ongoing implementation of project activities.

The project uses a broad range of guiding principles to achieve the results described above, including:

- Effective and innovative management and technical approaches
- Continued learning and ability to adapt as a result of experience
- Maximum use of local organizations
- Skilled Zimbabwean personnel
- Integration of gender equity concerns
- Flexibility to respond to changes
- Leveraging of other HIV resources

PURPOSE

The U.S. Agency for International Development (USAID)/Zimbabwe's Health Office is commissioning an independent mid-term assessment of its HIV/AIDS Partnership Project (PSP Zimbabwe). The co-funded aspects of the program, namely PSI, will be assessed jointly with DFID, which will assist in identifying a consultant to join the review. As the project is approximately half-way through implementation, the intention is to examine the following:

- Assess the project’s progress toward achieving the higher level results as stated in the contract’s objectives (i.e., whether or not the project is on target to achieve its goals).
- Identify strengths and weaknesses within the project’s portfolio.
- Provide recommendations for areas and activities that may warrant continued investment, as well as other key initiatives and approaches not covered by the project, but which would likely contribute to improving access to, use of, and quality of HIV/AIDS products and services.
- Provide recommendations for improving areas of performance weakness.
- Assess project management structures and provide recommendations for improving administration, coordination, and implementation of the project.

The assessment will draw from and build on a self-assessment from the Partnership Project, feedback from key stakeholders, including USAID/Zimbabwe and U.K. Department for International Development (DFID) staff, and key informant interviews with in-country partners. The overall goal of the assessment will be to determine the strengths and weaknesses of the program so as to inform the future direction of services provided by the Partnership Project. This evaluation will be used by USAID, DFID, and the Partnership Project to evaluate the project and to determine its course for the remainder of its life.

STATEMENT OF WORK

The assessment is expected to take seven to eight weeks. The external assessment team will develop a detailed scope of work and plan of action prior to the evaluation, based on the sample schedule provided in section VI below. The assessment team will have three main tasks:

- 1) Task 1: Review the Partnership Project’s technical and programmatic strengths, weaknesses, successes and constraints, identifying contributing factors. Based on the assessment findings, the team will present impact-level results achieved to date, document lessons learned, and make recommendations toward achieving planned results in the remaining period of project implementation.
- 2) Task 2: Evaluate the Partnership Project’s structure and management, including the roles and responsibilities of each partner within the consortium, and make recommendations for improving overall management of the program.
- 3) Task 3: Identify project activities that warrant continued investment as well as other initiatives and approaches not covered by the project but which would likely contribute to improving access to, use of, and quality of HIV/AIDS products and services.

Illustrative questions to assist in the assessment are provided below. The assessment team should refine, prioritize, and finalize evaluation questions in discussion with USAID and DFID prior to the start of the assessment. Additionally, the Partnership Project has provided more detailed questions by contractual component that they anticipate the assessment team will assist in solving.

TASK 1: Assess Progress to Date in Achieving Planned Results.

- 1) What has been the Partnership Project’s impact and progress to date in relation to planned results and performance indicators (provided in the Results Framework and the project’s Performance Monitoring Plan)?
- 2) What have been the Partnership Project’s most important lessons learned to date?
- 3) How has the Partnership Project supported the national HIV/AIDS strategy and scale-up of HIV-related products and services?
- 4) What contributions has the Partnership Project made to increasing Zimbabweans’ adoption of safer sexual behaviors and to reduce stigma?
- 5) How far is the program adopting evidence-based approaches in scale up of the behavior change program and other services?

- 6) To what extent are BCC programs addressing drivers of the epidemic in Zimbabwe (concurrency and gender inequalities)?
- 7) To what extent is the program addressing hard-to-reach groups such as young people and socially excluded groups (sex workers, etc)?
- 8) What are the assessment team's expectations regarding the project's future progress?

TASK 2: Evaluate the Partnership Project's Structure and Management.

- 1) What were the most significant structural or management challenges (e.g. with regard to project design, staffing, partnering, or funding) faced by the project?
- 2) The project mechanism is a separately managed task order under a multiple award IQC. What were the benefits and disadvantages of using this mechanism, particularly with regard to achieving project results? Suggest, if needed, alternate management/administrative models and mechanisms for consideration in the design of future initiatives.
- 3) Have the partners within the project achieved successful collaboration? Are the strengths of each contract partner leveraged effectively in the project? If not, what programmatic adjustments are recommended?
- 4) To what extent is the program promoting cost-effective approaches in the present difficult economic environment?
- 5) How far is the program managing and responding to financial and wider risks? Is the present risk assessment of the program valid?

TASK 3: Identify Project Initiatives and Approaches that Warrant Continued Investment and Identify Areas of Weakness and Solutions to Address the Shortcomings.

- 1) What are the key project initiatives, activities, and approaches that warrant continued investment in the future (consider each of the four components and subactivities outlined in the contract)?
- 2) What initiatives, activities, and approaches should be scaled back or eliminated altogether (consider also the Zimbabwean context)?
- 3) Identify how the project outcome can be strengthened through steps to address project weaknesses. What measures should be undertaken to address project weaknesses?
- 4) What are other promising initiatives, activities, and approaches not addressed by the project that should be considered for future investment both in the present policy context and an improving policy context (consider HIV/AIDS within the broader context of health systems strengthening in Zimbabwe)?

EVALUATION APPROACH

The assessment team shall use a variety of methods for collecting information and data. The following essential elements should be included in the methodology as well as any additional methods proposed by the team.

Pre-Assessment Briefing: The assessment team will hold preliminary discussions (prior to arrival in country) with the management teams of USAID and DFID to review the scope of the mid-term assessment, agree on the key research questions, and finalize the schedule. The outcome of this meeting will be a detailed Work Plan for the assessment, including milestones and deliverables with due dates clearly established. The Work Plan will be required one week prior to the team's arrival in Zimbabwe.

In addition to a formal in-briefing and debriefing, the team may contact the USAID management team as necessary to provide updates on progress and obtain additional guidance on logistics and additional data and information sources.

Document Review: The team may find it useful to consult a broad range of background documents apart from project documents provided by USAID/Zimbabwe. These may include documents that relate to HIV/AIDS testing and counseling services, social marketing of health commodities, and communication strategies that seek behavior change—particularly in increasing public knowledge of HIV risks. The team may also find the PSP-One

project website useful: www.pspiqc.org, as well as background information on the state of the Zimbabwean health care system.

USAID and the Partnership Project will provide the assessment team with a package of briefing materials, including:

- The SOW for the Partnership Project.
- Project quarterly reports, work plans and management reviews developed as part of routine monitoring.
- DFID annual reviews of PSI
- A self-assessment of the Partnership Project that will be completed in February 2008.

Key Informant Interviews: The team will conduct qualitative, in-depth interviews with key stakeholders and partners.

Key informants should include, but not be limited to

- Partnership Project staff (representatives of Abt Associates, Inc., PSI, FHI, Banyan Global, and any other implementing partner within the consortium)
- USAID staff, particularly the Partnership Project management unit
- DFID staff, particularly the staff responsible for services related to the work of the Partnership Project
- Partnership Project in-country partners, including the Ministry of Health
- Local implementing partners and service providers
- Beneficiaries.

Field Visits: The assessment team will conduct site visits to areas in which the Partnership Project implements substantial activities, such as VCT, PICT, behavior change communication, and social marketing.

DELIVERABLES

- 1) Approved Work Plan: This plan, to be given to USAID/Zimbabwe/DFID prior to the beginning of the assessment, should include, but not be limited to, the following items:
 - Milestones and deliverables with due dates clearly established
 - Key research questions, methods, and tools
 - Timeline for key activities, including preparatory activities (e.g., literature review)
 - Product due dates
 - Schedule of in-briefing and formal debriefing presentations
 - Schedule of informant interviews, both internal and external
 - Schedule of travel to field sites
 - Timeline for drafting the assessment report, requesting feedback, and finalizing the final report.
- 2) In-briefing and Debriefing Meetings: The team will hold an in-briefing meeting with USAID and DFID upon arrival in country. In addition, debriefing meetings with USAID and DFID are required to present major findings and recommendations of the assessment. This will be done subsequent to the data collection phase, but prior to the presentation of the draft report. The debriefing meeting will be an oral presentation and written summation of the findings. Succinct briefing materials appropriate for the audience will be prepared and distributed during the briefings. The meetings will be planned to include time for dialogue and feedback. The assessment team should also have an informal debriefing meeting solely with USAID management half-way through the assessment and prior to documenting major findings and recommendations, in order to ensure that they are on track.
- 3) Draft Report: The team will provide USAID, DFID, and the Partnership Project with a draft report that includes all components of the final assessment report. The draft report will be provided to USAID/Zimbabwe and GH Tech within five days of completion of field work and before the assessment team departs country. Reviewers will provide comments on the draft report to the assessment team leader within two weeks of receiving the report.

- 4) Final Assessment Report: Once the Team Leader submits the final draft to USAID and GH Tech, GH Tech is required to submit 5 hard copies and an electronic copy of the final report to USAID within 30 calendar days. The final report should include, at a minimum, the following: executive summary; scope and methodology used; important findings (empirical facts collected by evaluators); conclusions (evaluators' interpretations and judgments based on the findings); recommendations (proposed actions based on the conclusions); and lessons learned (implications for future designs). The report should be no longer than 50 pages, including annexes.

DURATION, TIMING, AND SCHEDULE

It is anticipated that the period of performance of this assessment will be approximately four to seven weeks, with one week of preparatory work, three to four weeks of in-country work, and two weeks of follow up.

The following is a sample schedule. The team shall propose a more detailed schedule and exact dates for the various components prior to initiation of the assignment. The in-country assessment will commence in August 2008.

Task/Deliverable	Timing	LOE			
		Team Leader	Second Team Member	Third Team Member	Total LOE
Preparatory Work					
Pre-assignment organization	2 days	2 days	2 days		4 days
Review background documents	3 days	3 days	3 days		6 days
In-Country Work					
Team travels to/from field	4 days	4 days	4 days		8 days
Pre-assessment briefing with USAID, DFID, and the Partnership Project	2 days	2 days	2 days		4 days
Information and data collection. Includes interviews with key informants.	6 days	6 days	6 days		12 days
Field visits.	9 days	9 days	9 days		18 days
Draft assessment report	5 days	5 days	5 days		10 days
Debriefs with USAID, DFID, and Partnership Project	1 days	1 days	1 days		2 days
Follow Up Post-Assessment					
USAID, DFID, and Partnership Project provide comments on draft report	10 days	0 days	0 days		0 days
Prepare final report	10 days	5 days	2 days		7 days
Total # days	52 days	37 days	34 days		71 days

TEAM COMPOSITION

A three-member assessment team is proposed. Team members should have knowledge of international public health in the context of HIV/AIDS. Between them, the team members should also have substantial knowledge of what it takes to implement a broad-based service delivery program for HIV/AIDS and a social marketing program for health commodities, and to develop communication strategies that alter behaviors within a developing country setting. Specifically, team members should have between them:

- 1) 5-10 years of professional experience in international public health in the field of HIV/AIDS. Additional experience in any of the areas of family planning/reproductive health, safe motherhood, child survival, and/or infectious diseases would be beneficial.
- 2) 5-10 years of professional experience in the area of project management and implementation. USAID project management experience is preferable.
- 3) Expertise in designing, implementing, monitoring, or evaluating/assessing public health programs in developing countries, particularly in Africa. Extensive expertise in program evaluation for any of the following areas is required for the team leader:
 - *Social Marketing*
 - *Private Sector Partnerships*
 - *Behavior Change Communications*
- 4) Knowledge of DFID annual reviews and expertise in behavior change communication.

In addition, each team member should have, at minimum, the following skills and experience:

- 1) A demonstrated understanding of the Zimbabwe country context
- 2) An advanced degree in public health, social sciences, business administration, or other relevant course of study.
- 3) Demonstrated skill in written and oral communication.
- 4) Demonstrated knowledge of USAID policies and procedures.
- 5) Ability to work effectively in, and communicate with, a diverse set of professionals.

The team leader must have excellent English language skills (both written and verbal) as s/he will have the overall responsibility for pulling together the different elements of the assessment for the final report. One or two local team members arranged by USAID and DFID may also be involved in the assessment as contributing team members to impart knowledge of Zimbabwe policies and procedures.

RELATIONSHIPS AND RESPONSIBILITIES

1. Overall Guidance: The USAID/Zimbabwe Health Team will provide overall direction to the assessment team.
2. USAID Contact: Peter Halpert, PHN Team Leader
3. DFID Contact: Wendy Takundwa-Banda, Deputy Programme Manager, and Rachel Yates, Senior Social Development Adviser
4. Partnership Project Contact: James Statman, Chief of Party.
5. Responsibilities:
 - GH Tech will be responsible for obtaining country clearances for travel for GH tech consultants.
 - Consultants will be responsible for coordinating and facilitating assessment-related field trips, interviews, and meetings in conjunction with the Partnership Project contractor. The consultants will coordinate all logistical arrangements pertaining to the assessment, including transportation, hotel arrangements, and communication, and the Partnership Project will assist to the maximum extent possible.

- Consultants will be responsible for submitting a budget for all estimated costs incurred in carrying out this review. The proposed cost may include, but not be limited to, international and in-country travel; lodging; M&IE; medical/medevac insurance; and other office supplies and logistical support services.
- DFID will be responsible for recruiting and contracting local consultants to focus on the PSI component.

APPENDIX B. PERSONS CONTACTED

UNITED STATES

Abt Associates, Inc.

Christopher Landry, Contract Administrator, International Health Division

Kathleen Novak, Portfolio Manager, International Health Division

ZIMBABWE

Abt/Zimbabwe

Martha Gcambatsha, Finance and Administration Manager, Zimbabwe HIV & AIDS Partnership Project

Dr. James Statman, Chief of Party, Zimbabwe HIV & AIDS Partnership Project

Godfrey Tinarwo, Deputy Chief of Party, Zimbabwe HIV & AIDS Partnership Project

Banyan Global – Zimbabwe

Givemore Tsikwa, Capacity Building Officer, Zimbabwe HIV & AIDS Partnership Project

Christian Development Agency (CDA)

Feni Mukondiwa, Project Accountant

Judith Musvosvi, Project Director

City Health Department, Bulawayo

Dr. Hwalima, Director

The Clinton Foundation HIV/AIDS Initiative

Tendayi Simoyi, Country Manager

Department for International Development (DfID) – Zimbabwe

Dr. Allison Beattie, Deputy Head (Programmes) & Basic Services Team Leader

Wendy Takundwa-Banda, Deputy Programme Manager

Dr. Rachel Yates, Senior Social Development Advisor

Development Data

Tendai Kureya, Executive Director

DDH & M

Paxedes Dzungare, Managing Director

Evangelical Fellowship Zimbabwe (EFZ)

Peter Bare, Program Officer

European Union

Barbara Plinkert, Head of Section/Social Sectors

Elizabeth Glazer Pediatric AIDS Foundation- Zimbabwe

Dr. Jo Keatinge, Technical Advisor

Patricia Mbetu, Country Director

FACT-Mutare

Jephias Wumdodo, Executive Director

Family Health International – Zimbabwe

Gladys Dube, Family Planning /PMTCT Advisor, Zimbabwe HIV & AIDS Partnership Project

Dr. Munyaradzi Murwira, Senior Family Planning Advisor, Zimbabwe HIV & AIDS Partnership Project

Zimbabwe HIV/AIDS Partnership Project & Behaviour Change Programme: A Joint USAID/DFID Assessment

Farm Community Trust

Taurai Malunga, Health, HIV/AIDS Advisor

Hope Humana

Rebecca Njopera, Site Principal

Chiedza Marisa, Resource Mobilization Officer

Pheneas Pendewas, Assistant Bookkeeper

Ideas at Work Production House

Lionel Murphy

International Organization for Migration (IOM)

Joyce Siveregi, National Office HIV/AIDS

Dr. Amouh Tete

Midlands AIDS Organization

Boniface Hlabano, Executive Director

Ministry of Health and Child Welfare

Dr. Owen Mugurungi, National Coordinator, AIDS & TB Unit

Mpilo Central Hospital

Matron Chikerema, Maternity Ward

Murambinda Mission/District Hospital

Dr. Glenshaw, District Medical Officer & Site Principal

National AIDS Council

Dr. Tapiwa Magure, Director

Raymond Yekeye, Operations Director

PSI/Zimbabwe

Erica Beta, National Distribution Manager

Kumbirai Chatora, Director–Marketing and Communications

Reason Chofamba, Regional Coordinator–Southern Region

Michael Chommie, Country Director

Roy Dhlamini, New Start Franchise Manager

Sylvia Sithole–Fundire, Program Coordinator

Karin Hatzold, Senior HIV/AIDS Advisor

Patience Kunaka, Training Coordinator

Silvia Madakadze, Site Manager

Robson Mafongoya, Regional Sales Coordinator (Northern Region)

Itai B. Matongerera, Regional Officer

Wellington Mushayi, Research Officer

Nick Ndebele, Regional Officer (Matabeleland)

Gerald Ngonyamo, Marketing Coordinator

Clara Nleya, I.E.C. Officer

Richard Shoko, Communications Manager

Noah Taruberekera, Head, Research Monitoring and Evaluation

Select Research

N. Bakasa, Senior Research Executive

Tov Manene, Managing Director

Tsungirirai

Nhyorowai Kanengeya, Finance & Administration Manager

Chiedza Mutandiro, Program Manager

John Brown Ncube, Director

UNFPA

Dr. Clemmens Benedikt, HIV Prevention Programme Manager

Unilever Zimbabwe

Maxen Karombo, Managing Director

USAID/Zimbabwe

Karen Freeman, Director

Peter Halpert, Health Team Leader

Derek Kunaka, Health Team

Amy Tohill Stull, Program Officer

Kevin Sturr, Team Leader–Democracy and Governance

U.S. Embassy

James D. McGee, Ambassador

UZ-HAQOCI

Dr. M. Mandivenyi, Site Manager

David Manyika, Finance Manager

Youth in Development Trust

Vongai Manungo, Projects Officer

Moses Mutyasira, Director

N. Tom, Projects Officer

Zimbabwe AIDS Prevention Project (ZAPP)

Winfreda Chandisarewa, Project Manager

Zimbabwe National Family Planning Council

Dr. S. S. Simela Chiriva, Executive Director

Zimbabwe Women's Resource Center and Network

Ms. Dorothy Adbanjo, Director

APPENDIX C. RISK SCENARIOS FOR PROGRAM IMPLEMENTATION AND ACHIEVEMENT OF ANTICIPATED RESULTS

TABLE 1. RISK SCENARIO 1: CIRCUMSTANCES REMAIN THE SAME— UNCHANGED RISK (MEDIUM)		
LIKELIHOOD	RISK FACTORS	PROGRAMMATIC IMPLICATIONS
Ongoing	Hyperinflation continues Continued legal barriers for forex dealers Increased or continued taxation	Exchange rate fluctuations make costs highly volatile. Cash shortages complicate implementation. RBZ FCA controls continue. Price controls limit cost-recovery. Staff motivation challenged.
Possible	Movement again restricted	Inability to reach some beneficiaries and risk to program outputs
Unlikely	Donors resort to sanctions on funding Relations with GOZ/MOH deteriorate	Loss of funding support Loss of policy and implementation support

TABLE 2. RISK SCENARIO 2: IMPLEMENTATION ENVIRONMENT DECLINES — INCREASED RISK (HIGH)		
LIKELIHOOD	RISK FACTORS	PROGRAMMATIC IMPLICATIONS
Possible	Hyperinflation worsens. Legal barriers for foreign exchange dealers increase. Increased taxation on US\$ spending Increasingly hard to procure goods and services	Outlet closures increase. Vendor and partner attrition Decline in roads, communications, electricity Reduced capacity to purchase goods/services Heightened forex shortages Need to pay recurring costs in advance Increasing time/effort used to cope with situation rather than delivery Staff attrition may rise.
Possible	Movement restrictions continue. Blurred lines of authority/power Worsening security	Outreach for T&C, IPC decreases or stops. Assets secured in central location Potential evacuation of international staff Increasing migration
Unlikely	Donor health sector sanctions Relations with GOZ/MOH deteriorate, preventing donor, project, and/or PSI from operating.	Retrenchment Project and/or PSI/Z not permitted to run HIV prevention interventions in Zimbabwe

TABLE 3. RISK SCENARIO 3: IMPLEMENTATION ENVIRONMENT IMPROVES — DECLINING RISKS (LOW)

LIKELIHOOD	RISK FACTORS	PROGRAMMATIC IMPLICATIONS
<p>Possible</p>	<p>Rate of inflation declines. Revaluation of Zimbabwean dollar Forex restrictions lifted and cash shortages eased. Taxation levels normalized Price restrictions eased Commercial sector policies revised to encourage foreign investment Power-sharing accords lead to greater political stability and more representative government.</p>	<p>Private sector rebuilds. Increased options for commercial partnering Rise in the numbers of potential outlets for goods or services Improvements in roads, communications, electricity Vendor/partner payments normalized Increased opportunities for staff retention Increased implementation capacity through current mechanisms & partners Potential for improved program outputs increases. Increased funding available within donor community Competition for resources</p>
<p>Unlikely</p>	<p>Changes in government leadership produce new health sector priorities or lessened emphasis on HIV/AIDS.</p>	<p>Reduced collaborative effort with public sector Decline in pace of delivery of HIV/AIDS services in public facilities</p>

APPENDIX D. SPECIFIC RECOMMENDATIONS FOR COMMUNICATIONS

SPECIFIC RECOMMENDATIONS FOR BEHAVIOR CHANGE COMMUNICATION

- Continuously update (annually) the BCC strategy to respond to the evidence coming from operations on the ground and research conducted.
- Scale up campaigns on concurrent sexual practices among the general population and socially excluded groups.
- Produce campaign materials for people living with a disability.
- Make a deliberate effort to reach more socially excluded groups in the BCC strategy, especially former commercial farm workers and displaced populations.
- Scale up the use of mass media campaigns, which are more cost-effective (\$5.65/1,000 people) and complement interpersonal communication. PSI/Z has to find ways to minimize the cost of reaching people through IPC. However, IPC is still an effective way of reaching people especially when complemented by aggressive mass media campaigns. IPC can also complement IEC materials in areas where there is no mass media coverage.

SPECIFIC RECOMMENDATIONS FOR SERVICE COMMUNICATIONS

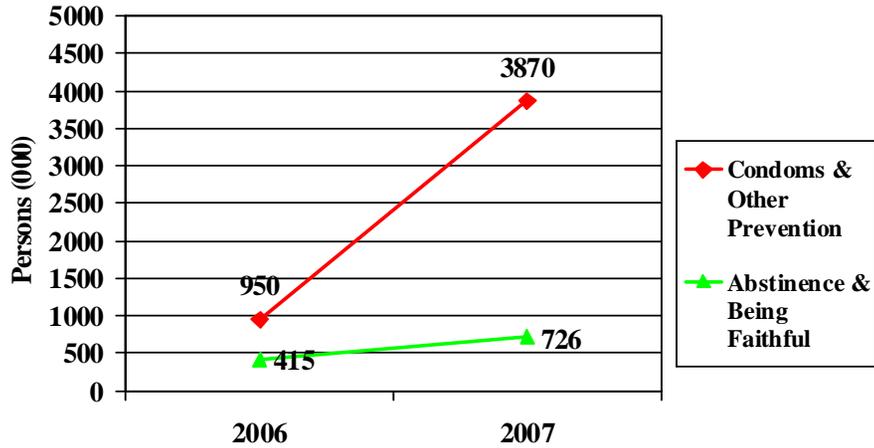
- Scale up campaigns on PMTCT services among the general population and socially excluded groups.
- Produce PMTCT, ART, and T&C services communication materials for people living with a disability and form strategic partnerships with organizations for people living with a disability.
- Aggressively market other key HIV and AIDS services, such as ART and T&C.
- Strengthen strategic partnerships with key stakeholders, especially those that work with socially excluded groups, such as former commercial farm workers and displaced people.
- Mix the mass media campaigns with interpersonal skills communication to complement each other.

SPECIFIC RECOMMENDATIONS FOR MARKETING COMMUNICATIONS

- Enhance the mix between mass media and interpersonal communication on New Start marketing.
- Include information on ART adherence and opportunistic infections in the New Life package.
- Conduct mass media campaigns on New Life and enhance the mix between mass media and IPC. The other option would be to completely drop New Life, transferring it to those with a competitive edge (the project seem to be struggling in providing post-test services).
- Target socially excluded groups, especially former farm workers and displaced people.
- Produce communication materials for people living with a disability and form strategic partnerships with organizations for them.
- Strengthen strategic partnerships with key stakeholders, especially those that work with socially excluded groups, such as former commercial farm workers and displaced people.

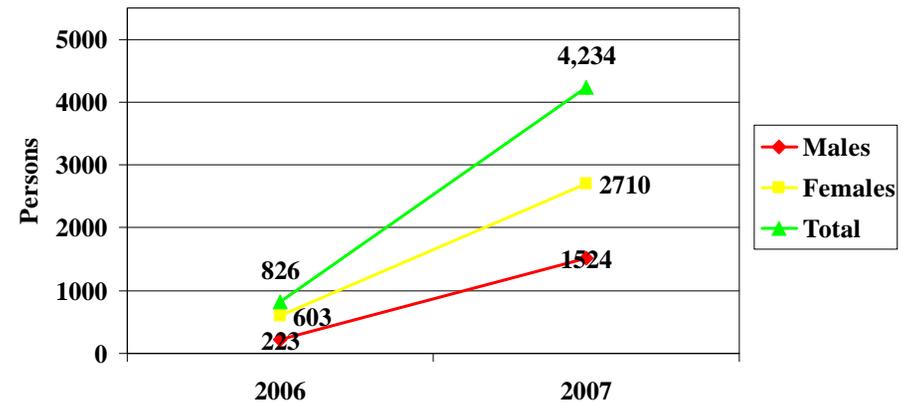
APPENDIX E. SELECTED GRAPHS OF DATA ANALYZED

Figure 15: Total Number (000) of Individuals Reached Through Mass Media by Message Content, 2006-2007



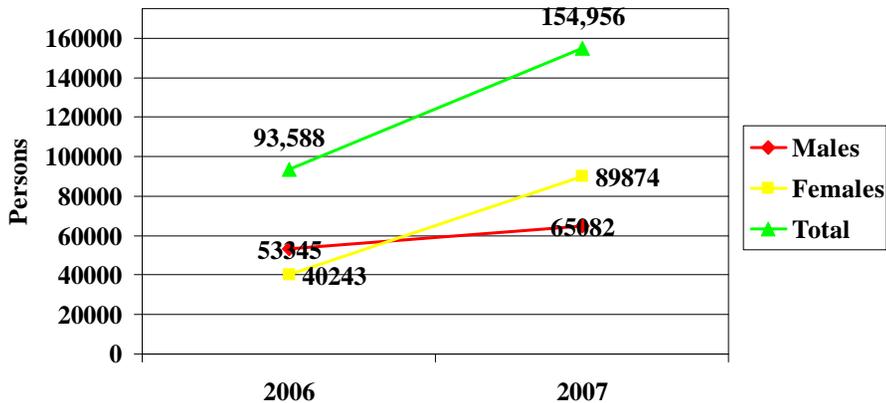
Source: PSI/Zimbabwe

Figure 16: Individuals Reached through IPC with Abstinence and Being Faithful Messages, 2006-2007



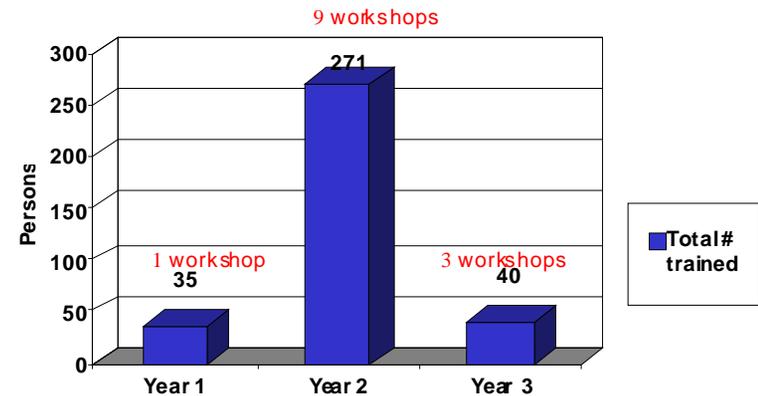
Source: PSI/Zimbabwe

Figure 17: Individuals Reached through IPC with Condom and Other Prevention Messages, 2006-2007



Source: PSI/Zimbabwe

Figure 18: Number of Persons Trained and Workshops Held for Strengthening Family Planning in PMTCT by the Zimbabwe HIV/AIDS Partnership Project



Source: Zimbabwe HIV/AIDS Partnership Project

APPENDIX F. DATA COLLECTION TOOLS

ZIMBABWE AIDS PARTNERSHIP PROJECT/BEHAVIOR CHANGE PROGRAM MID-TERM ASSESSMENT: INTERVIEW GUIDE FOR KEY INFORMANTS AND STAKEHOLDERS ZIMBABWE AIDS PARTNERSHIP PROJECT ASSESSMENT

Key informants and stakeholders for the assessment include several groups: Partnership Project staff (such as representatives of Abt Associates, Inc., PSI, FHI, Banyan Global, and other implementing partners); USAID staff; DFID staff; the Ministry of Health; other in-country partners involved in implementation; and, service providers.

General questions may be asked of any stakeholder or key informant, and responses may vary depending upon the individual's perspective or experience with the project. The general questions are primarily open-ended to allow the respondent to provide his or her own opinion of the emphasis and significance of project efforts. Some general questions designed for specific informant groups are identified as such below.

The nature and content of responses may suggest the need for additional probing questions to solicit the desired information. Consequently the interview guide also includes some possible probing questions that can be anticipated around the primary intermediate result areas of the project. Evaluation team members may also introduce additional questions to pursue interesting topics or examples provided by respondents or to solicit more specific information that would clarify any given response.

I. General Questions for Any Stakeholder Interview

1. What did you envision the Zimbabwe AIDS Partnership Project accomplishing? Were your expectations fulfilled? If not, why?
2. In your opinion, what is the greatest contribution made by the Zimbabwe AIDS Partnership Project to national HIV/AIDS needs?
3. How has the Zimbabwe AIDS Partnership Project contributed to the role the private sector now plays in addressing national HIV/AIDS needs?
4. What was the greatest challenge or constraint faced by the Zimbabwe AIDS Partnership Project? How was this challenge addressed?
5. If there is to be greater private sector contributions to HIV/AIDS services in the future, what will be the most important next steps?
6. If you were to begin the Zimbabwe AIDS Partnership Project anew today, would you do anything differently? If so, why?
7. How well has the Zimbabwe AIDS Partnership Project complemented and coordinated with the work of other players in the national HIV/AIDS effort?
8. What are the greatest challenges to sustaining the gains achieved in the Project thus far?
9. What activities within the Project do you think offer the greatest potential for the future or should be expanded?
10. In the future, what else could or should the private sector do to make further contribution to HIV/AIDS improvements in Zimbabwe?
11. Do you have any other comments or observations about the performance of the Zimbabwe AIDS Partnership Project?

II. Questions for Interviews with Those Involved with Implementation Areas or Service Delivery

A. Communications

1. How well has the Project's communication strategy tied into the national HIV/AIDS strategy?
2. How were research results used to both develop and determine the effectiveness of communication activities?
3. Do you consider the communications effort to be successful? If so, why?
4. What, if any, communication initiative did not produce the expected results and why?
5. How has the Project's behavior change communication (BCC) strategy addressed HIV/AIDS issues such as the adoption of safer sexual behavior or dispelling misconceptions that foster stigma and discrimination?
6. What have been the most successful examples of the BCC effort?
7. What were the greatest challenges or difficulties faced in the BCC work? Have these been overcome, and if so, how?
8. How has the Project strengthened HIV/AIDS communications undertaken in support of provider-initiated and generic voluntary T&C services; FP/PMTCT services; and ART services?
9. What progress has been made and what challenges have been encountered?
10. How has the project worked with advertising and media agencies to market and promote Project products and brands?
11. To what extent have these communication efforts contributed to brand recognition among consumers; willingness of the retailer or service site to feature products and services; and increased use of products/services?
12. What have been the greatest difficulties faced in service-oriented communications?

B. Delivery of Products and Service :

1. How has targeted research or strategic approaches to market segmentation guided public and private sector condom distribution?
2. In what ways did the Project work with the Technical Support Group (TSG) to identify and address gaps or overlaps in condom programming and distribution?
3. Are there any specific successes or lessons learned from the efforts to improve and expand the distribution of Project products?
4. What evidence exists that shows that the Project improved overall access to male and female condoms?
5. What has been the progress in product sales? How well are sales statistics linked to consumption within high-risk groups or target populations?
6. To what extent have the experiences of the Project led to opportunities to launch additional or new products that are compatible with the anticipated project results or could contribute positively to minimizing the HIV/AIDS epidemic in Zimbabwe?
7. How has the Project supported the MOHCW's transition to PICT?
8. Is the availability of client-initiated T&C widespread throughout the New Start Network and how successful has this effort been?
9. How well has the Project expanded the New Life post-test service network?
10. How has the Project helped the New Start network to offer client-initiated testing services, particularly for specific hard-to-reach client segments?

11. What has been the role of “centers of excellence” within the system of New Start sites?
12. How has franchising affected the participation of qualified NGOs, FBOs, and CBOs in expanding VCT services?
13. What has been the experience of quality assurance and sustainability of franchised services sites?

FACILITY/SITE VISIT CHECK LIST

1. Name of the Outlet/Service Delivery Site: _____

2. Location of the Site: _____

3. Type of Outlet:

Retail sales

Counseling

Testing

Referral

4. Type of Services Offered:

Product Sales

Products: _____

Testing

Counseling

PMTCT

FP

5. Client Volume

- a. Reported client volume (daily or weekly)
- b. Provider impressions of client preferences
- c. Reported client repeat use
- d. Predominant consumer category (A,B,D,E) served

6. Communication Materials Present

- a. Types of materials available
- b. Evidence of materials use
- c. Regularity of re-supply

7. Training Received

- a. Number of providers trained
- b. Availability of trained staff

8. Referral Linkages

- a. Knowledge of referral point
- b. Awareness of referral protocol

9. Product Supply

- a. Ease and regularity of re-supply
- b. Evidence of stock-outs?
- c. Price a barrier?

10. Supervision and Quality

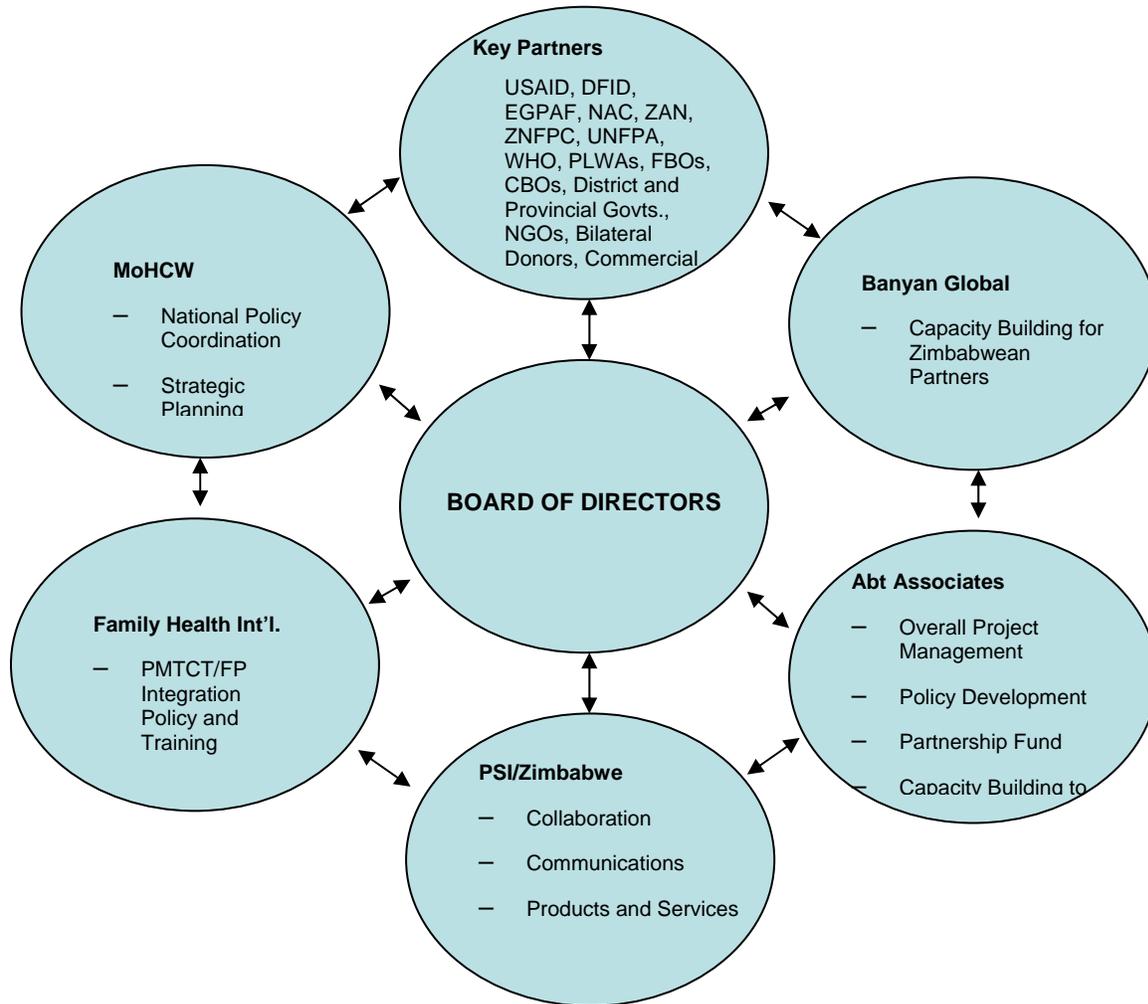
- a. Frequency of supervisor or detailer visits
- b. Awareness of national guidelines and quality standards
- c. Record keeping and reporting

APPENDIX G. SITES VISITED

- Murambinda M/Hospital
- Hopley Farm
- Epworth
- Chitungwiza
- Genesis New Start
- Mpilo Hospital
- Bambanani
- Matebeleland AIDS Council
- Nkulumane
- Bulawayo Area:
 - Alcohol sellers
 - Hairdresser shops
 - Pharmacy
 - Tuckshops
 - Grocery stores
 - General merchants

APPENDIX H. PARTNERSHIP PROJECT ORGANIZATION CHART

Zimbabwe HIV/AIDS Partnership Project



APPENDIX I. REFERENCES

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